FAMILY TOGETHERNESS: EXAMINING THE IMPACT OF PARENTAL PROCESSES, RELIGIOSITY, AND SPIRITUALITY AS PROTECTIVE FACTORS AGAINST RISKY SEXUAL BEHAVIORS AMONG AFRICAN AMERICAN ADOLESCENTS

By

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(Under the Direction of Pamela Orpinas)

ABSTRACT

African American adolescents are disproportionately affected by sexually transmitted infections. Positive familial factors such as consistent parental discipline, parental support, parental monitoring, and religious/spiritual beliefs have been found to influence adolescents' sexual behavior. This study examined the influence of parenting processes, religiosity, and spirituality on adolescents' sexual behaviors.

This mixed-method study consisted of two phases. In Phase 1, parents (n=75) and their adolescents (n=22) completed a survey measuring the study constructs. Participants were recruited from a major southeastern inner city. Bivariate analysis was performed to explore associations between parenting factors and behavioral outcomes. In phase 2, seven dyadic pairs (parents and adolescents) from the sample participated on one-on-one interviews. Bivariate analyses were used to identify significant associations between parenting factors, religious, and spirituality and sexual behavior outcomes. In addition, structured open coding was conducted to examined the value that adolescent placed on their family relationships and the influence of parents on sexual behavior.

Findings showed that parental perspective on adolescent sexual behavior is influenced by consistent discipline, increased parental support, and parental spirituality. Only half of the parents correctly identified their adolescents' sexual behaviors.

The results of this study expanded the understanding of determinants of positive parent-adolescent interactions and the contextual nature of the interactions as protective factors against sexual behaviors. Future studies should continue to investigate the importance of the parent-child relationship. In addition, interventions should find ways to integrate the entire family members, outside of mothers, to the sexual health education process.

INDEX WORDS: Sexual Health; Parent-Adolescent Relationship; Spirituality; Dyads; Parental Processes; HIV/STD Communication

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DEDICATION

In God is my salvation and my glory: the rock of my strength, and my refuge, is in God. Psalm 62:7

Wait on the LORD: be of good courage, and he shall strengthen thine heart: wait, I say, on the LORD. Psalm 27:14

And whatever you do, whether in word or deed, do it all in the name of the Lord Jesus, giving thanks to God the Father through him. Colossians 3:17

I dedicate my dissertation to my Father God, Lord Jesus Christ, my ever present helper the Holy Spirit. You oh God deserve all of the praise, glory, and honor for my dissertation. I could not imagine completing this journey without you leading me through the challenge times. Thank you for seeing me through this process. Without you none of this could have been possible.

To God be all the Glory! Amen.

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… and I pray that the fellowship of your faith may become effective through the knowledge of every good thing which is in you for Christ's sake. For I have come to have much joy and comfort in your love, because the hearts of the God's people have been refreshed through you, brother (and sister). Philemon 1:6-7

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CHAPTER 1

INTRODUCTION

The consequences of risky sexual behavior among adolescents and young adults are a public health concern. Unintended teenage pregnancies, sexually transmitted infections (STIs), and the acquisition of the Human Immunodeficiency Virus (HIV) are some of the morbidities and social problems that young people face today. While overall morbidity rates have decreased in the above areas over the last few decades. Adolescents (13-19 years old) and young adults (20-24 years old) are still at risk. While adolescents and young adults between the ages of 15 and 24 years represent only 25% of the sexually active population, they acquire nearly half of all new STIs (CDC, 2011; Satterwhite et al., 2013). A combination of cultural, biological, and behavioral factors increases the vulnerability of adolescents and young adults to STI acquisition (CDC, 2011; Satterwhite et al., 2013). Due to the health and social consequences that young people may experience, it is important that researchers understand what these factors are that increase acquisition. In addition, researchers need to be aware of what areas may need further research.

STI/HIV, African Americans, and Georgia

STI and HIV rates in adolescent populations

Sexually transmitted infections, when left untreated, can lead to serious health consequences such as sterilization, complications with future reproductive functions, and pelvic inflammatory disease (CDC, 2006; Weinstock, Berman, & Cates, 2004). Additionally, there may be a direct association between untreated STIs and the acquisition of HIV. Individuals who are

infected with an STI are three times more likely than an uninfected person to acquire HIV through sexual contact (Fleming & Wasserheit, 1999). STIs place individuals at a greater risk of HIV infection, and evidence suggests HIV is greatly affecting adolescents. The CDC (2011) estimates that adolescents and young adults aged 13-24 years account for 15% of reported HIV infections. In addition, half of all individuals with HIV acquired it during adolescence.

African Americans, STIs, and HIV

When investigating STI rates across the U.S. population, women and monitories are disproportionately affected. Young women are at greater risk of contracting an STI such as Chlamydia or gonorrhea during adolescence than they will be at any other time in their lives (CDC., 2005; Kasowitz et al., 2006). While African Americans are less than 13% of the population in the United States, they carry the greatest burden of disease for new HIV infections. The CDC estimated that 184,991 adult and adolescent HIV infections were diagnosed during 2001-2009. Among these diagnoses, 51% occurred among African Americans (CDC, 2013). Young African American women are often most heavily affected. African American females between the ages of 15-19 account for the highest concentration of gonorrhea of any age or ethnic group and made up at least two thirds of new AIDS diagnoses among women in 2009 (CDC, 2003, 2011). These statistics point to the importance of addressing the factors that increase the vulnerability of African Americans and young women to HIV.

HIV and the South

In addition to special populations, southern states are disproportionately affected by these health challenges, with steady increases of new infections in the southeastern part of the United States. Of new HIV/AIDS cases, 67% were reported from rural populations in the South, which is, Alabama, Georgia, Mississippi, Louisiana, and South and North Carolina. These regions have

the highest rates of death attributable to AIDS per 100,000 populations (Baumrind, 1966; Reif, Geonnotti, & Whetten, 2006). While rates of new infections have decreased nationwide, new infections are increasing in communities in southern areas. African Americans in southern rural regions make up 30% of the southern population, but comprise 57% of AIDS diagnoses (Baumrind, 1966; Reif et al., 2006; Sutton, Anthony, Vila, McLellan-Lemal, & Weidle, 2010). The HIV/AIDS rates in the rural South are complicated by poverty, lack of access to health care, limited educational resources, and other structural challenges (Sutton et al., 2010).

HIV/AIDS in Georgia

As of 2013, Georgia ranked fifth in the United States in the number of new diagnoses of HIV infections. The distribution of HIV diagnosis and people living with AIDS in Georgia is disproportionality high among the African American population. While African Americans are 30% of the population in Georgia, they comprise 55% of new HIV diagnoses and 74% of people living with AIDS (Georgia Division of Public Health, 2012). The main mode of transmission is through heterosexual contact. In terms of the adolescent population, while adults aged 30 and over make up a majority of the new HIV diagnoses there is significant increase during late adolescence and early adulthood. It is important to understand what may increase African American adolescents and young adults' risk prior to their entering adulthood. One way to investigate is to focus on the critical transition period between childhood and adulthood.

Another interesting trend in Georgia is the geographical concentration of HIV and people living with AIDS. Georgia has 18 public health districts; among those districts Fulton (43%) and DeKalb (45%) counties have the highest numbers and rates of HIV and AIDS (Georgia Division of Public Health, 2012). Additionally, two-thirds of people living with HIV in Georgia live in the

Atlanta metropolitan area. It is important to understand the environmental, social, and personal factors that are impacting these metro Atlanta communities.

Factors affecting risk behaviors

Sexual risk taking refers to behaviors that increase the risk of sexually transmitted infections and unintended pregnancies. In addition, risky sexual behaviors are activities related to sexuality that present an immediate physical or psychological health risk and may compromise future health outcomes as well as educational and occupational achievements (Barrow, Newman, & Douglas Jr, 2008).

Risk and protective factors

Behavioral scientists have identified factors that increase involvement in risk behaviors and factors that provide protection at personal, familial, peer, and community levels.

Studies have found that familial, social, and environmental factors can have positive and negative effects on risk behaviors. Adolescents who have less supervision and inconsistent discipline are more likely to report higher levels of risky behavior (Barnes & Farrell, 1992; Billioux, Sherman, & Latkin, 2012; DiClemente et al., 2001; Elaine, Carolyn, Loren, & Erika, 2003). Conversely, adolescents who have higher levels of social support, increased monitoring, and positive peer relationships were more likely to delay sexual debut and less likely to have multiple sex partners and engage in substance use (Ackard, Neumark-Sztainer, Story, & Perry, 2006; Baier & Wright, 2001; Barnes & Farrell, 1992; Baumrind, 1966; Hawes & Berkley-Patton, 2012). Since the late 1990s and the early 2000s research has moved toward identifying protective factors that can be adapted into interventions. Research suggests that interventions addressing factors outside of the individual may reduce risk behaviors (Baumrind, 1966; Chilcoat & Anthony, 1996; Jessor, Turbin, & Costa, 1998; Li, Stanton, & Feigelman, 2000; Mulhall, Stone,

& Stone, 1996; Sales, Milhausen, & DiClemente, 2006; Taylor-Seehafer & Rew, 2000). Two major factors have emerged from these studies: the impact of parents and the importance of religiosity and spirituality.

Family as a protective factor

In studying family factors, behavioral scientists have sought to understand the role of parents and familial environment on adolescents' adoption and maintenance of health risk and protective behaviors. Researchers have documented how behavior and the development of prosocial competencies or psychosocial maladjustment are influenced by parenting attitudes and practices (Kotchick & Forehand, 2002). Open displays of affection, active monitoring and involvement in children's activities, consistent but not harsh disciplinary actions, and positive reinforcement relate to high self-esteem, positive peer relationships, and less problematic behaviors (Baumrind, 1966; Brody & Flor, 1998; Kotchick & Forehand, 2002; G. R. Patterson, & Dishion, T. J., 1988). Parents are poised to influence and guide their children to behavioral choices. Because of the importance of family, it is necessary to examine, explore, and investigate how the structure and context of the parent-child relationship interact with adolescents' behavioral choices.

Religiosity and spirituality as a protective factor

In health research, religion and spirituality may reduce sexual risk behaviors of African American youth (Billioux et al., 2012; Hawes, 2012; Hawes & Berkley-Patton, 2012; Nunn et al., 2012). Religiosity is a multidimensional construct that can refer to the formal, outward, and institutional expression of the sacred (D. E. Hall, Meador, & Koenig, 2008; T. W. Hall, 2004; Hill & Pargament, 2008) and a person's behavior and attitudes toward religion (Marsiglia, Ayers, & Hoffman, 2012). Koenig (2001) defines religion as an organized system of beliefs, practices,

rituals, and symbols. Koenig (2001) continues that religion is designed to facilitate closeness to the sacred or transcendent (God, higher power, etc.) and foster an understanding of one's relationship and responsibility to others and the community. Religiosity has three dimensions: church involvement, value placed on church activities, and prescriptiveness (Kutter & McDermott, 1997). It has been measured by variables such as importance of religion to people, belief in God, frequency of prayer, or attendance to a church, synagogue, mosaic, or temple (Cotton et al., 2012). Spirituality has not been conceptualized as definitively as religion. Spirituality refers to an inner strength, interconnectedness (Dalmida, 2006; Dalmida, Holstad, Diiorio, & Laderman, 2009), internal, personal or private, and an emotional expression of the sacred (Cotton et al., 2012). In a sense, spirituality is a broader concept than religion. Spirituality centers on the acknowledgment of something greater than oneself. Spirituality encourages a personal quest for understanding life, meaning, and the relationship with the transcendent in a deeper and more meaningful way (Fry, 2000; Musgrave, Allen, & Allen, 2002; Seeman, Dubin, & Seeman, 2003; Sternthal, Williams, Musick, & Buck, 2012). In essence spirituality is the internal search for connectedness with the sacred and ones community through a mean-making process. Spirituality has been measured by reports of spiritual well-being, peace, connectedness, and coping (Cotton, McGrady, & Rosenthal, 2010). In this study, these two terms (religion and spirituality) are viewed as separate but interconnected concepts.

Religion and spirituality are important for the African American community. The Pew research forum stated that 79% of African Americans reported that religion is very important to their day-to-day lives (Life, 2009). In health-related research, it has been suggested that higher levels of religious and spiritual involvement modify the effects of stress and promote psychological well-being (Amick, 1995; Dalmida, 2006; Griffith, English, & Mayfield, 1980;

Griffith, Young, & Smith, 1984; Seeman et al., 2003). For sexual health, both religion and spirituality have been substantiated in the literature to be a protective factor among adolescents. Higher levels of spirituality were associated with less use of illegal drug substances (Hodge, Cardenas, & Montoya, 2001), later initiation of sex (Holder et al., 2000), lower levels of depression (Wright, Frost, & Wisecarver, 1993), lower frequency of sex and fewer sexual partners (B. C. Miller et al., 1997; J. L. Rodgers & Rowe, 1993; K. B. Rodgers, 1999).

While research on the impact of religion and spirituality on sexual health is scarce, very few studies regard the two as distinguishable but overlapping constructs. Religion and spirituality have been empirically investigated as either equated or separate constructs. In measuring the constructs, researchers differentiate between public (i.e., attending services, religious activities, etc.) and private (prayer, meditation, etc.) forms of religious practices, beliefs, or spirituality. However, little is known of the differential impact of public form and the private form of religion and spirituality on sexual health. One study has examined the difference between the two. In a study of African American adolescents, women who identified with higher levels of public religiosity (attending services and reading scripture) and private commitment (prayer, meditation, and valued beliefs) had a greater sense of self-efficacy, better communication with partners, an easier time refusing unsafe sex, and more likely use of condoms (2004). Future studies should investigate the difference between the public and private practice of faith for sexual health and behavior.

Statement of Problem

The substantial body of literature on the sexual behavior of adolescents and the consequences of risky sexual behavior clearly highlights the need to explore effective ways to address the risk. Investigating risky sexual behavior solely from a risk framework or from the

individual level provides limited insight into the challenges adolescents face. Researchers must explore external factors that mitigate risk. One way to achieve that goal is to use a social ecological framework to address pathways to protection. Although researchers have examined the protective factors from an ecological perspective, more research is needed to investigate social avenues of protection, which includes the influence of parents, religion, and spirituality. As stated earlier, parental influence and faith have been found to protect against risk. Therefore, it is important to gain a deeper understanding of how each of these factors encourages protection.

Gaps: The role of the family

Over the past three decades schools, community organizations, nonprofits, and faith-based organizations (FBOs) have embraced health programs. However, FBOs have primarily instituted health-related platforms addressing chronic disease, weight loss, and nutrition, while few engage family-centered sexual health interventions. Additionally, many sexual-health programs (FBO or non-FBO) for adolescents have minimal parental involvement.

Failure to sufficiently involve families (particularly the parents) in sexual health programs may be detrimental as they are key providers of encouragement, understanding, and reinforcement (Elaine et al., 2003). Parents are poised to influence and guide their children to behavioral choices. Because of the importance of family, it is necessary to understand how the structure and context of the parent-child relationship interact with adolescents' behavioral choices. Thus, FBOs seeking to create and implement effective programs would benefit from understanding the connection between parenting and desirable outcomes. To understand sexual exploration and involvement, it is important to investigate how adolescents perceive and value their parents and whether parents' involvement influences their risk choices. While investigations of risk factors have provided insight into risk-taking behaviors that lead to poor

health outcomes, few studies have investigated the association among parental support, monitoring, and discipline together as a protective factor. The research on parental monitoring has used mainly quantitative methods and has explored parental support, monitoring, and discipline as single constructs or with only two constructs combined (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Chilcoat & Anthony, 1996; Mulhall et al., 1996; C. A. Smith, 1997; Steinberg, 2001). In addition, current studies are investigating the cross section of the parenting practices and communication. One area that has been highlighted is direct conversation on sexual health. Future studies should examine parental influence from a qualitative perspective to further explore the context of the parent-child relationship.

Gaps: The role of religion and spirituality

The implications of church involvement for health have been heavily studied in the areas of mental health, chronic disease, and coping. Church involvement protects against depression, risky sexual involvement, and negative coping (Merrill, Salazar, & Gardner, 2001; Pardini, Plante, Sherman, & Stump, 2000). However, church involvement cannot be the sole measure of the influence of faith and religion on people's lives. Studies must use comprehensive measures that cover all aspects of faith. For spirituality, studies have found that spiritual practices like prayer act as a protective factor and a positive influence on health (Dalmida, 2006). However, little is known on how spirituality and religiosity interact with other key agents of change, like a parent, in an adolescent's life. It is important to understand how spirituality and religiosity interact to accomplish better sexual health research

Purpose of the Study

The purpose of this study was to investigate the influence of parenting factors, religiosity and spirituality on sexual risk reduction among adolescents. The study targeted youth and parents

who use faith and non-faith based community organizations in the Metro Atlanta area. Using a mixed method design the study was conducted in two phases. Phase 1 used quantitative methodology to investigate the association of parental behaviors, religiosity, and spirituality to risky sexual behaviors and sexual health communication. Phase 1 was investigated from the parents' perspective and from a smaller subset of paired data from the parent and the adolescent. Phase 2 used qualitative measures to examine the context of the parent-child relationship, risk behaviors, and sexual values.

The study had the following Phase 1specific aims which will be divided by the parent perspective and the dyadic response:

Quantitative Evaluation of Parent Perspective

1. To examine the association among parental reported parenting practices (consistent parental discipline, parental support and parental monitoring) and parental perceived adolescent's sexual behavior.

    H_1: Parents who report higher levels of parenting practices will report lower levels of perceived adolescent's sexual behavior.

2. To examine the association among parental religious and spiritual attitude (levels of religiosity and spirituality), parental perceived adolescent sexual behaviors, and parental sexual values and beliefs (support for delayed sexual activity/abstinence).

    H_2: There will be a negative association between parental religious and spiritual attitudes and perceived adolescent's sexual behavior. As the parents report higher levels of religious and spiritual attitudes the parents will also report lower levels of perceived adolescent sexual behavior.

H_3: There will be a positive association between parental religious and spiritual attitudes and parental sexual values and beliefs. As the parents report higher levels of religious and spiritual attitudes the parents will report higher levels of support for delayed sexual activity or abstinence (sexual values and beliefs).

3. To examine the association between parenting practices, religiosity, and spirituality and parent reported sexual health communication.

H_4: The parenting practices (consistent discipline, parental support, and parental monitoring) will be associated with high levels of sexual health communication.

H_5: There will be a negative association between parents that report higher levels of religiosity or spiritualty and the parents reported sexual health communication. As the parents levels of religiosity increases their level of sexual health communication will decrease.

Quantitative Evaluation of the Dyadic Responses

4. To examine the association between parenting practices, religiosity, and spirituality and adolescent reported sexual behavior and adolescent reported sexual health communication, and to examine the level of concordant responses between the parent and the adolescent on parenting practices, adolescent sexual behavior, and sexual health communication.

H_6: The parenting practices (consistent discipline, parental support, and parental monitoring) will be associated with lower reported levels of adolescent sexual behavior and high levels of sexual health communication.

H_5: There will be a negative association between parents who report higher levels of religiosity/spiritualty and adolescent sexual behavior and sexual health communication.

H_6: There will be discordance between parent and adolescent responses on parenting practices, adolescent sexual behavior, and sexual health communication.

5. To examine the association between parental sexual values and beliefs (support for delayed sexual activity or abstinence) and adolescent's beliefs and sexual values (support for delayed sexual activity/or abstinence).

H_6: There will be a positive association between parents who report higher levels of support for delayed sexual activity/or abstinence and adolescents who report higher levels of support for delayed sexual activity/or abstinence.

Qualitative Evaluation

Phase 2: To gather a deeper, contextual understanding of the parental-child relationship that reduces risk behaviors.

1. What values do adolescents and parents place on their family interactions and relationships? How do those values affect their views of the parent-child relationship? How is the parent-child relationship defined by both the parent and the child?
2. What sexual behaviors are parents supportive of (abstinence or protected sex) and why? How does the parents' own personal sexual history inform how they present sex to their adolescent? How does the parent's family of origin experience affect how they approach sexual health with their adolescent?
3. How do religion and spirituality inform the parental and the adolescent's decision making

in terms of sexual health? How are faith, spirituality, and religious practices discussed in the home?

Based on the combined results of the quantitative and qualitative phases, I will propose strategies for faith- and community-based organizations to address sexual health within their communities.

Public Health Implications

Insight from African-American families whose parenting practices encourage protection can be used in family-centered interventions and health campaigns targeting this population. Research has mainly investigated the risk factors that affect the African American community, but rarely addresses the protective factors among members of the community and the mechanics behind those factors. Future findings can aid public health professionals in implementing effective interventions to decrease STI and HIV disparities between African Americans and those of other races.

Definitions

Definitions of the terms and concepts central to this study have been presented throughout the chapter. To solidify the terms they are presented here as well.

African-American- defined for this study as a self-identified person native to the United States with African ancestry, which is often untraceable to a specific African country. This term is often used interchangeably with Black, which can also refer to a person of African ancestry native to another country.

Adolescent- defined for this study as youth ages 12 to 18 years of age

Risk factors- defined in this study as any circumstance that may increase risky behaviors

Protective factors- defined in this study as any circumstances that may promote healthy behaviors and decrease risky behaviors

Religion- the public practice of or engagement in religious activities. It has been measured by variables such as importance of religion, belief in God, frequency of prayer or attendance.

Spirituality- broader concept than religion that centers on the acknowledgment of something greater than oneself or of private behavior

CHAPTER 2

REVIEW OF THE LITERATURE

The family is the most influential and essential social context for adolescent behavior. Adolescents use their families as models, and different family processes (support, supervision, discipline) and factors such as religion and spirituality may influence their behaviors. The function of the family highlights how important it is to understand the relationship between parental processes and their children's health. This review of literature begins with an overview of adolescence and the parent-child relationships. Next, the review defines parental processes (parenting style, support, supervision, and discipline), religion, and spirituality. The review examines how the mediating factors of religion and spirituality may explain the relationship of parental processes to sexual risk behavior. Finally, the review considers the limitations of past measurement techniques of parental processes, religion, and spirituality and the need for sound theoretical frameworks for explaining adolescent sexual health and underscores the importance of qualitatively defining the mediating factors that influence protection against risk taking behaviors.

Adolescence

Adolescence has been defined as a time of great transitional changes that involve significant shifts in physical, emotional, social, and cognitive development (CDC, 2006). During this time, adolescents enter a unique period where they are no longer children, but have not yet gained all the skill sets needed to enter adulthood. To gain these skill sets, youth must question

and explore their identities. For decades developmental psychologists, and most recently behavioral scientists, have studied how adolescents make this transition, the importance of the transition, and how these shifts affect adolescent health and well-being (Barrow et al., 2008; Hallal, Victora, Azevedo, & Wells, 2006; Laird, Marrero, & Sentse, 2009; Moreira-Almeida, Lotufo Neto, & Koenig, 2006; Sales et al., 2006; Sinha, Cnaan, & Gelles, 2007). Erik Erikson (1994) a developmental psychologist, noted that during this period children are exploring their independence and developing a sense of self, apart from their parents. In the past, the transitional phase has been depicted as a time of "storm and stress" for parents and adolescents (Erikson, 1994), and in some cases this transitional turmoil has been generalized as a normative experience for adolescents. However, the storm and stress of adolescence cannot be generalized, and much of the rebellion or parental turmoil is neither bilateral nor predictable. Cicchetti and Rogosch (2002) found that the majority of adolescents cope successfully with the demands of development during this period with little or no dilemma. Erikson's studies (1980, 1994) have further bolstered this claim, noting that young people who receive proper encouragement and reinforcement will emerge from adolescence with a strong sense of self and a feeling of independence and control. From Erikson's perspective, during adolescence children are shifting their views of life, relationship, and identity to form a solid sense of autonomy.

As adolescents navigate through the changes in their bodies and cognitive development, they are also in the process of renegotiating their relationships with family, friends, and community (DeVore & Ginsburg, 2005). The hope is that the adolescents' worldviews will expand, and they will orient themselves as productive independent adults. With the discovery of independence and their navigation of self-identity, adolescents start to make substantial decisions about who they are and what choices they will make. Recent studies have shown that during this

time young people make pivotal choices about their health and develop attitudes and health practices that they will carry with them into adulthood (di Mauro, 1997). Examples of some of the choices young people make range from physical activity and substance use to sexuality. All of these choices have been considered normal experimentations of adult life that adolescents may experience. However, great concern arises for adolescents when these normal behaviors become destructive and detrimental to their health. Researchers have defined such processes as risk-taking behaviors.

Risk taking during adolescence

Risk is defined as a chance of loss, whereas risk-taking is often defined as engaging in behaviors that may have harmful consequences (B. C. Miller et al., 1997; Nunn et al., 2012). For the period of adolescence, a greater expression of risk-taking behaviors is typical. Unfortunately, many of the behaviors that youth may participate in put their health at risk and may eventually culminate in morbidity or mortality (Hawes, 2012; Payne, 2008). Annually, the CDC tracks adolescent risk behaviors with the Youth Risk Behavior Surveillance (YRBS). Through the YRBS the CDC has identified six risk behaviors that affect adolescents: unintentional injuries and violence; tobacco use; alcohol and substance use; sexual risk taking behaviors; obesity; and physical inactivity (CDC, 2011). While adolescents are at risk of experiencing any of the mentioned behaviors, for this study sexual risk taking is the main focus. As stated earlier adolescence is a pivotal time of habit formation. As adolescents transition to adulthood, their personal experiences during puberty may influence their procession into sexual maturity. It is important to explore the risk behaviors that encapsulate sexual risk-taking.

Sexual risk-taking has been proposed as a set of negative sexual behaviors (Donovan & McEwan, 1995). The behaviors include but are not solely exclusive to multiple sexual partners,

early onset of sexual intercourse, substance use before or during sex, and improper condom or contraceptive use. Research has focused on these behaviors and the resultant findings bolster the need for further research.

In the 2011 YRBS surveillance the CDC (2011) reported 47% of adolescents surveyed had vaginal sexual intercourse at least once and 33% of those surveyed were currently sexually active. Of the 33% who were currently sexually active, 60% had used a condom at last sexual intercourse while 17% reported using birth control pills prior to last sexual intercourse; however the remaining 13% had not used any form of contraceptive (CDC, 2011). Since the 1990s, there has been a slight decrease in sexual activity and an increase in protective behaviors among youth. However, young people are still engaging in risky sexual behaviors at an alarming rate. From the same YRBS survey, researchers found that of the currently sexually active adolescents, 15% had had sexual intercourse with four or more partners in their lifetimes and 23% had used alcohol or drugs before last sexual intercourse (CDC, 2011). These behaviors have detrimental personal and public health implications. Risky sexual behaviors can increase vulnerability to other STIs – notably (HIV/AIDS) – and they can lead to emotional distress and in rare cases even death.

Sexual activity within subgroups indicates that sexual activities vary by gender, race, ethnicity, and age. Older minority adolescents were more likely than others to have had sex (CDC, 2011)

Previous studies have identified psychosocial factors associated with risky sexual behavior among African American adolescents. Adolescents who report higher levels of depression, lower levels of self-esteem, and a sense of hopelessness are more likely to engage in early sexual activity and unprotected sex and to report higher levels of pregnancy (Bachanas et al., 2002; Keller et al., 1991; Miller-Johnson et al., 1999; C. A. Smith, 1997). Substance use is

also considered a risk factor. While under the influence of alcohol or drugs, adolescents are more likely to engage in unprotected sex and may become victims of unwanted sexual encounters (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2007; Fortenberry, 1995; Hodge et al., 2001; Huurre et al., 2010; Jones, Hussong, Manning, & Sterrett, 2008; Kiesner, Poulin, & Dishion, 2010; Leigh et al., 2008; Millstein et al., 1992). It is imperative to understand what factors influence risk and protective behaviors among adolescents.

A sizable body of literature has examined the relationship of parenting practices, adolescent development, and risk taking behaviors. In studying family factors, behavioral scientists have sought to understand the role of parents and familial environment on adolescents' adoption and maintenance of health risk and protective behaviors (DiClemente et al., 2001; Jessor et al., 1998). The literature has indicated that parenting processes are related to adolescent sexual risk-taking behaviors. The next section discusses how parental influence has evolved and the conceptualization of the parent-child relationship.

Parenting Processes

For over 60 years, developmental psychologists have examined parent-child interaction. Often this interaction is called the parent-child relationship and has been mostly studied in the form of attachment and parenting process. Bowlby (1969, 1973, 1980) was the first to examine how attachment could explain the parent-child relationship. Attachment has been defined as a life-span construct that states that children maintain attachment bonds to their parents across childhood and into adulthood (Bowlby, 1980). Often called "attachment theory," the basic premise is the importance of the quality of the relationship interactions and the ability of the child to see the parent as a secure base. The secure base or lack thereof can produce attachment patterns that can have far-reaching effects into childhood, adolescence, and adulthood. In

addition, in examining attachment, scholars have established that parenting practices are a key contributor to family well-being and relationships. Past studies have documented how behavior and the development of prosocial competencies or psychosocial maladjustment are influenced by parenting attitudes and practices (Kotchick & Forehand, 2002). The next sections define parenting practices and discuss specific parenting practices and the connection to sexual health.

Parenting practices

Parenting attitudes and practices are the actions or steps parents take with their children, and these interactions can often be viewed as positive or negative effects on the parent-child relationships. For the purpose of this study the attitudes and practices of parents are summed together as parental processes. Parenting styles, parental warmth (often times called support), communication, monitoring and supervision, and consistent discipline have all been parenting practices that have been studied for their effects on development and more recently health choices. The following sections discuss how each of these processes has been used in health-related research.

Parenting style

Parenting styles are one of the most salient and often studied predictors of adolescent behaviors (Abar, Carter, & Winsler, 2009). Parenting styles are a typology of parental characteristics blended by well-known researchers: Baumrind and the team of Maccoby and Martin. Baumrind (1978) first discussed parenting with the concept of parental control and formulated the classic parenting styles of authoritative, authoritarian, and permissive. Maccoby and Martin (1983) reassessed Baumrind's typology and added additional dimensions of warmth (parental acceptance, nurturance, and involvement) and behavioral control (demandingness, responding to need, and demanding positive behavior) (Baumrind, 1966; Kapungu, Holmbeck, &

Paikoff, 2006; Maccoby & Martin, 1983). Table 2.1 displays the definition and examples of each parenting style.

Table 2.1 Definition of Parenting Styles and Appropriate Examples

Style	Definition	Examples
Authoritative	Clear parameters for the adolescents behavior with reasonable and rational negotiation within set boundaries	These type of parents encourage autonomy and independence, they are responsive and warm, and use strict sanctions only when necessary
Authoritarian	Attempt to shape, control, and evaluate the behavior of adolescents through strict and absolute standards and use of punitive measures	Uses harsh rules, sets extreme and sometimes unattainable standards
Permissive	Encourage autonomy but provide little direction	These parents have minimal consequences for misbehavior
Neglectful	Low on warmth and attention to the adolescent	Very unresponsive to their children and these parents provide little to no guidance

Research on parent-child relationships has found consistently that authoritative parenting is associated with positive outcomes. The studies have found that open displays of affection, active monitoring and involvement in children's activities, consistent but not harsh disciplinary actions, and positive reinforcement relate to high self-esteem, positive peer relationships, and less problematic behaviors (Baumrind, 1978; Brody & Flor, 1998; Kotchick & Forehand, 2002; G. R. Patterson, & Dishion, T. J., 1988). The combination of warmth and control are believed to be the main contributors to the positive outcomes found in authoritative parenting. For health behaviors (particularly sexual health), numerous studies have shown that authoritative parenting is a moderator for risk-taking behavior in adolescents (Abar et al., 2009; Baumrind, 1966; Brody & Flor, 1998; Maccoby & Martin, 1983; Steinberg, 2001). The authoritative parenting style includes several key parental processes that have been used to measure the quality of parental

involvement. For the purpose of this study the main focus is on these processes: support and warmth, discipline and monitoring.

Parental support and warmth

In looking at health outcomes and prevention of risk behaviors, scholars believe that parents and families provide many of the factors that protect adolescents from engaging in risky behaviors. Parental warmth (often times called support), communication, monitoring and supervision, and consistent discipline are parenting practices that have been studied for their effects on development and more recently health choices (Barnes & Farrell, 1992; Li et al., 2000; K. B. Rodgers, 1999). Borawski et al. (2003) examined how two parenting practices, monitoring and trust, interact with several single domain factors of substance abuse, sexual activity, and protective actions for sex-related acts. Borawski and colleagues (2003) found that perceived parental monitoring, combined with trust, served as a significant protective factor against sexual activity, tobacco and marijuana use in females, and alcohol use in males. Additionally, less perceived parental monitoring is also associated with increased participation in antisocial activities, sexual risk taking, and increased substance abuse or use (Barrera et al., 2002; Borawski et al., 2003; Chilcoat & Anthony, 1996; DiClemente et al., 2001). Studies have found that increased parental warmth (connectedness and support) is associated with lower sexual risk taking, later age of first intercourse, consistency of contraceptive use, and lower substance use (Danziger, 1995; Jaccard, Dittus, & Gordon, 1996; Luster & Small, 1994; Scaramella, Conger, Simons, & Whitbeck, 1998). These findings highlight the importance of parental support as adolescents transition into adulthood because the more connected the youth feel the less likely they are to participate in risk-taking behaviors. In addition to parental warmth, two other parenting practices have extensively been researched: parental supervision and discipline. The

next two sections define supervision and discipline and highlight the methodological studies that have investigated the relationship of the two with risky behavior.

Parental supervision: Defining supervision

Parents are often the first line of authority for children. The parent is not only the provider, but also is in charge of modeling positive behavior and setting rules. As children mature into adolescents and search for their own autonomy, parents adjust their supervision and authority to allow for more freedom and independent decision making by the adolescent (Dishion & McMahon, 1998). Parents start to move away from dictating every facet of their child's life and instead focus on reducing the impact of negative behaviors. As discussed before, one of the key protective factors in the familial network is parental monitoring, better known as parental supervision. Parental supervision is often combined with the overall definition of parental monitoring. Parental monitoring has been conceptualized as a set of correlated parenting behaviors that involve the parents' knowledge of their child's whereabouts, activities, and friends. Monitoring also consists of open lines of communication between parents and child (Borawski et al., 2003; Dishion & McMahon, 1998; Jacobson & Crockett, 2000).

As Kerr, Stattin, and Burk (2010) have noted, although most researchers conceptualize parental monitoring as a deliberate action on the part of the parents to track their child's whereabouts, most researchers *operationalize* the construct differently: "the measures that are most commonly used do not address what parents do, only what they know" (p. 366). Research indicates that parents generally believe they are knowledgeable about their adolescent's activities, although their knowledge varies across categories of activity. Research has suggested that open lines of communication and knowledge of an adolescent's whereabouts are important in reducing high-risk behaviors (Barnes & Farrell, 1992; Borawski et al., 2003; Chilcoat &

Anthony, 1996; DiClemente et al., 2001; Dishion & Loeber, 1985; Li et al., 2000; K. B. Rodgers, 1999).

To summarize, parental supervision has been defined in several different research studies as knowledge, communication, and action. Monitoring, in this sense, is a systematic measure of the parents' knowing where their children are and whom they are with, and, in a sense, is also the ability of the parents' rules to supersede every action, whether the parent is present or not (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006). Because of the nature of most studies, monitoring has been assessed from the adolescent's perspective in most health-related studies. Thus, parental monitoring has been consistently called perceived parental monitoring. To understand how supervision is considered a protective factor against risky behavior, particularly high-risk sexual behavior, a closer look at past studies is necessary.

Parental supervision and risk-taking behavior

Several studies throughout the mid-1990s looked at the interaction of levels of parental monitoring and adolescents' involvement in risk-taking behaviors (Baker et al., 1999; Flannery, Williams, & Vazsonyi, 1999; Kim, Hetherington, & Reiss, 1999; Spencer, Dupree, & Swanson, 1996). Most of the research on perceived parental monitoring has investigated the role of parenting practices in health risk-taking behaviors among middle-class, white adolescents. Borawski et al. (2003) examined how two parenting practices, monitoring and trust, interact and affect substance abuse, sexual activity, and protective actions for sex-related acts. Borawski and colleagues (2003) found that perceived parental monitoring, combined with trust, served as a significant protective factor against sexual activity, tobacco and marijuana use in females, and alcohol use in males. Other studies have also shown that less perceived parental monitoring is

associated with increased participation in antisocial activities, sexual risk taking, and increased substance abuse or use (Chilcoat & Anthony, 1996; Mulhall et al., 1996; Steinberg, 2001).

The studies completed in the last decade have substantiated the influence of parenting practices on risk behavior. However, these studies have limitations. As stated before, the majorities have been conducted in white middle-class communities and are either from the child or the parents' perspective. This is a serious limitation for application to other adolescents because it is well known that urban black female adolescents are at higher risk of engaging in risky behavior such as substance and alcohol use and subsequently acquiring STIs and HIV. The following section addresses research on parental supervision in black communities; however, few studies have assessed the parent's and child's perspectives together.

Parental supervision among urban African-American female adolescents

Baker and colleagues (1999) studied the independent effects of perceived parental monitoring on substance use and sexual behaviors. Adolescent females at an urban-based clinic rated the extent to which they were directly and indirectly monitored by their parents through a survey. Of 174 females sampled, 41% were classified as being sexually experienced. Researchers found that direct parental monitoring when with peers was associated with less use of alcohol and cigarettes. In a similar study, DiClemente and colleagues (2001) examined the influence of less perceived parental monitoring on a range of adolescent health risk behaviors and outcomes. Recruiting from an urban family clinic, researchers surveyed 522 black females between the ages of 14 and 18 years from low-income neighborhoods. DiClemente et al. (2001) found consistent patterns of health risk behaviors and biological outcomes (STI results) to be associated with less perceived parental monitoring. Adolescents perceiving less parental monitoring were more likely to be engaging in sexually risky behaviors(less condom use,

multiple sex partners) and were more likely to report a history of substance use, including alcohol. The findings demonstrate a consistent pattern of health risk behaviors and adverse biological outcomes associated with less perceived parental monitoring.

Other studies have sought to understand parental supervision and risk behaviors. Using sexually active black females between the ages 14 to 19 years from an urban health clinic, Bettinger et al. (2004) studied how the level of perceived parental supervision and communications were associated with reduced gonorrhea and Chlamydia incidence. They found a link between parental supervision and disease acquisition. When adjusted for age and baseline STIs infection, higher levels of perceived parental supervision were associated with reduced infection (Bettinger et al., 2004). This link supports the body of evidence indicating parental supervision can result in lower STI rates in urban populations.

Though evidence suggests parental supervision is one protective factor for reducing sexually risky behavior among adolescents, studies also show that parental supervision is not the only protective factor. In Romer et al.'s (1994) study on high-risk behavior among African-American youths aged 9 to 15, he found that parental monitoring was only a protective factor for early sexual initiation and future sexual encounters or condom use. These findings suggest that parental monitoring is less effective with more established sexual behaviors. Romer et al.'s results underscore that monitoring alone may be insufficient to protect against risk-taking behaviors, but instead should be combined with other parenting practices like communication and discipline. Communication has been found to be a highly effective protective factor, along with discipline and supervision. While it is an effective protective factor, for this study the focus is only on supervision and discipline. Communication will be measured as a covariate factor. However, the researcher is most interested in exploring concepts that have not extensively been

examined as a combined factor. The following sections examine how discipline is a protective factor.

Discipline

Discipline has been defined as the methods parents use to discourage inappropriate behavior and gain compliance from children (Locke & Prinz, 2002). Oftentimes discipline is thought to encompass negative or harsh actions, but, in fact, discipline involves several different behaviors like inductive reasoning, negotiation, or coercion. For this study, the focus is on the techniques that parents use to implement discipline. Discipline behaviors can be categorized into two techniques: effective or less effective behaviors. Lisa Locke and colleague (2002), a parenting research expert, differentiates effective from ineffective discipline practices:

> Examples of discipline practices deemed more effective include use of clear rules and requests, direct reinforcement of appropriate behavior incompatible with the undesirable behavior (DRO), time out from a reinforcing environment, brief withdrawal of privileges, and application of reasoning and induction. Examples of discipline practices deemed ineffective include use of unclear rules and requests, excessive attention (social reinforcement) for inappropriate behaviors, use of harsh physical punishment without sufficient reinforcement for appropriate behaviors, and frequent reliance on coercion. (p. 887)

Research has shown that discipline actions (time-outs, spanking, etc.) are most effective for younger children and ineffective for adolescents (Baumrind, 1978; Kotchick & Forehand, 2002; Locke & Prinz, 2002). However, the broader construct of discipline styles has a greater impact with older youth (Locke, 2002). Discipline style has been conceptualized as consistent, inconsistent, strict, or permissive. The majority of parents use a combination of styles and

practices based on situational demands (Grusec & Goodnow, 1994). However, the bulk of the research on discipline styles has been in child psychology; behavioral scientists have only begun to look at styles' effect on health risk behaviors.

Parenting styles, discipline and risk-taking behaviors

Discipline has rarely been researched as a single construct in the health field. Instead, it has been lumped with a group of parenting practices called parenting styles. Baumrind (1978) typologies of authoritarian, authoritative, and permissive parenting have been studied extensively. Early studies found that adolescents from families who were high on authoritative parenting fared better in academics across all ethnic groups (DeVore & Ginsburg, 2005; Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987). Authoritative parenting has been a positive factor for risk behaviors.

Pittman and Chase-Lansdale (2001) studied parenting practices on risk behavior in a sample of lower social economic status (SES) urban girls. The authors found that girls whose mothers were viewed as having authoritative parenting style were less likely to have ever had sex, been pregnant, or had problem behaviors. More studies need to be done that examine the relationship of parenting styles on sexual behavior. In addition, because discipline styles can affect children well into their teen years, further research is needed examining discipline as a single construct outside of parenting styles. In particular, what are the parenting techniques (effective or less effective) being used and what style is present (consistent, inconsistent, strict, or permissive)? In addition, researchers should investigate other avenues of protection that may involve the boarder ecological environment of the adolescent.

One area that has been investigated is the impact of religion and spirituality on sexual health. The next section discusses how religion and spiritualty have been investigated in the health literature and their connection to sexual health.

Religion and Spirituality

A review of the literature on parental influence on adolescent behavior would be incomplete without addressing the importance of spirituality and religion in the lives of families and their offspring. As stated in Chapter One, these factors play an important role as a mechanism of the parent-child relationship and as a moderator for risk behaviors. The next section discusses spirituality and religion as a protective factor in maintaining health, trends of faith in the United States, the empirical data that supports these factors as moderators, and the theoretical implications for sexual health and future research and public health interventions.

Religion and spirituality extended definitions

Religion and spirituality are perhaps the most complex constructs in the human continuum of belief associations, behaviors, and attitudes. Nearly every culture has a set of religious beliefs that set the standard for socialization(Arnett, 2002). Authors argue that the common standards for socialization are self-regulation, role preparations, and providing a source of meaning (Arnett, 2002). Religion and spirituality play a key role in the structure and foundation of society by providing a guide post for many who may affiliate with a particular religion or spirituality. For example in some societies religion may inform the very laws that govern the society, dictating how persons may interact with others and how they engage with the world. Whereas, in other communities religion and spirituality may be used as guide posts for personal decision making instead of being markers of societal governance. Regardless of their usage, religion and spiritualty may play a key role in decision making for various individuals.

In many of the disciplines, religion and spirituality have been defined as interchangeable. However, in the past decades various authors have argued that religion and spirituality should be seen as separate and contrasting concepts (H. Koenig, King, & Carson, 2012; H. G. Koenig, McCullough, & Larson, 2004; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). In Koenig and colleagues' definition, religion is more community-focused, formal, organized, and behaviorally oriented whereas spirituality is more individualistic, less visible, more subjective, less formal, less systematic, and more emotionally oriented (H. Koenig et al., 2012; H. G. Koenig et al., 2004; Pargament et al., 2004). In the scientific literature religion is often called religiosity. Religiosity has been defined as a formal, written doctrine, an outward community-level adherence to sacred ceremonies and rituals such as church, temple, or mosque attendance (Daly, 2005; Hill & Pargament, 2008; Taylor, Chatters, & Jackson, 2007; Taylor, Chatters, & Levin, 2004; Tisdell, 2003; Triplett, 2012). In contrast, spirituality has been defined with an emphasis on the individual and not the outward religious activity. Spirituality definitions emphasize individual, private senses of connectedness and an increased search for the sacred (Hill & Pargament, 2008).

Spirituality captures the personal connection that individuals have with a religious experience. Tisdell's (2003) definition extends spirituality to encompass the meaning-making process. During this process spirituality may facilitate how people construct knowledge, process life experience, resolve dilemmas, and nurture personal resilience (Tisdell, 2003; Triplett, 2012). When studying the adolescent population, it is particularly important to assess the impact of religion and spirituality on identity formation. Developmental psychologists have investigated how faith and spiritual development evolve in adolescence (Fowler & Dell, 2006; Kessler, 2000).

In Fowler's spiritual and faith development model seven stages of development are discussed. Table 2.2 displays Fowler's stages of development.

Table 2.2 James Fowler's Seven Stages of Faith Development over the Lifespan

Stage	Age	Explanation
Pre-stage: undifferentiated	0 – 2 years	Develops trust and mutuality with the one providing care. In this phase the quality of interactions underlies the development of faith.
Stage 1: Intuitive-Projective	3 – 7 years	In this stage imagination is formed and the child becomes aware of cultural expectations and values. Symbols are important part of faith development during this stage.
Stage 2: Mythic-Literal	8 – 11 years	During this stage children move beyond awareness to acceptance and adopt cultural rules, expectations, and values. However they may not engage in critical reflection on their beliefs. During this stage the foundation of faith and development is greatly forming.
Stage 3: Synthetic-Conventional	12 – adulthood	During this stage adolescents may conform to religious authority. This stage is marked by the desire to form their own personal relationships and identity. There is tension due to the need for independence and the desire to confirm.
Stage 4: Individuative-Reflective	Mid 20's to late 30's	This stage is marked with angst and struggle. Personal responsibility is developed and there may be an openness to address conflicts in one's beliefs.
Stage 5: Conjunctive faith & Stage 6: Universalizing	Rarely reached	Self-actualization

Ultimately, Fowler states that it is during the time of adolescence when beliefs are defined by personal relationships and increased abstract thinking (Fowler, 1988, 1991; Fowler & Dell, 2006). While there are debates about the testability of Fowler's faith model, there are merits to addressing faith from a developmental stance. Understanding how faith development coincides with adolescent development may help explain the decisions that adolescents make. Due to these developmental shifts it is important to examine the impact of religiosity and spirituality on adolescence and risk taking behaviors.

Religion and spirituality in the United States

In the last decade the measurement of spirituality has gained increased interest due to the shifting attitudes in the United States toward religion and religious expression. A decline in religious identification occurred between 1990 and the 2000s (Kosmin, Mayer, & Keysar, 2001). In the late 1990s and early 2000s, 92% of Americans surveyed were affiliated with a religion, and 71% were members of a church or synagogue (Worthington Jr & Sandage, 2001; Worthington Jr et al., 2003). However, in a study done in 2010 researchers found that the fastest growing religious category in the United States is the nonaffiliated category (R. Putnam & D. Campbell, 2010; R. D. Putnam & D. E. Campbell, 2010).

In another study conducted by the Pew Research Center's Religion and Public Life Project, 35,000 adults were interviewed on religion in the United States (Lugo et al., 2012). This survey found that the 18-29 age blocks comprised the largest block of nonaffiliated people. Interestingly, in other studies nonaffiliated individuals still maintained traditional beliefs (Burke, Van Olphen, Eliason, Howell, & Gonzalez, 2012; Pond, Smith, & Clement, 2010). This pattern was supported with the National Longitudinal Study of Adolescent Health (ADD health). The AD health study that found religion, across all sampled populations, was still important despite the decline in participation. While the data indicate disconnects or gaps between perceived importance of religion versus actual religious practice, research states that a growing number of adolescents and young adults identify with being spiritual over being religious (C. L. Grossman, 2010). In studying the impact of religion and spirituality on well-being and health, it may be important to examine the concepts separately.

Religion and spirituality in the African American community

Continually in research it has been stated that the African American population is greatly connected with and influenced by spiritual and religious involvement with the sacred (Braithwaite, Taylor, & Treadwell, 2009; Taylor et al., 2004). In one study African Americans reported that religion is very important at a 79% rate compared to 59% of the general population (Lugo et al., 2012). In this study it was found that African Americans, regardless of their level of involvement, valued religion in their lives. Historically speaking, the Black church has been seen as an established and influential cornerstone within the African American community (Berkley-Patton, Moore, Hawes, Thompson, & Bohn, 2012; Lincoln & Mamiya, 1990; Mattis, 2002; Pattillo-McCoy, 1998). The church has served not only as a facilitator of religious and spiritual experience, but also as a historically rooted gathering place. The Black church has served various ages and socioeconomic statuses, and it provides a unique venue for growth through prayer, worship, and reading scripture (Berkley-Patton et al., 2012; Lincoln & Mamiya, 1990; Mattis, 2002; Pattillo-McCoy, 1998). Given the importance of faith and religious practices within this population, it is important to understand the influence faith may have on the everyday experience of African Americans. Do the principles and messages received in church play a vital role in shaping behavior or decision making in the individual's life? Can the religious experience influence the person's perceived susceptibility to disease such as STI's and HIV? Some studies have examined this at length and have found that both public and private expressions of faith can regulate behaviors, indicate values and norms, impact social environments and networks, and potentially protect followers from risk behaviors (Taylor, Chatters & Levin, 2004; Braithwaite, Taylor & Treadwell, 2001). The next section discusses how religion and spirituality have played a pivotal role in health behaviors.

Religion and spirituality as a protective factor

The influence of religion and spirituality on adolescent outcome behaviors has been examined in various studies across disciplines. For adolescent health a majority of the studies conducted has focused solely on the impact of religiosity on health outcomes. For general disease and medical procedures researchers have found various patterns. Previous studies have indicated that increased religiosity is associated with improved recovery time from a major illness or procedure (Chatters, 2000). Religiosity has also been associated with lowering stress levels (Chatters, 2000) and reduction of depressive symptoms (Molock & Barksdale, 2013). The factors within religiosity may provide positive outlooks to diseases and in a sense provide a buffer that improves recovery time for some diseases. Outside of general disease, studies have examined the impact of religiosity on various risk-taking behaviors. Burke et al. (2012) administered an online survey on alcohol and drugs to 2,312 college students and found religiosity as a protective factor. Religiosity was associated with lower alcohol use, lower tobacco and marijuana use, and less episodic drinking. While Burke's study supported religiosity as a protective factor, there were conflicting findings for spirituality. When measuring spirituality as separate from religion, students who self-identified as spiritual were found to have only less episodic drinking (Burke et al., 2012). The findings from the Burke study highlight the importance of measuring religion and spirituality as separate constructs.

Repeatedly in the literature studies have found that highly religious African American adolescents tend to engage in fewer risky sexual behaviors then non-religious adolescents (Bachanas et al., 2002; Ball, Armistead, & Austin, 2003; Barry, Padilla-Walker, & Nelson, 2012; Barton, Snider, Vazsonyi, & Cox, 2012; Burke et al., 2012; L. Miller, Davies, & Greenwald, 2000; L. Miller & Gur, 2002). While religiosity has been studied at length as a protective factor, very few studies have examined the impact of spirituality as a single construct on health

behaviors among African American adolescents. The studies that have examined the construct have investigated spirituality in conjunction with an overall spiritual well-being. In T. L. Davis, Kerr, and Kurpius (2003) study they operationally defined spiritual well-being as faith, meaning, and purpose as a way to encompass all aspects of spirituality. The authors used a cross-sectional survey to measure 45 adolescents' spiritual well-being and anxiety. By using the State-Trait Anxiety Inventory, the Spiritual Well-Being Scale, and the revised Allport-Ross Religious Orientation Scale, the researchers were able to capture both religiosity and spirituality. The researchers found that the higher the spiritual well-being, existential well-being, religious well-being, and intrinsic religious orientation were among males, the lower the anxiety (T. L. Davis et al., 2003). Among females they found that only lower existential well-being was associated with lower anxiety among females (T. L. Davis et al., 2003). Overall the researchers found that spiritual well-being and female gender were the best predictors of anxiety from the variables studied (T. L. Davis et al., 2003). The findings from this seem to contradict each other in the positive impact of spirituality on health. It could be interrupted that the form of measurement should have addressed each dimension of religion and spirituality. This study highlights the importance of using a multidimensional measure of religiosity and spirituality. Another approach that could be used to fully address religiosity and spirituality is in qualitative research.

Qualitative designs and multidimensional measures

Recently other studies have embraced multidimensional measures and coupling the measures with qualitative research designs. As stated earlier capturing the impact of spirituality on health behaviors has been difficult because of the challenges in defining spirituality. It may be difficult to generalize findings to the larger population because of the vague nature of the concept. Yet, researchers have made strides in using quantitative measures to capture the

construct of spirituality. However, the contextual dimensions may be lost if solely using a quantitative measure. Studies in the past feature in depth interviewing, focus groups, and case studies to further investigate the impact of spirituality on health behaviors. One researcher interviewed 42 white adolescents to examine the impact of religion and spirituality on coping with grief and loss. The major themes that emerged were the sense of meaning and the need for spiritual growth. Oltjenbruns (1999) found that the stronger the connection adolescents had with their faith, the more they used that faith as a source of coping because it helped make meaning out of their grief. While coping can be captured using a survey, the richness and contextual nature of spirituality may have been lost. There are few studies that quantitatively and qualitatively explore the concepts of faith, sexual health, and risk taking behaviors among African American adolescents. Using both methodologies will give researchers the opportunity to capture the data in a rich and full capacity. Using a mixed methods design to capture the key concepts of parental process, religiosity, and spirituality would be well suited to address some of the methodology inconsistencies. There is a great need to explore these variables from various design perspectives.

Parenting Processes, Religiosity, and Spirituality

Throughout adolescents' lifetimes they will be exposed to various influences (peers, media, etc.), but parents may serve as the most important mediator of behavior and social norms. Among other values, adolescents develop their religious and spiritual beliefs within the family context (Landor, Simons, Simons, Brody, & Gibbons, 2011). The proposed research study seeks to explore the connection between parenting processes, religiosity, and spirituality and ultimately answer this question: Do parents use religion and spirituality to transfer their values to adolescents and in essence create a type of social control within their families? Few studies have

examined the influence of the parents' own religiosity on adolescent sexual risk behavior. Myers (1996) examined the intergenerational transfer of family values among over 400 people. He found that parental religiosity was the strongest influence on the religiosity of their children. T. B. Smith, McCullough, and Poll (2003) found that parental religiosity has a significant impact on the adolescents' religious attachment. As stated earlier, research has found that adolescent religiosity can act as a protective factor against risk-taking behaviors. If the parent can influence the child through various parenting processes, how does the parents' own religiosity influence the adolescents? In turn how does the spiritual influence from the parent affect the adolescents' risk behaviors?

Gaps in the literature

To summarize, adolescence is a critical time of habit formation, and some of the choices that adolescents make can lead to detrimental consequences. Several factors are involved in developing risk and protecting adolescents, particularly family interactions and the role of religion and spirituality. While there has been extensive research in the area of parenting processes, religion, and spirituality, there are still gaps in the literature. First, it is still unclear how support, supervision, and discipline interact to protect African American families. Parental involvement, supervision, and monitoring are key factors that influence adolescent behavior. However studies are missing other areas of parenting, similar to parenting style and extending beyond the knowledge of the child's whereabouts. As stated in Chapter One, the majority of parental supervision studies have used quantitative measures. Such measures do not adequately represent parents' and adolescents' perceptions of supervision. In addition the measures cannot expound upon the contextual aspects of the parent-child relationship. Additional limitations in the literature include the lack of parenting process studies on risk behavior with African

American adolescents and parental influence regarding religion and spirituality. There are also limitations in how religion and spirituality are measured. Few studies have examined how the parent's beliefs influence the child's risk-taking behavior. In addition few studies capture both the parent's and the child's perceptions of their relationship. Finally, as stated throughout Chapters One and Two there is an opportunity to increase understanding of the risk and protective factors adolescents face leading to sexual risk taking by investigating these topics through a qualitative and quantitative lens. Thus, this study proposes a social ecological framework as an appropriate method for capturing both qualitative and quantitative data.

In light of these research implications, this study will investigate the relation of family environment, particularly parental support, monitoring, and discipline, with adolescent risk-taking behaviors. In addition, this study will examine the impact of religiosity and spirituality on sexual risk-taking behaviors.

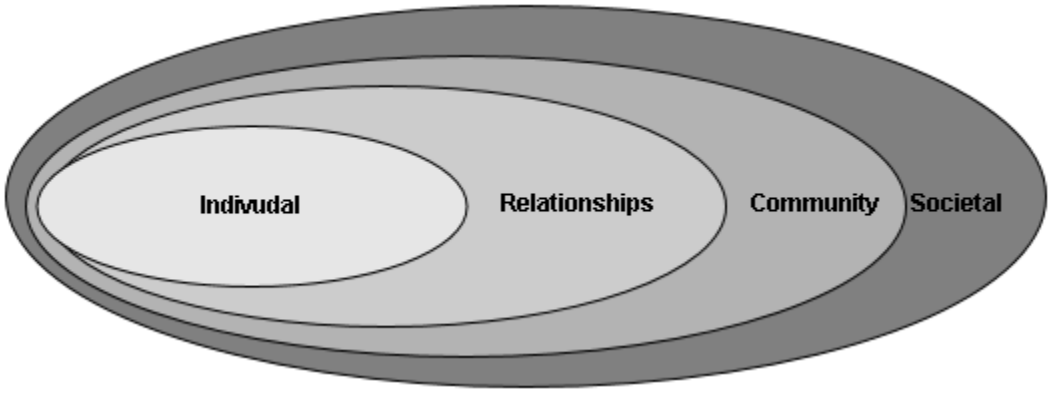
Conceptual Model

The theoretical base of this study is the social ecological model that was adapted from Bronfenbrenner's bioecological model. The Bronfenbrenner's bioecological model suggests that environmental and contextual systems of relationships influence individuals' behavior (Bronfenbrenner, 1979). According to the bioecological model, human development exists within certain ecological systems with levels that are interconnected. Within this model, the individual is the center of the system and the corresponding levels consist of familial, peer, societal, and cultural influences. Bioecological model has been the framework for social ecological model. The CDC developed an adapted four level model that consider the inter-play of the individual, relationships, community, and societal factors (Dahlberg & Krug, 2002).

The model recognizes that influences on behaviors interact across different levels and so there are likely to be multiple risk factors and opportunities for improved health at each level that work together to change behavior.

For this study, the adapted CDC social ecological model was used because of the focus of on the transactional relationship between the parent and the child. Figure 2.1 displays a graphical representation of the model.

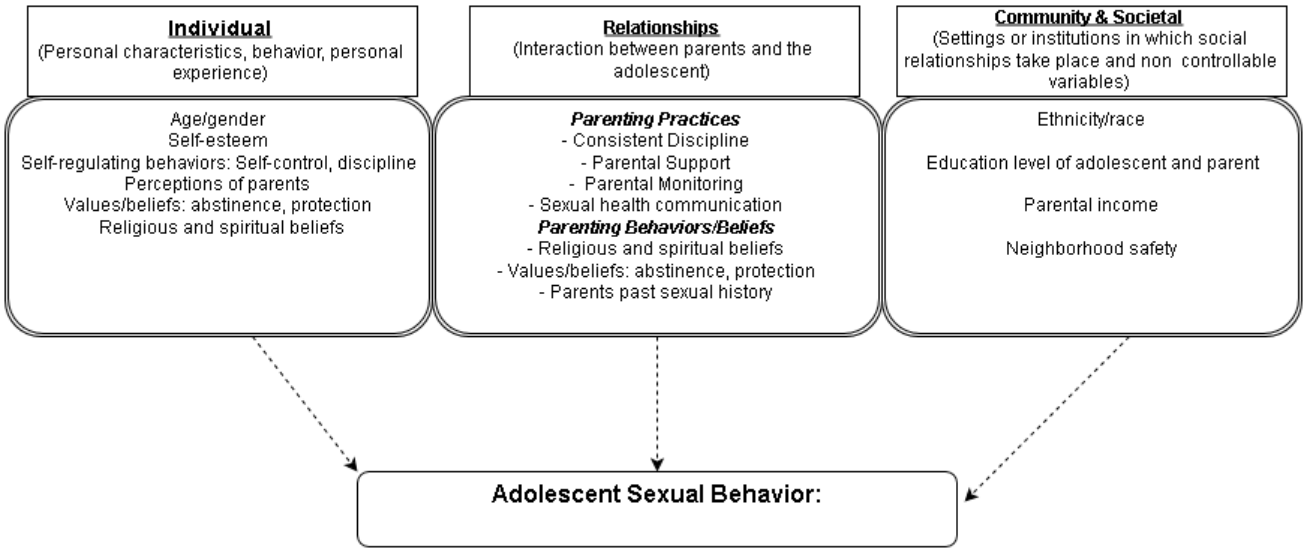
Figure 2.1 Display of the CDC Adapted Social Ecological Model



The first level of the model is the individual. On the individual level, for this study, would be the psychological characteristics and behaviors of the individual. The next level in the model is the interaction of relationships. For this study, the interactions of the family on the adolescent's behaviors were studied. The larger context in which the behaviors are embedded would be the community. The last level of the model is the societal level, which has the least direct effect on the adolescent because it is the cultural or societal milieu at large. This milieu may include attitudes, practices, and convictions shared within the society. Thus, to understand high-risk sexual behaviors and protective factors among adolescents, it is important to examine the actions of adolescents within the context of their physical and social environments (DiClemente et al., 2004). The social ecological model has been successfully used in previous health studies (Malmström, Sundquist, & Johansson, 1999; Romer et al., 1994; Santiago,

Wadsworth, & Stump, 2011; Singh, Siahpush, & Kogan, 2010). Taking the key constructs from the model, I developed a conceptual model to examine the key factors that affect the adolescent African American population. Figure 2.2 displays the conceptual model for this study. The next section discusses the model and the supporting research that guided the creation of this model.

Figure 2.2 Theoretical Framework with Conceptual Factors



The Individual

The microsystems include the stable characteristics of the adolescent that he/she brings to the interactions. For this model, it is defined as the psychological characteristics of self-esteem, mental health, and self-regulating behaviors like self-control and discipline. This construct also includes the adolescents' perception of their parents.

Relationships: Parenting Practices

The relationship level is the interaction between one or more people. For this model that will consist of the adolescents interaction with their parents. Family is considered a main agent of socialization, including sexual health socialization (E. C. Davis & Friel, 2001). Past studies have documented how behavior and the development of prosocial competencies or psychosocial maladjustment are influenced by parenting attitudes and practices (Kotchick & Forehand, 2002).

Parenting attitudes and practices are the actions or steps parents take with their children, and these interactions can often be viewed as positive or negative parent-child relationships. Open displays of affection, active monitoring, involvement in children's activities, consistent but not harsh disciplinary actions, and positive reinforcement relate to high self-esteem, positive peer relationships, and less problematic behaviors (Baumrind, 1978; Brody & Flor, 1998; Kotchick & Forehand, 2002; G. R. Patterson, Reid, & Dishion, 1992). When studying the parent-adolescent relationship and its impact on sexual health, it is important to look at the key constructs of parenting practices like monitoring, communication, and support.

Relationships: Parent's sexual behavior

Parenting is a complex set of behaviors that can either positively or negatively affect the growth and well-being of children. For sexual exploration and involvement, it is important to investigate how adolescents perceive and value their parents and whether parents' involvement influences their risk choices. While investigations of risk factors have provided insight into risk-taking behaviors that lead to poor health outcomes, little research has looked at the direct relationship of the parents' sexual behavior to the adolescents' views of their parents and their own risk behavior. Several studies have looked at the impact of single mother households on teenage pregnancy, but few studies have traced the importance of the parent's viewpoint of sex on the actual sexual behavior. This construct will allow the researcher to investigate the link between the parent's actions and the child's behavior.

Relationships/Individual: Religious practices of both the parent and the adolescent

Research has linked adolescent religiosity, especially church attendance, prayer, and participation, with sexual attitudes and behaviors (Rostosky, Regnerus, & Wright, 2003). Thornton and Camburn (1989) noted that adolescents who hold strong religious beliefs and pray

have less permissive attitudes about sex and report less sexual activity. Other studies have found reduced avenues of risk (number of sexual partners, age of sexual debut, etc.) to be linked to level of religiosity. While studies have supported the positive impact on sexual health of the adolescent's religiosity, few studies have examined the connection and influence of parents' religiosity on the adolescents, particularly the parents' practices related to sex. The proposed model will seek to understand the link between the parent's religious practices and the adolescent's behavior. Bidirectionality may characterize this relationship, meaning there is an interchange between the individual and the relationship level such that each affects the other.

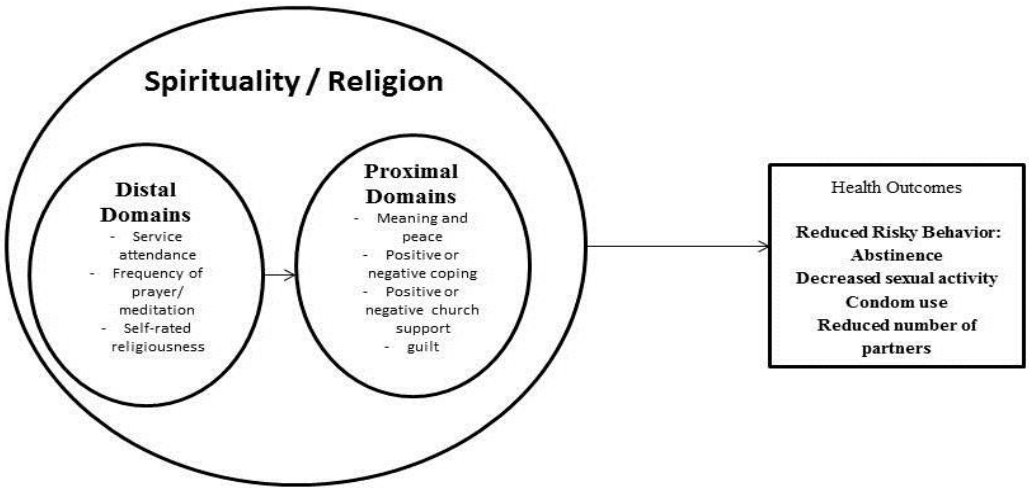
Societal and Community: Moderators (cultural variables and values)

The societal and community features the influences (moderators) that are out of an individual's control. For this model, the levels would be combined to include the adolescent's ethnicity/race, education level, neighborhood safety, and parental income. These are variables the adolescents cannot change, but they can affect sexual health. Ethnicity/race can affect an adolescent's susceptibility to risk behaviors and other health disparities (CDC, 2003, 2006, 2011, 2013; Kasowitz et al., 2006). As stated earlier African Americans comprise 51% of new STI cases (CDC, 2006). While ethnicity cannot be changed, researchers must consider it when studying factors that influence sexual health. Education, income, occupational status, and neighborhoods affect the psychological well-being of the individual and the family (Malmström et al., 1999). Researchers have found that poor neighborhood quality and low socioeconomic status are associated with a number of health problems (Santiago et al., 2011). By assessing these variables, the proposed research will be able to provide insight into the influence that the moderators have on the adolescents' behavior.

Framework for religiosity and spirituality

Throughout this chapter the limitations of studying religiosity and spirituality as a combined construct have been stressed. Researchers have answered the call to investigate the difference with the distal-proximal framework of spirituality and religion. The creator of the frame work Pargament (2001) states that there should not be a branching of the terms, but instead both constructs should be viewed from a distal and proximal lens (Cotton et al., 2010). Distal domains by Pargament's definition examine the individual behaviors of church attendance, prayer, or meditation, and proximal domains engage the functions of these activities (spiritual support, coping, meaning making) (Pargament, 2001; Pargament et al., 2004; Pargament, Tarakeshwar, Ellison, & Wulff, 2001). In Cotton et al.'s (2010) review of this material the authors called for future studies to use this framework with adolescents because it could aid in understanding the relationship of religious and spiritual constructs to promoting health sexual behaviors among adolescents. Figure 2.3 displays how the distal-proximal framework will be used in the current study.

Figure 2.3 Adapted Distal-Proximal Framework for Current Study



The results from this study will be used to provide parents, adolescents, church lay members, health professionals, and policy makers with insight and data to better understand the

parent-child relationship. The study will also provide insight into the relationship of spirituality, faith, and sexual health. This study will add to the current research by examining the preceding concepts from a qualitative and quantitative perspective.

CHAPTER 3

METHODOLOGY

This mixed-method study used quantitative and qualitative methodologies to explore the perception of African-American families of their parent-child relationship. Perceptions were investigated from the parent and adolescents perceptive. The goal of the study was to investigate how aspects of the parent-child relationship (parenting factors, religion, and spirituality) influence sexual risk reduction or prevention among adolescents. The target population consisted of African-American families living in a large metropolitan area in a southeastern state.

This chapter is organized in three sections. The first section describes the mixed method approach. The second section details Phase 1, which corresponds to the quantitative components. The last section describes Phase 2, which is the qualitative component of the study.

Study Design: Mixed Method Approach

The current study used mixed-methods methodology with the emphasis on a sequential explanatory design. Mixed method research incorporates strategies derived from qualitative and quantitative methods within a single project (Teddlie & Tashakkori, 2009). In contrast with traditional research, mixed method designs require several phases. The phases are identifying the theoretical lens that guides methodological choices, the hierarchy of the data, the order in which the data will be collected, and integration of the data (Crotty, 1998; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). The researcher's interest is in examining the parent-child

relationship and spirituality from a quantitative and qualitative perspective to understand their influence on adolescent sexual behaviors.

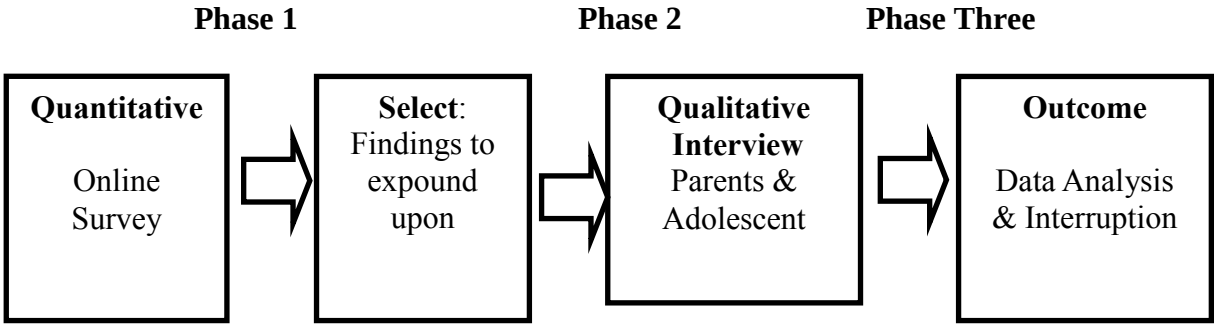
Using mixed methodology provided a greater understanding of the parent-child relationship because it not only explored the relationship from validity measures but also expounded explanations from the respondents. For this study, the qualitative pieces allowed the researcher to examine the interpretive approaches (i.e., narrative stories, personal examples, etc.) parents and adolescents used to define their relationship. By examining the relationship through this additional lens, the researcher focused on meaning rather than solely numbers. As stated in the earlier chapters, the majority of research in this area has focused on the quantifiable aspects of the parent-child relationship. Solely using one methodology means that the contextual aspect of the parent-child relationship may be lost. Various authors and qualitative inquiry textbooks state that combining qualitative and quantitative methods provides extended robustness in analysis and the approaches complement one another by taking advantage of each other's strengthen (Green & Caracelli, 1997; Greene, Caracelli, & Graham, 1989; Miles & Huberman, 1994; Tashakkori & Teddlie, 1998). The researcher's subjectivity statement and the guiding stance for the design can be viewed in Appendix A. The next section will discuss the sequential explanatory design. The next section discusses the sequential explanatory design used in this study.

Sequential explanatory design

The sequential explanatory design is a two-phase mixed methods design (Ivankova, Creswell, & Stick, 2006). The purpose of this design is to use the qualitative data to help explain or build on the quantitative results. For the current study, qualitative data highlighted how certain parenting processes protected against risk. This study consisted of three phases: quantitative data

collection phase, qualitative data collection phase, and analysis and interpretation of findings. The mixing occurred at the level of the research questions and interpretation. Figure 3.1 provides a graphical representation of the research design.

Figure 3.1 Graphical Representation of the Study Design



The following two sections discuss the methodology (participants, procedures, and measures) of Phases 1 and 2. Phase three will be discussed in chapter 4.

Phase 1: Quantitative Methodology

Participants

The sample consisted of parents/caregivers and their adolescent children between the ages of 13-18. Participants were 75 African-American caregivers and 22 adolescents. Parent or caregiver was defined as a male or female (biological, step-parent, relative, or legal guardian) who was currently caring for an adolescent in their home.

Additional analysis was conducted for a combined dyadic sample of the parents and adolescents that completed the entire survey. Of the 97 participants, 22 parent-adolescent dyads were pulled for the additional analysis. Forty-eight of the adolescent participants either did not complete the adolescent survey due to parent intervention or had several missing items. Only the dyadic pairs that completed the entire survey were included for the dyadic analysis. However,

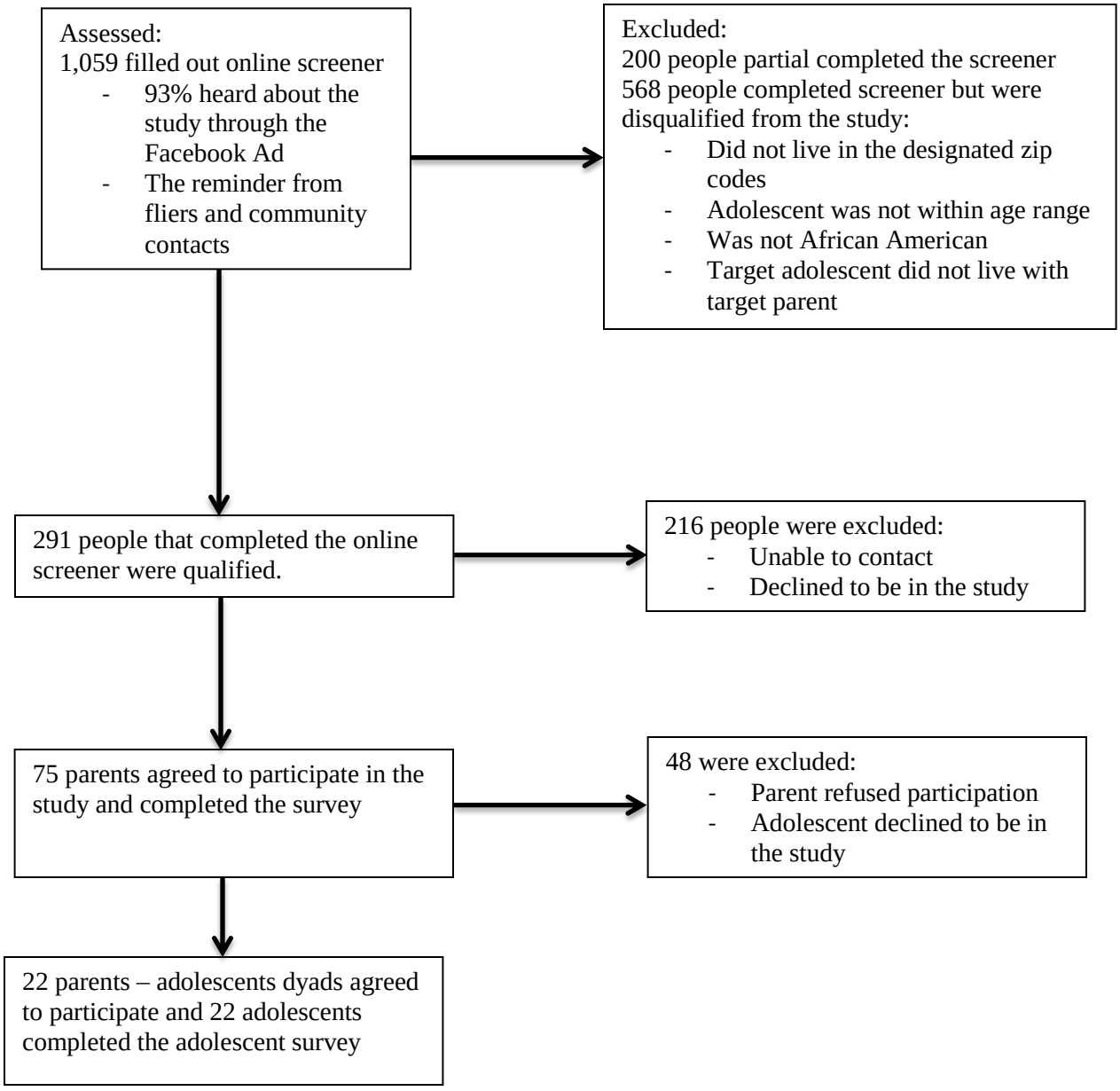
because the quantitative data was used to provide supplementary information for the qualitative analysis the full parent database was explored for additional findings.

To participate in the study, families had to meet the following criteria: (a) self-identify as being Black or African American, (b) have an adolescent between the ages of 13 and 18, and (c) identify one primary caregiver (parent, guardian, or caregiver) who lives in the same home of the adolescent being interviewed.

Participants were recruited through community outreach programs, and faith-based programs, and social media sites. The researcher first contacted various community organizations and requested permission to recruit at their sites. The researcher presented her study at the meetings. In addition to meetings, a Facebook advertisement was used. Three zip codes were used to narrow down the sample population. Zip codes within a certain metro Atlanta area 30314, 30315, and 30316 were used to identify participants in the region. The zip codes were used for the Facebook ad to ensure that participants came from the targeted community. Recruitment occurred from September 2014 to February 2015.

To obtain the samples a two part screening process was created. If participants indicated that they were interested in the study they were sent an email link to an online study screener. Parents filled out the online screener and if a parent was eligible additional screening took place over the phone. Figure 3.2 displays the recruitment and enrollment consort map.

Figure 3.2 CONSORT Flow Diagram of Recruitment and Enrollment



Procedures

Informed consent was obtained for all participants and assent for the adolescents. Parents provided parental permission prior to contacting the adolescent. Once participants were recruited into the study, the parent and the adolescent completed an electronic survey at community locations (e.g., gym, church meeting hall) or in their home. The survey took approximately 45 minutes to complete. Participants received a gift card for $10 if they completed the survey only or $15 if they completed the survey and the interview. To encourage confidentiality the parent and the adolescent took the survey in separate rooms or areas.

Survey Measures

Table 3.1 summarizes the measure properties for the parent and adolescent survey. The full survey is in Appendix B. The alphas were calculated from the study.

Table 3. 1 Measure Properties for Parent and Adolescent Surveys

	Construct	Measure	Description of Measure	Internal Consistency	Reference
			Demographics: Covariates		
1	Parent Employment, Economic Status, Parent and Teen demographics	General demographic items from the YRBSS & BRFSS	7 items assessing gender, age, education, living situation, marital status, and geographic location	N/A	Adapted from CDC (CDC, 2013)
2	Socioeconomic status	General demographic items from the YRBSS & BRFSS	4 items assessing job status, housing security, government assistance, and income	□□□	Adapted from CDC (CDC, 2013)
			Protective Factors		
3	Consistent Discipline	Alabama Parenting Questionnaire	The APQ is a 42 item self-report inventory specifically developed for examining the relationship between parenting practices and children's disruptive behavior (Shelton, Frisk & Wootton, 1996). The adapted version of the discipline subscale is a 5-item, 4-point Likert scale, ranging from 1 = usually to 4 = never. The three items that were negatively worded were reverse coded. Scores ranged from 10 to 20. Higher scores signified consistent discipline whereas lower scores represented inconsistent discipline.	□□□□□	Frick, Christian, and Wootton (1999)
4	Parental Support	Quality of Parent-Child Relationship Flourishing Children	The parent scale is an 8- item scale on a 4-point Likert. The adolescent scale is a 6- item scale on a 4-point Likert. The responses range from None of the time=0 to All of the time=4. The maximum score for this scale equals 24. Higher scores indicate higher quality.	Parent scale (□=.86) Adolescent scale (□=.92)	Lippman, Moore, and McIntosh (2009)

	Construct	Measure	Description of Measure	Internal Consistency	Reference
5	Parental Monitoring	Parental Monitoring Assessment	The parental monitoring assessment (PMA) is a 6-item modified 5-point Likert scale. The responses range from 1 never to 5 always. Examples of the questions are "My parents know where I am after school or I tell my parent(s) who I am going to be with before I go out". Higher scores indicated higher levels of parental monitoring.	□□□□□	Luster and Small (1994)
			Sexual Behavior		
6	Sexual Health Behavior	Sexual behavior items from the YRBSS	Measures of risky sexual behavior included the number of vaginal sex partners reported in the past 7 and 90 days. The number of sexual partners was categorized into one partner or less, or multiple partners of (2 or more). Also, risky behavior also assessed with one question asking use of substance during sex " the in the past 90 days how many times did you have sex while high on drugs or alcohol".	N/A	Adapted from CDC, 2013
7	ASAI	Adolescent sexual activity Index	10 items that cover a board spectrum of adolescent sexual behavior. The items were presented by scaling the activities from hugging to sexual intercourse. An index score from 0 -10 was calculated as the sum of the 10 items.	□=.92	Hansen, Paskett, and Carter (1999)
8	Sexual Health Communication	The Parent-Teen Sexual Risk Communication Scale (PTSRC-III)	The PTSRC-III provides a valid and reliable measure for assessing adolescents' perceptions of parent-teen sexual risk communication. 8-item scale on a 4-point Likert.	□□.93 (mothers) □□□□88 (fathers)	Hutchinson (2007)
			Belief & Value Factors		

	Construct	Measure	Description of Measure	Internal Consistency	Reference
9	Beliefs and Sexual Values	Attitudes Towards Abstinence	9-item scale used to assess attitudes toward abstinence among adolescents. Both the parents and the adolescents completed the survey	□□□□65	Miller et al., (1998)
10	Religious & Spirituality	Multi-dimensional measure on Religion and Spirituality	*Carrying religious and spiritual beliefs* Two questions assessed the extent one carries their religious or spiritual beliefs into their everyday life. 4 point liket scale. *Level of religiosity and spiritualty.* Two questions measured how religious or spiritual a person considers themselves on a 4 point scale. *Organized Religious Activity* ("How often do you attend church, synagogue, or other religious meetings?"), *Non-organized Religious Activity* ("How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?")	alpha values ranging from 0.75 to 0.88	Hill and Pargament (2008) H. Koenig, Parkerson Jr, and Meador (1997) Szaflarski et al. (2006)

Demographics

Parent Employment and Economic Status. Parents were asked their current job status (0= *no*, 1= *yes*). Parents were also asked if they receive government assistance (TANF, food stamps, WIC, or section 8 housing/housing subsidies), and they had to select no or yes for each.

Parent/Guardian Demographic Variables. Demographic measures included gender, relationship to the adolescent (i.e. Biological mother, Biological father, Step-parent, etc.). The parent/guardian marital status was also assessed. Parental education level was determined by asking the highest level of education the parents has completed. Finally, SES was assessed through neighborhood SES. Four items measuring safety, presence of garbage and litter, poor or dilapidated housing, and vandalism such as broken windows or graffiti were used. Higher scores meant a lower neighborhood SES. Housing security will be determined by the question, "Have you ever been homeless?" Response options are 0 = *no* and 1 = *yes*. Respondents were also asked how often they move to a new home or apartment.

Adolescent Demographic Variables. Demographic measures will include gender (Are you male or female), education "what was the last grade that you completed in school." Housing security will be determined by the question, "Have you ever been homeless?" Response options are 0 = *no* and 1 = *yes*. Respondents were also asked how often do they move to a new home or apartment (1 = *every 6 months or less*, 2 = *every year*, 3= *every 2-3 years*, 4 = *4-6 years*, 5= *7-10 years*, and 6 = *10 or more years*).

Parenting Processes

Consistent Discipline. The discipline scale was adapted from the Alabama Parenting Questionnaire (Frick, Christian, & Wootton, 1999). The APQ is a 42 item self-report inventory specifically developed for examining the relationship between parenting practices and children's

disruptive behavior (Shelton, Frisk & Wootton, 1996). The adapted version of the discipline subscale is a 5-item, 4-point Likert scale, ranging from 1 = usually to 4 = never (i.e., "when you have done something wrong, how often does this person discuss with you why what you did was wrong?"). All but two items where negatively worded ("when you have done something wrong, how often does this person stop talking to you?" and "when you have done something wrong, how often does this person discuss with you what should have done?"). The three items that were negatively worded were reverse coded. Scores ranged from 10 to 20. Higher scores signified consistent discipline whereas lower scores represented inconsistent discipline.

Parental Support. Quality of Parent-Child Relationship was used. The parent scale is an 8- item scale on a 4-point Likert. The adolescent scale is a 6- item scale on a 4-point Likert. The responses range from None of the time=0 to All of the time=4. The maximum score for this scale equals 32. Higher scores indicate higher quality of support (Parent scale α=86; Adolescent scale α=.92).

Parental Monitoring. The parental monitoring assessment (PMA) is a 6-item modified 5-point Likert scale. The responses range from 1 never to 5 always. Examples of the questions are "My parents know where I am after school or I tell my parent(s) who I am going to be with before I go out." Higher scores indicated higher levels of parental monitoring (α = 90).

Sexual Health Behaviors. Both the parent and the adolescent were asked "Have you ever had sexual intercourse?" or "To your knowledge has your adolescent ever had sex?" Responses were recorded as either 0 =*No* or 1= *Yes*. The following definition was included with the question: "This is when a guy puts a penis in a girl's vagina."

Sexual behavior was also measured with the adolescent sexual activity index (ASAI) (Hanson, Paskett &Carter, 1999). This is a 10 item measure that covers a broad spectrum of

adolescent sexual behavior. The items were presented by scaling the activities from hugging to sexual intercourse. The behaviors that are considered pre–coital acts are often precursors to sexual intercourse including holding hands, hugging, kissing on the cheek, lips, or mouth, touching genitals or allowing genitals to be touched. Responses were recorded as either 0 =No or 1= Yes. An index score from 0 -10 were calculated as the sum of the 10 items. The scale is constructed by adding the behaviors to produce a total score. Both the parent and the adolescent completed the measure (α =93).

Sexual Health Communication. The Parent-Teen Sexual Risk Communication Scale (PTSRC-III) 8-item scale on a 4-point Likert scale was used (Hutchinson, 2007). The PTSRC-III provides a valid and reliable measure for assessing adolescents' perceptions of parent-teen sexual risk communication. Responses ranged from 0 = *None* to 4 = *Extensive*. A summary score was created by summing the responses. Possible scores can range from 0 to 32. Higher scores reflect greater parent-child communication about sexual risk (α =93 mothers; α= 88 adolescent & fathers).

Beliefs and Sexual Values. The Attitudes Toward Abstinence scaled assessed parents' and adolescents attitudes toward abstinence. The scale was adapted from a previous study. The scale consisted of a set of 9 items measuring the parents' and adolescents' values about the appropriateness of adolescent sexual intercourse. Participants responded to statements like "It is important for me to not have sexual intercourse before *I* get married" and "Even if I am physically mature, that doesn't mean I'm ready to have sex." Three items were reverse-coded negative statements such as "It is all right for teenagers to have sexual intercourse before they are married if they are in love" during the data analysis process. Responses were recorded on a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Total summed scores

for the scale ranged from 9 to 45, with higher scores indicating a more positive attitudes toward abstinence. Cronbach's alpha for the scale was 0.68 in this study.

Religious & Spirituality Measures. Religious and spirituality were measured with several items form the Multi-dimensional measure on Religion and Spirituality. *Religious preference* was measured with an open ended question that asked "What is your current religious preference?" Respondents were able to type in their response. *Organized Religious Activity* was measured "How often do you attend church, synagogue, or other religious meetings?" Responses were recorded on a 5-point Likert scale ranging from 0 = *never* to 5 = *more than once a week*. *Non-organized Religious Activity* was measured with questions like "How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?" Responses were recorded on a 7-point Likert scale ranging from 0 = *never* to 7 = *more than once a day*. *Carrying religious and spiritual beliefs* was measured with two questions that assessed the extent one carries their religious "I try hard to carry my religious beliefs over into all my other dealings in life" or spiritual beliefs into their everyday life. Responses were recorded on a 4-point likert scale ranging from1 = *strongly disagree* to 4 = *strongly agree*. *Level of religiosity and spiritualty.* Two questions measured how religious or spiritual a person considers themselves on a 4 point scale with a question like "To what extent do you consider yourself a religious person?" Responses were recorded on a 4-point likert scale ranging from1 = *not at all* to 4 =very. Alpha values ranged from 0.75 to 0.88.

Survey Data Analysis

For the quantitative phase, bivariate and multivariate analyses were used to analyze the data. First correlational analyses were used to examine consistent parental discipline, parental support and parental monitoring, quality of the parent-child relationship as it relates to risk-

taking behaviors. Then a total risk index was calculated for the risk behavior by adding all of the yes responses. In addition a total adolescent sexual activity score was calculated from the ASAI sexual activity measure.

Finally, parent-adolescent concordance was assessed through mean comparisons, chi-square analysis, and Kappa statistics. All analysis was conducted with SPSS, version 23. Due to the limited sample size regression analysis was not conducted for the dyadic database. The quantitative analysis was used to identify key associations in the adolescent, parent, and dyadic database. Therefore, the quantitative phase of this study was used as a secondary method to inform the creation of the qualitative phase.

Phase 2: Qualitative Methodology

Based on the results from the quantitative phase and results from past studies, the qualitative study assessed salient themes from the parent-child relationship. The following subsections detail the participant characteristics, data collection, and data analysis.

Interview Participants

Seven caregivers and 7 adolescents (N=14) were interviewed. All caregivers were women and their ages ranged from 35-63 years of age. Six caregivers were the biological mothers of the adolescent and one caregiver was the grandmother. Five of the adolescent participants were female and two male. The average age for the adolescent sample was 15 years of age. During the consenting process for Phase 1 of the study, participants were all given a chance to consent for the optional interview. After Phase 1 was completed families were contacted and offered a chance to be a part of the one-on-one interviews.

Data Collection

The one-on-one interviews covered topics on parent-child communication about their day-to-day life, topics on sexuality, discipline, religion and spirituality, and the creation of a health program. Two families were recruited for pilot testing the interview guide. Their responses were not included in the main analysis because their results guided drastic changes to the interview guide. The family pairs were interviewed separately. To ensure confidentiality and to build trust the parent was always interviewed first. This was an important factor that became known during the pilot testing phase. Both adolescents in the pilot testing expressed fear of their response being shared with their parent. To ease that fear the adolescent was interviewed on a separate day. All interviews were conducted by the researcher and were recorded with a digital recorder and then transcribed verbatim using an online transcription service. Each of the interviews was between 35 - 50 minutes in duration. Please view Appendix C for the parent and adolescent interview guides.

Interview Data Analysis

I identified central issues from parental support, monitoring and discipline literature thought to be most salient for an understanding of determinants of positive parent-child interactions. In addition, I also identified concepts of from the quantitative phase that could be expounded upon with qualitative inquiry. A combination of predetermined structural codes and emergent theme approach were used to develop the codebook and analyze the data. The first step in this process was to create structural codes related to each of the categories of questions during the interviews. After the predetermined categories were developed the emergent themes approach was applied. This second step of the codebook development involved the creation of an initial list of "open codes" based upon the concepts and themes that emerged from reviewing the transcripts. Open coding allows for overarching codes to be listed from the previous

predetermined sections. In the open coding process the independent coder makes an initial list of codes based upon the major topics, concepts, or themes that are revealed in the first transcript reviewed. After creating the initial list of open codes additional transcripts are reviewed, the list is modified, and connections are made between the codes.

For the codebook development process, three transcripts from the overall sample of 14 participants were reviewed by two independent coders. The coders reviewed and selected major overlapping themes from the transcripts. After the coders independently assessed the transcripts, they then developed codes separately. Subsequently, they met to develop a codebook. During the second meeting, the coders discussed their selected codes and decided on the major constructs. Once the codebook was developed to asses major themes, inter-coder reliability was conducted with an .80 kappa. MaxQDA version 11 was used for qualitative analysis.

Trustworthiness

Reliability and validity are the corner stones in qualitative and quantitative research that ensure data trustworthiness. To safeguard that a study is in fact measuring what it says it will measure, a researcher must examine three areas: internal validity, reliability, and external validity. Internal validity is concerned with how close research findings are to reality. The researcher used two strategies to heighten internal validity: member checks and memoing. Member checks allow participants to review findings to see if they are congruent with what they said, and the memos will help clarify researcher bias (Creswell, Klassen, Plano Clark, & Smith, 2011). Reliability in qualitative research is concerned with whether the findings are consistent with the data that were collected. It seeks for findings that are dependable. The researcher pilot tested the individual interview guides with participants to enhance reliability. Last, external validity is concerned with the transferability of findings to other situations, not with

generalizability as is quantitative research. The inclusion of thick, rich description from the transcripts and the memos enhanced external validity.

Ethical Consideration

This study posed little to no risks to participants. Prior to beginning this study, approval was obtained by the University of Georgia Institutional Review Board. Participants all signed electronic consent and assent forms prior to data collection and were informed that they may withdraw from the study at any time without penalty. Participants were all assigned random identity labels and for the interviews selected participants chose a pseudonym to keep their identifying information confidential.

CHAPTER 4

RESULTS

In explanatory mix-method designs, qualitative data are used to contextualize quantitative data. For this reason, the quantitative portion of this study is addressed first, followed by key findings from the qualitative piece.

Phase 1: Quantitative

Participant Demographic Characteristics

The average age of the 75 parents/caregivers was 39 years of age (SD = 7.25) and over 88% (66) of the sample were female and 12% male. Three participants were grandparents and the rest of the sample was the biological parents of the adolescents. To simplify the writing, the adult participants are referred to as "parents." Most parents were married to the biological parent of the target adolescent. Table 4.1 details the parent demographic information.

The average age of the 22 adolescents was 15 years of age (SD = 1.75). The sample was evenly divided by gender (12 females and 10 males). Forty-eight percent of the sample lived in a two-parent home and 87% identified their mother as their primary caregiver and the person who knows what they are doing the most of the time. The last grade completed in school was also assessed. Two of the adolescents had completed the 6^{th} grade, four the 7^{th} grade, four the 8^{th} grade, four the 9^{th} grade, two the 10^{th} grade, three the 11^{th} grade, and three the 12^{th} grade.

Table 4.1 Frequencies and Percentages for Parent Sample Demographics (N=75)

Demographic	*n*	%
Gender		
Female	66	88
Male	9	12
Work Status		
Working	58	77
Not Working	17	10
Highest level of school or degree		
Some High School	3	4
GED/High School Diploma	5	7
Some Technical School/Technical School Graduate	5	7
Some College	23	31
Associate degree	9	12
Bachelor degree	7	9
Some Graduate Work	9	12
Advance degree or post-graduate degree	14	19
Receiving Social Services		
Yes (TANF, SNAP, Food Stamps, WIC)	33	44
No	31	41
No response	11	15
Marital Status		
Currently married to adolescents biological parent	46	61
Never married to adolescents biological parent	18	24
Divorced or separated to adolescents biological parent	8	10
Divorced and remarried	3	4
Religious Preference		
Christian	32	43
None	13	17
Baptist	10	13
Nondenominational	9	12
Seventh Day Adventist	3	4
Catholic	2	3
Spiritual	2	2
Islam	1	1
Buddhist	1	1
Pentecost	1	1

Note. Because participants could select more than one response and due to rounding error, some percentages may not sum to 100%.

Univariate Analysis of Constructs

Parenting Practices, Religiosity, and Spirituality

Table 4.2 presents the means and standard deviations for the parenting practices investigated in the study. Of the 75 parent participants, 66 (88%) were classified as providing consistent discipline, high parental support and high parental monitoring. Parents with a male target adolescent or female target adolescent had very similar means.

Table 4.2 Means and Standard Deviations of Parenting Practices

Parenting Practices	**M**	**SD**
Consistent Discipline	17.56	(2.65)
Parental Support	20.60	(3.28)
Parental Monitoring	27.57	(3.18)

Note: Consistent discipline scores ranged from 10 to 20. Parental support scores ranged from 9 to 24. Parental monitoring scores ranged from 18 to30. Higher scores indicate stronger support for the constructs.

Table 4.3 displays the means and standard deviations and the frequencies of the religious and spiritual constructs. A majority of the parent sample stated that they pray a few times a week, read religious material less than once a month, and attend a religious service monthly or weekly. On average, the lowest score for the parents was their level of religiosity and the highest was their score on carrying their spiritual beliefs into their daily lives.

Table 4.3 Means and Standard Deviations for Religious and Spiritual Constructs

Religious and Spiritual	**M**	**SD**
Religious Person	2.68	(0.95)
Spiritual Person	3.20	(0.72)
Carry Religious Beliefs	3.15	(0.81)
Carry Spiritual Beliefs	3.27	(0.73)
Religious Practices		
Prayed outside of church	4.91	(2.08)
Listened to religious programs	3.11	(2.29)
Read the bible or other religious literature	3.11	(2.10)
Attended religious services	2.59	(1.66)
Took part in other religious activities	1.85	(1.53)

Note: Responses ranged from 1= never to 7 = more than once a week for religious practices.

Parents Assessment of Adolescent's Sexual Risk

In terms of sexual behavior, only nine parents reported that they believed that their child was sexually active. Parents' perception of whether the adolescent had participated in sexual behaviors leading to sexual intercourse was also assessed. The parents' knowledge of their child's pre-sexual intercourse sexual behavior can be described as follows: 8% (6) of parents reported that their teens had not engaged in any pre-sexual intercourse behavior; 43% (32) reported knowledge of 1-3 pre-sexual intercourse behavior behaviors; 49% (37) of parents reported knowledge of at least 4-8 pre-sexual intercourse behaviors. The majority of the parents did not report risky sexual behaviors of their children (number of sexual partners and early age of first sex). Table 4.3 details the distribution of the frequencies for all of the sexual health constructs within the adolescent sexual health inventory measure.

Table 4.4 Frequencies and Percentage of Yes responses to Adolescent Sexual Experience Inventory by Gender

Adolescent Sexual Experience Inventory	Overall Distribution of Yes Responses		Parents of Adolescent Males (N=40) Who Reported Yes	Parents of Adolescent Females (N=35) Who Reported Yes
	N	%		
Hugged	66	88%	93%	83%
Held hands	38	51%	55%	46%
Time alone	31	41%	47%	34%
Kissed by opposite sex	42	56%	68%	43%
Kissed the opposite sex	37	49%	58%	40%
Cuddled with opposite sex	36	48%	55%	40%
Laid down with opposite sex	12	16%	20%	11%
Sexual intercourse	9	12%	15%	9%

Responses were recorded as either 0 = *No* or 1 = *Yes*.

Adolescent Reported Parenting Practices and Adolescent Sexual Behavior

Of the 22 participants, the majority (17) was classified as receiving high monitoring. For discipline type, over 13 reported that they received consistent discipline. In terms of primary caregiver support 14 self-reported receiving positive support from their mother and 10 reported positive support from their father. Four participants indicated that they did not have contact with their father.

In terms of sexual behavior, eight (38%) adolescents reported having ever had vaginal sex and the same eight reported that they have had oral sex. Of the participants who reported that they had had sexual intercourse, the average age of the first sexual relationship was 13 years of age. In terms of pre-sexual intercourse sexual behavior, 11 (52%) reported 1 to 3 pre-sexual intercourse behaviors and 10 (48%) reported 4-8 pre-sexual intercourse behaviors. As a whole, the majority of adolescents did not smoke cigarettes (90%) and had not used marijuana in their

lifetime (76%). Almost half (n=9, 43%) of the adolescents had had more than one alcoholic drink at one time.

Sexual Health Communication within the last year

In addition to assessing parental knowledge of their adolescent's sexual experience, sexual health communication was also assessed. The majority of the parents reported low levels of sexual health communication with their adolescent. The lowest rated items were conversations about contraception, HIV/AIDS, and condom use. The most frequently rated conversations were about postponing or not having sex, strategies on how to resist pressure from peers and dating partners, and direct conversations about STDs. Table 4.5 displays the means and standard deviations for each sexual health communication category.

Table 4.5 Means and Standard Deviations for Parental Reported Sexual Health Communication[1]

Question	***M***	***SD***
Total Sexual Health Comm.	1.87	1.01
Postponing or not having sex	2.30	1.35
How to resist pressure from peers and dating partners	2.00	1.35
STDs	1.94	1.16
Peer pressure and sexual pressure from dating partners	1.85	1.29
Ways to protect against STDs and HIV/AIDS	1.83	1.28
Contraception	1.77	1.17
HIV/AIDS	1.70	1.29
Condoms	1.56	1.43

[1] Sexual health communication was scored from 0 = none to 4= extensive of having a conversation within the last year.

Bivariate analysis: Parent sample

Bivariate correlations between each of the parenting, religiosity, and spirituality variables and the sexual experience, sexual beliefs and values, and sexual communication measures were

examined to understand the strength of the association between the variables. As shown in Table 4.6, some correlations were statistically significant. Consistent discipline and the adolescent sexual experience index were negatively correlated (r = -.402). Parental support and sexual health communication were positively correlated (r = .393). Parental self-identification with being a spiritual person was positively correlated with higher sexual values and beliefs (r = .385). In addition, positive correlations were found with the sexual values and beliefs and parents who reported that they carry their religious beliefs (r =.425) and spiritual beliefs (r = .369) into their daily life.

Table 4.6 Bivariate Correlations of the Parenting Process, Religiosity, and Spirituality to the Pre-sexual intercourse behavior, Sexual Values and Beliefs, and Sexual Communication

		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1	Consistent Discipline	-								
2	Parental Support	.595**	-							
3	Parental Monitoring	.797**	.737**	-						
4	ASAI	-.402**	-.161	-.296**	-					
5	Sexual Health Comm.	.085	.393**	.175	.142	-				
6	SBV	.363**	.278*	.336**	-.203	-.035	-			
7	Religious person	-.109	.032	-.050	.144	.093	.229	-		
8	Spiritual person	.265*	.263*	.289*	-.204	-.064	.385**	.257*	-	
9	Carry religious beliefs	.248*	.316**	.252*	.116	.172	.425**	.332**	.348**	-
10	Carry spiritual beliefs	.320**	.386**	.333**	-.019	.187	.369**	.069	.469**	.796**

**Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed). ASAI is the Adolescent Sexual Experience Index. The SBV is the sexual beliefs and values measure. Responses were recorded on a 5-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. Total summed scores for the scale ranged from 9 to 45, with higher scores indicating more positive attitudes toward abstinence.

To examine the impact of parenting practices (consistent discipline, parental support, parental monitoring), sexual health communication, sexual values and beliefs, religious and

spiritual constructs on the parents perceived adolescent sexual behavior multiple one-way analysis of variances (ANOVA) were conducted. To evaluate the impact, four groups were created from the sexual experience variable. The first group was categorized as the no sexual experience (n=6); the mean age for the adolescents in the group was 15 (SD = 2.34). The second was categorized as low sexual experience behavior, which involved hugging or holding hands (n=24); the mean age for the adolescents in the group was 16 (SD = 1.18). The third group was categorized as moderate sexual experience behavior which involved kissing, cuddling, and or lying down with someone (n=36); the mean age for the adolescents in the group was 14 (SD = 1.66). The final group was categorized as sexual intercourse which involved vaginal sex (n=9); the mean age for the adolescents in the group was 14 (SD = 1.09). There were significant differences between several variables. Table 4.7 displays the means and levels of significance for the significant outcome variables. The four groups did not differ in sexual health communication, sexual values and beliefs, and all religious constructs.

Table 4.7 Means and significance levels of outcome variables on perceived adolescent sexual behavior

	No experience	**Low experience**	**Moderate experience**	**Sexual intercourse**	**P value**
Consistent Discipline	19.2	18.9	17.5	13.2	$p < .0001$
Parental Support	21.0	21.6	20.9	16.3	$p < .0001$
Parental Monitoring	29.2	28.6	27.9	22.6	$p < .0001$
Spiritual Person	3.0	3.5	3.1	2.8	$p = .021$

Post hoc comparisons using Least Squares Difference analysis indicated that the following groups were significantly different from each other: 1) Consistent Discipline: no and low experience groups were similar, but significantly different from all others; 2) Parental Support: sexual intercourse group was significantly lower than all others; 3)

Parental Monitoring: sexual intercourse group was significantly lower than all others; and 4) Spiritual Person: the low experience group was significantly higher than the moderate experience and sexual intercourse groups. In all variables, the sexual intercourse group reported worse scores in consistent discipline, parental support, parental monitoring, and parental spirituality.

Dyadic Analysis Results

I conducted a series of concordance analysis between the adolescents and their parents (n=22). Based on the adolescent sexual experience index, three groups were created: low experience (n= 5) refers to hugging and holding hands; moderate experience (n=8) refers to kissing, cuddling, and or lying down with someone; and sexual intercourse (n=9) refers to having had vaginal sex. None of the 22 adolescent participants reported "no" sexual behavior experience.

Important differences were observed between the parents perceived levels of sexual experience behavior of their children and the adolescents reported sexual experience. While statistical difference cannot be examined due to the small sample size, it is important to note the discordant responses within each group. Approximately half of the parents and adolescent (n=10) matched on their description of the adolescent sexual experience behavior. Even though nine adolescents reported having had sexual intercourse, only one parent correctly reported this behavior. Overall the adolescent were engaging in more sexual behavior then the parents reported.

Table 4.8 Cross tabulations of Parent and Adolescent Reported Sexual Experience Behavior

		Parent Reporting				
		None	Low	Moderate	Sex	Total
Adolescent	Low	1	**4**	0	0	5
	Moderate	0	3	**5**	0	8
	Sex	2	2	4	**1**	9
Total		3	9	9	1	22

Note: Bold reflects concordant results between parents and adolescents.

Parenting practices, Religiosity, Spiritualty, and the adolescent's actual behavior. Multiple one-way ANOVA's were conducted to assess whether mean scores of parenting practices, religiosity and spirituality differed among the three groups of adolescent reported sexual behavior experience. No significant differences were found.

Parent sexual values and beliefs and sexual health communication against the adolescent reports. Bivariate correlations between the parent and the adolescent reported sexual beliefs and values, and between the parent and adolescent sexual communication were examined. The correlation between parent reported sexual health communication and adolescent reports of sexual health communication was statistically significant, r = .485, p =.048. There was a marginally positive significant correlation between the parents reported sexual beliefs and values and the adolescent's reports, r = .459, p = .064.

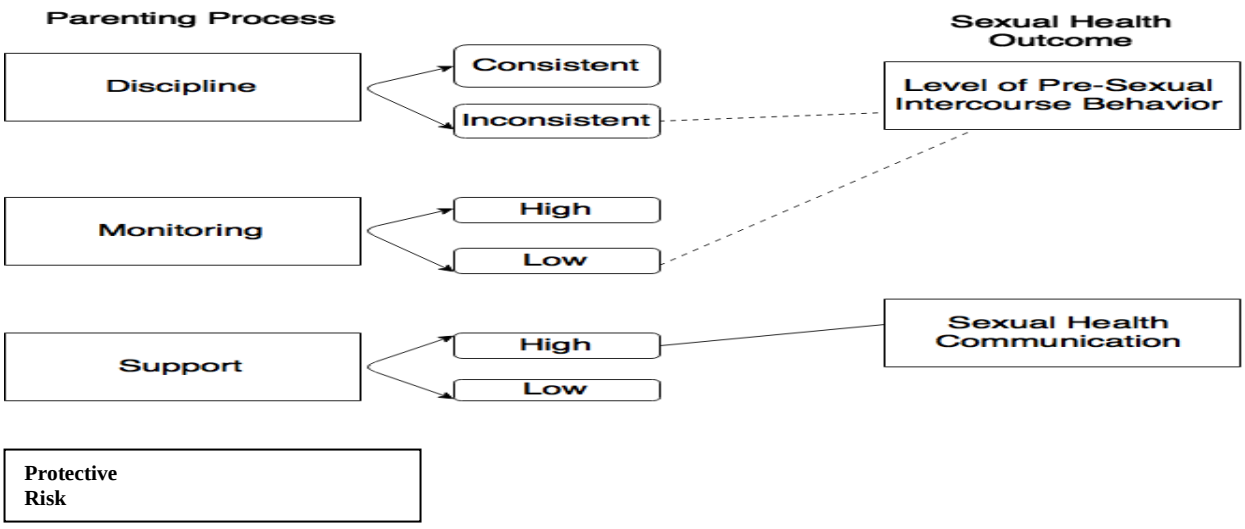
Concordance Analysis. Mean parental monitoring scores for adolescents (M = 28.10, SD =3.35) and parents (M= 28.48, SD = 1.50) were not statistically different. Mean scores for sexual health communication were significantly lower for adolescents (M= 11.52, SD = 9.00) than their parents (M = 17.09, SD = 7.32), *t* (42) = 2.26, p=.029. In addition, parents reported higher levels of parental discipline (M = 24.48, SD = 1.44) than adolescents (M= 19.80, SD= 3.16, *t* (42) = 3.66, p =.001.

Concordance between parent and adolescents in specific topics of sexual health communication was investigated. Kappa coefficients were used to examine the ratio of times parents and adolescents agreed in their responses. Kappa coefficients ranged from .03 to .41. The highest degree of concordance was found with conversations about STDs, condoms, and postponing sex (.28 - .41).

Mixed Method Triangulation

The mixing of the methods occurred through identifying key associations from the quantitative phase and creating an interview guide that expounds on the associations. From these results, particularly the multivariate logistic regression, this study aims to explore underlying functions of the parenting process and highlights the effects of parental monitoring, support, and discipline constructs on their adolescents' sexual health outcomes. Figure 4.1 displays a suggested model of the significant findings.

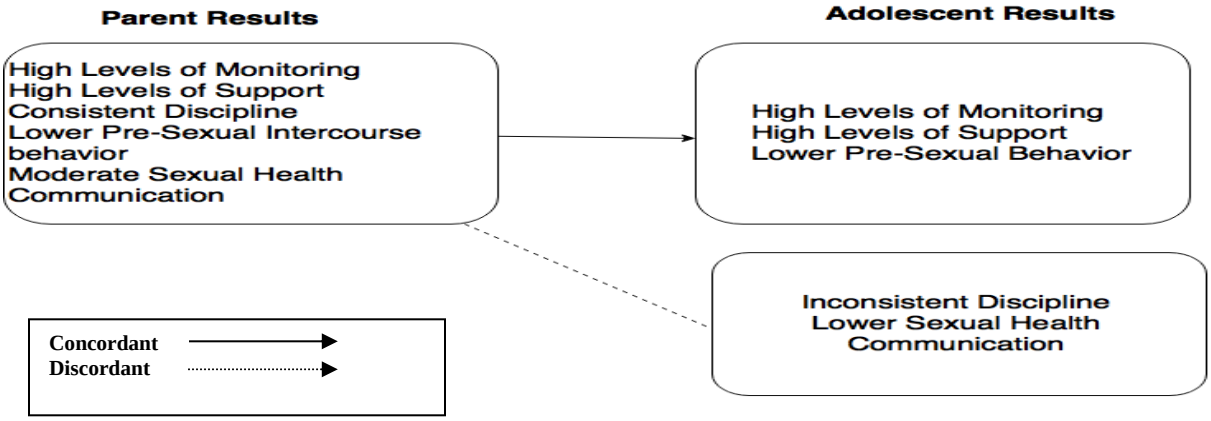
Figure 4.1 Model of Significant Findings from Quantitative Phase from the Parent and Analysis



The findings visibly exhibit how some parenting processes, pre-sexual behavior, and sexual health communication are perceived by parents and adolescents. The results also display

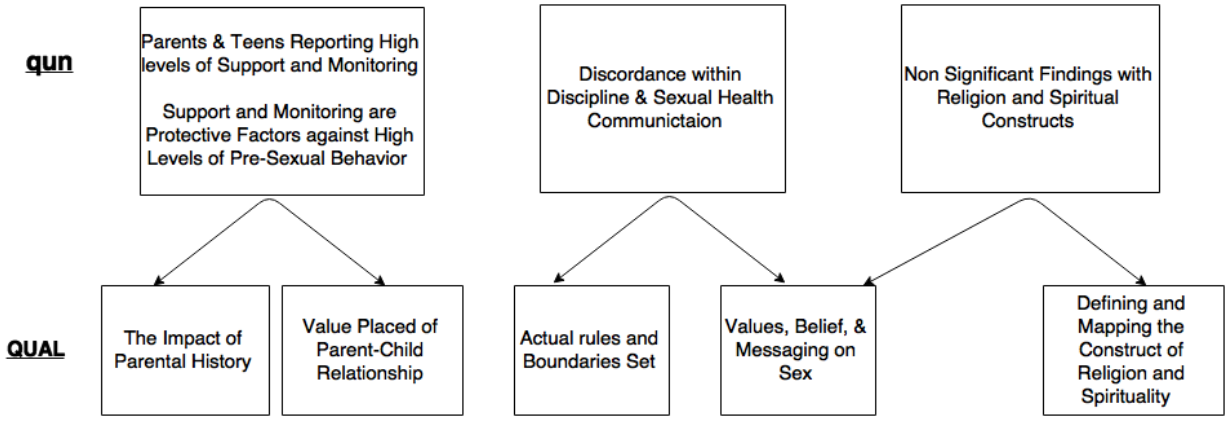
the parenting process association with risk or protective behavior. From the findings from the concordance analysis, a model of the contextual nature of sexual health communication between parents and teens was developed. Figure 4.2 displays a model of the dyadic results.

Figure 4.2 Model of Significant Findings from Dyadic Analysis



The results of this study indicate religious and spiritual constructs were not consistent as found in previous studies. The mixed methodology of this study offers insight into this discrepancy. Figure 4.3 visually demonstrates the connection between the quantitative (qun) and qualitative (QUAL) findings in this study.

Figure 4.3 Graphical Representation of Mixing Process



Phase 2: Qualitative Interviews

As Figure 4.3 displays, the data generated from the quantitative component led to examining the influence of the parental family interactions, the value that adolescents place on their parents, the rules and boundaries set by parents, the barriers to sexual health communication, and the adolescents and their parents' values and beliefs of sexual behavior. In addition, the construct of religion and spirituality was expounded upon.

Demographics

Seven caregivers and seven adolescent participants (N=14) were interviewed. All caregivers were female and their ages ranged from 35-63 years. Six caregivers were the biological parents of the adolescent and one caregiver was the grandmother. Since all of them had a parental function, I will refer to them as parents.

Two parents grew up in a dual parent household, two in a divorced home but had contact with the other parent, and three in a single parent home. The parents were split on their level of closeness with their primary caregiver. The impact of that relationship will be discussed later in the chapter. Four of the seven parents reported a history of abuse (sexual or physical). In addition, teenage pregnancy and substance abuse were experienced by all but two of the parents interviewed. The parents stated that these experiences impacted their current relationship with their adolescent.

Of the participating adolescents, two were female and two were male. The average age for the adolescent sample was 15 years of age. All of the adolescents indicated that they were not sexually active. Three of the adolescents indicated that they had a closer relationship with their father. Three of the dyadic pairs consisted of single parent house-holds: one divorced, two never married to the biological father.

Theme One: Values Parents and Adolescents Place on Family

To expound on the high scores of parental monitoring and parental support, teens and their parents were asked to describe the structure of their home and their relationship with their child. From these two questions two overarching themes emerged: parent-adolescent view of the relationship and discipline.

Parents & Adolescents View of Relationship. Parents described their relationship with the child prior to adolescence. Parents described the relationship through two lenses of communication and quantity of time. Often the parents stated that they spent more time with their child prior to adolescence and that they had open lines of communication. Parents were also asked to describe if the relationship changed once the child entered adolescence. All of the parents stated that there was a shift. While some reported less time spent together, they reported an increase in the quality of time spent with their teen. All of the parents indicated that their teens were spending more time with their peers. Three mothers explained that they had built in rules to engage with their teens friends. As one mother stated "I need to know what and who you are bringing into my home."

Among the adolescent transcripts, three major topics emerged: personal changes, communication, and quality of time. Within the personal changes, the adolescents spoke of the biological changes that they experienced, the sense of maturity, and the ability to engage with their peers privately. A female adolescent also stated,

> *With my friends, my dad really trusts or it all depends on whom my dad trusts because my mom doesn't really interact with my friends like that. The friends that my dad trusts, it's like, "Go ahead." I get to go all around Vine City. If they're going out, I can go out with them. It's just like a bit more freedom and I like it.*

In addition to their personal changes, the teens spoke of the relational shifts they experienced with their parents. Prior to adolescences, the teens felt physically closer to their parents:

> *"Actually, I used to do a lot more things with him, because when I was little, I used to have so much fun with him. I'm kind of in the middle. My dad, he'll interact with me more. I don't want to watch TV. I don't want to play on the computer. I want to sit there and bug my dad, all day. It's like the funniest thing ever to me." (Female, 14)*

Another teen stated that there has always been a sense of continuity in her relationship:

> *"Me and my mom, we have always been close. I mean, it ain't much for me to tell because I'm the good child, so it ain't much that I do. Most of the time, if I had a problem with my friends, I will come to her and I will tell her."*

However, when there was a shift, many of the adolescents connected this shift to a family stressor like divorce or illness.

> *"My mom? Kind of changed. When I was younger, me and her see eye to eye, but now we don't know. Ever since I've been with my dad, me and him started to see eye to eye because we're like boys... My mom took me from everybody down there, just to bring me down here, it changed everything. I used to make people laugh, and I had a lot of friends that wanted to hang out with me, and as what I'm doing this weekend. Down here I don't have that.*

It is important to understand the context of the parent-child relationship and how that relationship may impact trust and the type of support the teen may receive. As indicated by past studies, parental trust and support can protective against risky health behaviors.

Discipline. To delve deeper into the discordance between the adolescent and the parents' perception, the topic of consistent discipline was explored. To identify the discrepancy, we asked

the parent to describe their house rules and the consequences if the rule was broken. In addition the parents shared a time the adolescent broke the rules and their response. I also asked the adolescent the same questions but then asked them to expound on the situation the parent shared. Using this tool I found that a majority of the parents had direct rules about behavior at school, time alone with peers, and general chores. The adolescent agreed with these rules. However, there were discrepancies within the rule breaking narrative. All of the narratives involved a time the adolescent left the home without the parents' permission.

Parents stated that they provided a clear explanation of the consequences and followed up the punishment with a discussion. However, the adolescents stated vastly different responses. One teen described how her mother responded when she returned home:

> *"When I got home, I came straight to the church. No. Yeah. I went home first, then I came back here because it was Sunday night. My mom, she was right there. She got down to me. She's, "Don't do that."* ***Interviewer:*** What happened? Did you face any types of consequences for any of the things that you told me about? Were there any types of consequences? **Teen**: No. That was just it.

Another teen described a time that she left her home with her twenty-something year old aunt, without her mother's permission:

> *I was like Kiki told me to go, Kiki told me to go. We got a whooping and my granddaddy came. He had got on my auntie, he was like you shouldn't have her doing that if you knew her momma told her no. So, I had got in trouble for that. I never did it again.*
>
> ***Interviewer****:* Did you guys discuss it after you got punished? After the whooping? **Teen**: No. I don't remember

While the teens indicated that they did not receive a thorough follow-up, the parents stated that they did discuss the issue, along with providing a punishment. This narrative was consistent across all of the dyads. It is possible that the discordance was found in the explanation of the rules and the consistency of the punishment. It is important to investigate this area because of the connection between discipline, monitoring and sexual risk taking.

Theme Two: Sexual Health and Sexual Health Communication

Results indicate adolescent sexual health and sexual health communication between parent and child are impacted by the following: 1) parents' history on the current relationship between the adolescent and parent, 2) parental history with sex and sexual health, and 3) sex messaging the adolescents had received as well as parents' views on sex and the sex messaging they were communicating.

The impact of parental history. While parents were able to communicate with their child about everyday events, they found it difficult to discuss specific detailed conversations about sex. However, the mothers also revealed that their motivation to push through the uncomfortable conversations was directly related to their own upbringing.

One of the major themes that emerged across the parent and adolescent interviews was the impact of the parent's relationship with their own primary caregiver. Parents were asked to describe relational shifts and challenges of entering adolescences from their own personal history and their experience with their adolescent.

Many parents reported that they had positive interactions with their own caregivers. However, a few parents stated that they did not have a close relationship. One mother spoke openly about the impact of her relationship with her mother:

"…but me and my mom, we didn't have a good relationship. She stayed to herself. When she had a boyfriend though, she really didn't ... I was like the mother and she was like the daughter, so we didn't have a good relationship at all."

Parents indicated that the relationship that they had with their caregiver informed their current experience with their adolescent. The same mother also stated the following in regards to her relationship with her children:

"Totally different. I show my kids love. I show it to them, I give it to them. I'm supportive of them. The way I was raised, I didn't see it. It wasn't shown to me, it wasn't taught to me. That's why I always said when I had kids I was going to be a different parent than my mother, and believe whatever they tell me."

When matching the qualitative responses to the measure of support scale in the survey I observed a similar theme. Over 68% of the adolescents classified their relationship as close or very close.

Many of the parents felt that the status of their relationship allowed them to discuss with their kids about various topics. One parent stated:

"It's certain things that he'll come to me about, and I'll give him my opinion. But as I always talk to him, I'm going to say he listen but sometimes he don't. But we talk because I am open."

Many of the adolescents supported the parent's response. However, there were discordant responses in terms of whom the adolescent felt closest too in their family. While one mother reported a very close relationship, her adolescent stated the following:

"Yeah. We're in the same room most of the time. There's 20% communication between us because we're both on two different devices. We don't usually talk or anything. I don't get it but I'm used to it."

This teen went on to say that she communicates most with her father. Three adolescents (1 female, 2 males) indicated that their fathers were their closest allies and felt more comfortable speaking with them about their day-to-day life.

Parents past experience with sex and sexual health. This section will discuss the parents' background with sex, sexual health communication with their parents, and their understanding/experience with sexual health.

Sex talk. In addition to understanding the parent-adolescent relationship the parent's history with sex emerged as a major theme in terms of sexual health communication. Many parents explained their personal experience with sex during their upbringing. Of the seven parents, only two had talked about sex with their parents. For the rest, many of the messages received were demands "Don't have sex" or "You better not get pregnant." Often, parents did not explain the reasoning behind their directives.

Past negative experiences. Some parents discussed past substance abuse and others negative sexual health decisions. Nikki, a 35-year-old single mother, stated:

"*It's best for the parents to talk to them instead of the way I learned. I don't want my kids to learn from the streets. I wanted them to learn from home, that way when the streets do talk to them, they already understand. At least some of it, because you can't tell them everything, but at least some of it. I try to be one hundred with my kids about sex. I don't want them to have kids early like I did, so it was best for me to talk to them."*

Sarah, a 50-year-old married mother, stated:

"When I started drinking and doing the drugs. Not my marijuana just drinking heavily and everything because I feel that I wasn't loved…..I made bad choices. I ended up in rehab. I tell her all the time don't be like me. I don't want to see you…and no one have to struggle. I don't want to see her struggling to finish school. You have to have a career, know what you want to do, what you want to be, and just start life like that."

Dede, another mother, said the following:

"I have been in your shoes [her sons]. I have been there, done that, what you're doing. I'm a lady but you're a man, as in, being a tomboy. Whatever I tell you is from my own health, and my own perspective of what I have done, and I don't want you, since you growing up now to become a man, don't do the things that I have done back in my days. I want you to be better than me. As, achieving in high school, get your high school diploma. Go to college if you choose to, or find you a good job."

The parents often tied their adolescent's future success to their ability to avoid negative sexual consequences.

Sexual Health Communication. Both the adolescent and the parent were asked to describe the conversations that they had about sexual health and dating relationships. Several sub categories emerged: defining sex and the reasons for sex talks.

Defining sex. Younger adolescents (13-14) described sex as unappealing. One adolescent comments:

"It's nasty. You don't do it until after you get married. It's nasty."

On the other hand, older adolescents describe sex from a values perspective. One 15-year-old male said:

"I really think it's for married people who make promises to another, and who knows that are going to be together for life. That's when kids come in, when parents are married, or something like that. You know your parents aren't going to split up."

While all of the parents stated that they discussed sex from both a biological and value perspective, only one of the teens discussed sex from a biological perspective. Kiki, a 15 year old female, said:

"I know sex is with girls and boys. Oral sex is just like feeling the vagina (laughter) and that's it. I don't think teenagers should have sex."

Reasons for sex talks. Adolescents identified the reasons for why they talk about sex with each their parents or others: trust and warmth, knowledge and experiences, discomfort/comfort.

Trust, warmth and a connection was typically assigned to a non-family member. Some adolescents sought sexual health communication from a trusted family member due to discomfort with discussing topics with their parents. For example, one adolescent describes her experience discussing sex with her sisters:

"No. My sisters. They took care of that. My parents asked my sisters because it made me feel weird. I talk to them more. I can easily communicate with my sisters. My sisters, they talked to me about that kind of stuff or I learned that in health class."

This teen's parent also admitted discomfort discussing sex with their adolescent:

"Yeah, because for me it can be very hard for me to talk to her about that because I don't feel comfortable with it. Maybe I could give her some point of views. What to look for in a person but she have her own choice. I can't make her choice for her. So she talks to her sister."

However, most of the parents and the adolescents stated that they were willing to discuss sex because of the level of trust and support they felt between each other. All but one of the parents stated that they were comfortable with discussing their beliefs regarding sex.

Theme Three: Sexual Health Communication Content, Values and Beliefs on Sexual Health

The next major theme that emerged was the values and beliefs on sexual health. Four subthemes emerged from the adolescent and parent interviews: 1) relationship values 2) readiness for sex 3) consequences: STD/HIV and pregnancy, and 4) protective behaviors.

Relationship values. All the parents stated that they had direct conversations with their teens about the importance of knowing your partner. The parents' conversations centered on knowing your partner's status, commitment level, and trust worthiness. The adolescents mainly spoke of the desire for a partner they could marry or someone to whom they could be committed. From this section subthemes surrounding the concept of commit emerged: defining commitment, the function of commitment, and the importance. The adolescents defined commitment as an act of security:

> *"Commitment is when you want to give all your love and support to this person. When you're for sure this is what you're going to be doing or what you're going to be paying attention to for this period of time, for a certain period of time."*

All teens defined marriage as the highest level of commitment. Marriage was seen as a function of the committed relationship. One male teen stated,

> *"I know what's wrong, and what's not wrong. Sex is not for everybody. I think it's for married people, and grown-ups. Who know what they're doing and who they really love. I really think it's for people who really love each other, and state commitment. Who's going to stay together and stuff like that. That's what I think it's for."*

Adolescents thought that commitment was important for two reasons: limiting the spread of disease and reducing heartache. According to a 15-year-old male:

> *"Some parents have kids, having sex ... Who's at home, whoever catches the disease, or have a baby, or can be both. You can have a disease and have a baby. That's why it's really important to get married before you start anything."*

Similarly, a 14-year-old teen highlighted the importance of commitment as it relates to limiting the spread of disease:

> *"It is important because if you're not committed to that person or if you want to hang with that person for a while, and you're planning on leaving him, in a couple of months or whatever. That's not commitment. You're spreading, if you catch anything, you'll be spreading that, if you're not committed to that person. To one person, that you're planning on being with for this period of time."*

Finally, adolescents stated that a committed relationship helps protect against engaging in non-monogamist relationships.

> "*I know that's right because if you really love this person, would you go back to have sex with somebody you really don't love, when you have somebody on that you love. It just don't make sense, and that's how diseases start spreading around, because you're going from person to person to person. That's really messed up because some people really love the person. Some people who really love the person they really love, the person sometimes go behind the person and cheat and lay up with this person. That's really important, be with the person you really love, not the person you just don't care about." (Male teen, 15)*

"Because if it just like somebody like who you just go with, then he probably not ready for responsibilities and probably just like don't have a bond to be able to stay together to have a child. If you been with somebody for years then you know each other and y'all be ready for a child. You don't just want anybody, just to have a baby by anybody." (Female teen, 16)

When comparing the adolescent responses the sexual values and belief measure from phase one, these findings are consistent. These results provide a contextual finding to why teens strongly agreed with the marriage/committed relationship positive questions.

Readiness for sex. All the adolescents stated that they were not ready for sex, that they were too young and not ready to take on the risk of STDs or pregnancy:

"Because they too young. And they're not ready for a child then. Then they get STDs. Like my cousin, she 18 and that's it, she know she wasn't ready for a child, and now she have a child. And she get frustrated and stuff, and I tell her, well you shouldn't have done what you did because with unprotected sex one thing you going to get is either an STD or a baby. You got a baby. Be lucky by that, instead of an STD. I know I'll marry before nothing like that. So that's why I'd rather not have sex and can nobody change my mind about it." (Female, 16)

However, many of the teens discussed with their parent or extended family member what would make them ready. When both adolescents and parents were asked to define readiness all stated a particular age. The 14 year old female stated:

"She told me how old you should be when you start getting like that. Just that….. She said at least 22, around there."

Some teens and parents stated that when they reach a level of independence then they will be ready. These statements contradict earlier statements about their desire to wait till they are married or in a committed relationship.

Consequences: STD/HIV and Pregnancy & protection methods. Parents mostly promoted delayed sexual activity and condom use. They often paired the conversations with consequences of unprotected sex. However, the messages were different depending on the gender of the adolescent. Nikki, the single mother with a daughter, stated:

> *"I don't be too quick to talk to her about it because I don't want her to have it yet, but I know it can happen. I just mainly be asking her when she do it, does she think she's going to tell me. She be like, "No!" I think she will though." I want her to be like, "Mama, I'm having sex. Can you take me to go get some birth control?" That's all I want to hear. I don't want to hear what she's doing with him or none of that, but like, making sure she's using protection.*

Interestingly, parents of the male adolescents spoke openly about condoms. For example, one adolescent described what he learned from his mother:

> *"My mom says all the time 'Never have sex without a condom, or use protection. Make sure the person is checked, make sure you're checked. If you really love this person you'll really wait, and wait till you're married ….make sure that person has no type of disease or anything, or you know just no type of disease that can harm you or anything. Or just on the safe side make sure you don't have no disease or anything.' [Teen's response]Still if you're not married, and you both have no disease, you still have to use protection before you start having sex."*

Several parents stated that their child will have sex even though they desire them to wait. Due to this belief, the parents often provided a two-prong message of delaying sex and protecting against sexual transmitted diseases and pregnancy.

Protective Behaviors. The final subtheme to emerge from the adolescents' transcripts was protective behaviors as it relates to their peers. All of the adolescents stated that they were not sexually active for a variety of reasons (too young, STD, pregnancy, etc.). From the transcripts, the fear of peer shaming emerged as an additional reason for not engaging in sexual activity.

Peer shaming. For the purposes of this study, peer shaming is defined as the aggressive nature of teens to exposing another teen's sexual behavior. Exposing was defined as submitting pictures of teens engaging in sexual acts, bullying, and the use of social media to expose past sexual behavior. All the teens stated that they did not engage in sexual acts, specifically oral sex, because they did not want to be embarrassed as many of their peers had been. Below is an extend narrative of one teens experience with peer shaming:

> *"She had sex with this boy and he say they only have oral sex and she was saying that she was pregnant. He put on Facebook like, "I don't know why she is saying she pregnant by me because she only gave me head". It just went around school. She was crying about it but like she just don't care. Even though that happened she still tell people like, she going to go meet a boy and they about to have sex and she could have just met [the boy]. I be like, she not trying to change, so my friend, I don't want her hanging around her because they going to think you the same way. And a lot of girls that I went to school with, now they pregnant, so I just try to stay away from them."*

Another teen shared the following:

"When they have oral sex, the dudes, the guys, they record it and put it online, or the go around telling their friends, spreading it around the school. When he goes around the school, that's when it heads back to the girl and she starts feeling ashamed about herself. That's when they start feeling bad, after the fact that they did it. That's what's going on in schools."

All the teens acknowledged that the peer shaming is wrong and that they desire to avoid being a part of the shaming.

Theme Four: The Connection of Religion and Spiritualty to Sexual Health

Various health studies have found positive and negative connections between sexual health and religion and spiritualty. However, within in this study very few connections were found. The qualitative phase of this study gives further insight into this discrepancy. First, adolescents and parents were asked to define religion and spirituality as well as classify themselves as religious or spiritual. Next, study participants were asked the importance, if any, their beliefs have on their decision making as well as sexual health.

Defining religion and spirituality. Parents defined religion by certain activities such as praying, reading the bible or going to church; whereas, the adolescents defined religion by acts or feelings:

"*Something you really believe in. Something you trust, and believe, unlike some people. Religion is God, that you trust in God, that you know about him. Christians, religion is God. That's the way I look at it, the religion is something you know about, or something you trust. Just anything you love, mostly anything, you'd cut anything off for your religion. That's what I think religion is like. Something you really love. (Male, 16)*

Religious belief is like when you believe in God and you're just deep in to it and you don't play about it. You take it real serious." (Female, 15)

One teen found it difficult to define the word religion and instead used the terms faith and belief which can be consider acts.

"*It's about the same thing. Faith is when you say, "I believe in God. He's my faith." Say, you believe in God. He's ... How do I want to explain this? I'm going to do belief first then, so it'll make sense when I say, "faith." Belief. Belief like you ... I believe that you can do this. That means that I know that you can do this. I'm for sure that you're going to be able to do this if you just keep trying and stuff. That's just about the faith thing is faith. That's what I meant to say."*

In terms of spirituality, parents were split in their responses. Some parents tied spirituality to certain acts such as worship or "catching the holy ghost."' Other parents defined it as a feeling that is tied to prayer. Adolescents defined spirituality as a personal connection to one self and beliefs and completely separate from religious acts. For example, two adolescents describe spirituality as the following:

"Spiritual is like you believe in something you know is a higher power but you don't know what is the higher power, you just know there is one. You have faith in it, but you are not like deep in to religion."

"Invisible, something in yourself, nobody else believes in but just you. Only something you know about. Like, spiritual. It's just something you know about, nobody else knows, and what you know that's true, that's what I think. Mostly talking about yourself, you don't know what the other person think, it's just you spiritually, what you think. What you actually know about this person, or someone like that."

Classification. Only one parent and one teen classified themselves as religious while the rest classified themselves spiritual people that engaged in religious acts.

> *"… but I believe there is a God. I just don't know, but I believe. Certain stuff that it was because of God. I'm not like deep into church and the bible, but I believe in God." (16 year old female)*

Importance of beliefs and the connection to sexual health. Adolescents and parents stated that the combination of their spiritual and religious beliefs helped them make decisions. The major areas that they identified as areas where their beliefs inform their decisions included: health scares, financial problems, relationships, and for teens, bullying.

Sex and beliefs. In terms of mapping a direct connection from religious or spiritual beliefs to sexual health, all of the adolescents had a difficult time contextualizing the concept. Many stated that they did not know or could not thoroughly explain. However one teen was able to draw a small connection between her faith and decisions regarding sexual activity:

> *"I have to have faith that when I get older, I'm not going to be 16 and have a child because it'll be hard to go to school like that with 16 and you have a child having to go to school and everything. That would not be ... That wouldn't be easy and that's my future. I have to have faith that if I do anything ... I won't, but, if I were to do anything now the result in my future would break down horribly." (Female, 14)*

These results highlight the need further investigate religion and spirituality as it relates to decision making regarding sexual activity. While research participants have a personal understanding of their beliefs, there seems to be disconnect with how their beliefs inform their decision making in regarding sexual activity.

CHAPTER 5

DISCUSSION

This study had two objectives: to investigate the influence of parenting processes, religiosity, and spirituality on adolescents' sexual behaviors and to examine the underlying contextual links to the parent-adolescent relationship and its impact on sexual health. Due to the sequential nature of the study, a third purpose emerged: to understand the impact of parental processes on sexual health communication. This study used multiple research methods to gathered information from both the parent and the adolescent. The results of this study expanded the understanding of determinants of positive parent-adolescent interactions and the contextual nature of the interactions as protective factors against risk-taking behaviors. This chapter discusses the findings from Phases 1 and 2 and the implications of these findings, followed by limitations and recommendations for future research.

Parenting practices, perceived adolescent sexual behavior, and sexual health communication. In the quantitative phase of this research study (Phase 1), parenting practices, religiosity and spirituality where investigated to examine their protective nature among African American parents and adolescents. Consistent discipline, parental support, and parental monitoring were the main parental practices. Findings partially supported the hypothesis that these practices may decrease the likelihood of adolescent participation in sexual behaviors from the parents' perspective. Only parental discipline was associated with a perceived reduction of adolescent sexual behavior. Parental support was not associated with adolescent sexual behavior

but it was with sexual health communication. These findings are consistent with previous studies on urban and ethnic minority youth that state increased parental practices serve as protective factors against sexual behavior and other adverse behaviors (Bohnert, Anthony, & Breslau, 2012; Elkington, Bauermeister, & Zimmerman, 2011; Harris, Sutherland, & Hutchinson, 2013; Lee, Stuart, Ialongo, & Martins, 2014; Lowe & Dotterer, 2013). In this study, parental support and discipline were the strongest indicators of protection.

Parental support was defined as a sense of connectedness, warmth, trust, and protection. Parents may be more likely to give sexual health information when they feel connected to their child. This connectedness may lay the groundwork for trust and willingness for the adolescent to delay sexual activity or engage in protective behaviors. Aspy and colleagues (2006) reported that parental support and connectedness were positively associated with sexual abstinence and condom use, among those sexually active. In addition, in a similar study on dyadic responses between mothers and sons, researchers found that when both the mothers and the sons reported higher levels of connectedness, acceptance of sexual health messages was higher (Santa Maria, Markham, Engebretson, Baumler, & Mccurdy, 2014). Consistent discipline was the greatest indicator of protection in terms of adolescent sexual experience behavior. Again the underlying nature of consistent discipline may explain why it supersedes the need for consistent monitoring. If a parent is able to enforce rules and communicate with their adolescent this may also provide a sense of trust and protection.

Religiosity, spirituality, parental sexual values and beliefs. Prior research studies have found that highly religious parents and adolescents report less sexual behavior and that religion can act as a protective factor (Bachanas et al., 2002; Ball et al., 2003; Barry et al., 2012; Barton et al., 2012; Burke et al., 2012; L. Miller et al., 2000; L. Miller & Gur, 2002).The findings from

this study did not support this tenant. None of the religious constructs had a significant association with perceived adolescent sexual behavior and sexual health communication. One explanation is that very few parents viewed themselves as religious. However there was significance when comparing the parents' religious and spiritual beliefs to the parents' stated beliefs about adolescent sexual behavior. The sexual values and belief measure assessed the parents' and adolescents' perception of appropriate adolescent sexual behavior. The findings from this measure were partially consistent with past literature that has found an association between religiosity, spirituality, and sexual attitudes and beliefs. The current study displays the discord between religious/spiritual actions and attitudes. While many of the parents reported that they do not view themselves as religious they identified themselves as spiritual people who carry their religious or spiritual beliefs into every aspect of their lives. As discussed in Chapter 2, spirituality refers to an inner strength, interconnectedness (Dalmida, 2006; Dalmida et al., 2009), internal, personal or private, and an emotional expression of the sacred (Cotton et al., 2012). Spirituality centers on the acknowledgment of something greater than oneself. Spirituality encourages a personal quest for understanding life, meaning, and the relationship with the transcendent in a deeper and more meaningful way (Fry, 2000; Musgrave et al., 2002; Seeman et al., 2003; Sternthal et al., 2012). More research is needed to investigate the connection of spiritual attitudes and sexual behavior and beliefs.

Dyadic responses. There was discordance between the parents and adolescents in terms of consistent discipline. Parents were more likely than their children to state that they provided a positive and nurturing environment for their teens. These findings were consistent with past studies. Researchers have stated that parents will tend to over report their parenting behaviors (Borawski et al., 2003; DeVore & Ginsburg, 2005; Wight, Williamson, & Henderson, 2006).

Associations between the parents self-reported parenting processes and adolescent risk behavior was also assessed. Parents reported perceived that their adolescents were less sexually active than what the adolescents actually reported. These findings again supported with past studies that state parents have a tendency to under report adolescent risk for various reasons, lack of knowledge, shame, or lack of communication with their teen. Due to this under reporting adolescent sexual behavior index was assessed (Hansen et al., 1999).

Teens did report more pre-sexual intercourse behaviors and more sexual intercourse. However, overall the teens were not engaging in risky sexual behavior. While the teens reported more sexual intercourse (nine teens), a majority of the teens were not engaging in sexual intercourse.

The major themes from the qualitative interviews highlighted that these teens were not ready for sex and they viewed sex as an act of reserved for committed relationships. These findings led to a deeper investigation into sexual health communication, messaging and the impact of the parent-adolescent relationship.

Findings from the quantitative study provided valuable insight for the qualitative phase. The qualitative phase permitted an in-depth exploration of the underling factors of parental support, consistent discipline, sexual health communication, and insignificant findings. The qualitative phase noted that parental supervision involves more than the parent knowing where the child is and whom they are with at the time. Instead, adolescents' perception was driven by the ability of the parent to consistently provide support, protect them, and be available. The parent-adolescent relationship themes also revealed that rules, goals, and values were embedded throughout the relationship and increased the quality of the relationship. These findings provide a contextual nature to the concept of parental support and discipline. Interesting findings that

emerged from the qualitative interviews included: impact of the parental history, the content of the messages, gender differences, peer shaming as a protective factor and the participation of fathers and extended family members.

Parental History and the Conceptual Model. The impact of parental history was a major theme that emerged from the study. Parents consistently stated that their relationship with their own caregiver greatly informed their current relationship with their adolescent. The parents past history encouraged the parents to foster support and connectedness with their adolescent. These salient themes are congruent with Phase 1 findings on parental support. In addition, this theme may help explain why some familial homes provide high levels of support and connectedness (Ackard et al., 2006; Bachanas et al., 2002; Barnes & Farrell, 1992; Barrera et al., 2002; Szaflarski et al., 2006). The parents' history also motivated the parents to talk about sexual health and substance use.

One alarming theme that emerged was the high rate of physical, emotional or sexual abuse all but one of the parents reported. While studying violence, abuse and injury was not a purpose of this study, it may aid researchers to investigate the impact of intergenerational violence on sexual health outcomes. In a qualitative study on intimate partner violence, researchers found that past parental abuse experience encouraged conversations about healthy dating behaviors (Akers, Yonas, Burke, & Chang, 2011). Parents felt it was their obligation to inform their adolescents of unhealthy behaviors so that they could protect them. These findings highlight the need for future studies to incorporate parental history in adolescent sexual health studies. The findings from the current study also encourage a renewed examination of the conceptual model and the ecological framework. It may be important to add a layer that encompasses the transgenerational impact of parental history on adolescent sexual behavior.

Sexual Health Messaging. Both parents and teens discussed fear of STDs, importance of condoms, and prevention of pregnancy; however, there was little discussion on HIV and contraception. While the parents and the adolescents identified conversations about condoms and pregnancy prevention, the content of the messages was limited. The conversations were single-prong messages that warned the adolescents to not "get pregnant" or to delay having sex. However, the conversations did not provide strategies on how to avoid pregnancy through consistent use of condoms and birth control. In addition, no specific strategies were given on how to delay having sex outside of encouraging the adolescents to wait. This finding highlights a specific area to train parents and adolescents. While both parents and teens indicated that they discussed the dangers of getting an STD, very few were able to provide accurate knowledge of STDs. Empowering parents with factual information and encouraging the families to talk specifically about HIV and contraception would be a useful tool. In addition, both parents and teens discussed a desire for a committed relationship; however, there was little to no discussion on how to develop a healthy relationship. Creating or adapting programs that highlight how to form healthy relationships would be a useful tool for this community.

Parents also delivered different messages to their female or male teens. Girls mainly received directives about pregnancy and STDs; whereas, boys received a two prong message of delaying sex, but if they do have sex, to use condoms. Sexual health communication between parents and teens should encompass a holistic message that is matched with strategies. To simply discuss fears with teens is not enough. Families should be at the forefront with providing concrete ways to reduce risk and to create healthier relationships.

Peer Shaming. Another interesting finding that emerged was the influence of peer shaming and social media. For the adolescents in this study, the aggressive nature of relational

aggression, bullying, and negative peer socialization seemed to act as a protective factor. Adolescents avoided sexual acts, specifically oral sex, for fear of embarrassment in the public arena (via Facebook, Twitter, etc.). The theme articulated by the adolescents was a desire for self-protection and security. Peer shaming, which is widely seen as negative, was encouraging the teens to resist engaging in risky behavior. Given the overwhelming presence of social media in the day-to-day life of adolescents, more research is needed in this area.

Finally, in terms of extend family members and fathers, parents and teens expressed the importance of additional family members in their understanding and knowledge of sexual health. Extended family members may help parents who are not comfortable with discussing sexual health with their teens. Also, for some teenagers may be easier to discuss sexuality with other family members. In a mixed-method study of a large diverse middle school sample, Grossman and colleagues (2015) found that more sexually active teens reported speaking to extend family members. Fathers were also important in the qualitative interviews. While mothers are often seen as the primary sexual health educators, fathers' involvement in sexual health should be investigated more. Teens expressed that their fathers impacted their lives and some teens asked them for additional sexual health information.

Limitations

While this study was unique in its multifaceted approach through mixed-methodology and from gathering data from both the parent and the adolescent, there were limitations. Given that this study is cross-sectional, it is not possible to make casual inferences from the results. The sequential explanatory design of the study allowed further exploration of key concepts form the survey in the interviews. However, due to the limited sample size of the qualitative interviews, it is not possible to apply those results to the general population. Inferences are also limited by the

self-reporting nature of the data due to social desirability. Finally, the small sample size of the adolescent sample limited statistical analyses with the dyad dataset. The low adolescent response rate could have been attributed to a parent's unwillingness for their teens to participate. Despite these limitations to generalizability, participant interview and survey responses provided a new level of depth to understanding to the parent-adolescent relationship and sexual health communication.

Implications and Recommendations

Future studies should continue to investigate the importance of the parent-child relationship. In addition, interventions should find ways to integrate other family members, besides the mothers, into the sexual health education process. Finally, even with the increased focus on the ecological model, many interventions still focus on risk reduction at the individual level. While there is great need to focus on how individuals can reduce their risk, there is still a need to integrate the entire ecological framework in the discussion. Often, sexual health communication is seen as divided into pre-sexual behavior that focuses on delaying sex and post-sexual behavior communication that only focuses on reducing risk. Sexual health communication should be an ongoing conversation with a two-prong message at any level (pre or post sexual intercourse). In other words, the adolescent should receive a holistic messages that cover all concepts of sexual regardless of their sexual behavior. As this study suggests sexual health communication, if taken place in a supportive environment, can be well received.

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Appendix A - Subjectivity Statement

Qualitative researchers and students are often encouraged to state their subjectivity to their research studies. The statement is used to qualify the investigators' relationship to the research by addressing their cultural, historical, personal, and professional background (Koch, 1994). In addition to qualifying study limitations, the subjectivity statement allows the researcher to address biases that may appear due to background and past experiences. For this statement, the voice is written in first person.

I, the researcher, am a first generation Nigerian-American female who has spent the majority of her life in the U.S. South. My Nigerian heritage has greatly influenced my research interest in the family and the impact the family has on behavior. I come from a cultural background that greatly values family and the relationship that children have with their parents. Growing up in that type of culture has pushed me to investigate how other cultures view family and the influence of the parental behavior on the child. I first approached this topic in my undergraduate career by pursing psychology with a focus on child development. After graduating I started working as a project coordinator in a Child Studies Center. My time there encouraged me to view the familial relationship from several different viewpoints (positive and negative).

My journey into sexual health research began during my Master of Public Health program. I worked on several sexual health projects as a student, and after graduation I worked as a project coordinator. As coordinator, I was responsible for data management, recruitment, and data analysis. I also gained experience with presenting our findings by publishing articles and research conferences.

My desire to investigate sexual health from a faith perspective comes from my own personal faith background. As a Christian, I feel that the core beliefs of my faith drive my

decision making and ultimately the choices that I make. Ultimately my faith influences my personal convictions and beliefs on sexual health. I personally believe that sex is a beautiful gift for all and is best maintained in a committed relationship (i.e., marriage) between two committed people. While I view my faith as a positive impact on my life, I understand that others may view faith through restrictive lenses. In investigating sexual health from a faith perspective, I must keep an open mind of how others view faith and be prepared for positive, negative or indifferent responses.

Finally, as a black woman I am greatly interested in investigating the impact of sexual health choices on my community. From my perspective research has mainly investigated the African American community as a risk factor, focusing only on the negative outcomes and brushing over the positive outcomes. Very few researchers view the African American community from a positive viewpoint (i.e., what is actually working). As a researcher I want to highlight the families who are doing well and the adolescents who are not engaging in risky behavior. There is value in knowing what influences these individuals to not engage in risky behaviors.

By addressing my research bias and understanding how my background plays into my bias, I will take great steps to control theses biases. I will take great pains to suspend my beliefs during the data collection and analysis of my research.

Stance. There are several designs that have been constructed to achieve a mixed method study. When selecting a design, the researchers must decide the overall stance for their study. Once that purpose or stance is identified, then the particular design can be selected. For this study the stance that was selected was Greene's (2007) complementary strengths stance, which focuses on the assumption that alternate paradigms are importantly different and methods

implemented with different paradigms should be kept separate from one another. For this stance the paradigmatic assumptions of the nature of the research, the role of the researcher, values of the research, and the language are vital, as well as the context and theory. The differences between the paradigms are valuable and should be preserved to maintain methodological integrity while expanding the scope of the study (Greene, 2007). For the current study the researcher was interested in examining the parent-child relationship and the intersection of religiosity and spirituality on sexual health from a quantitative and qualitative perspective. Using the complementary stance allowed the researcher to maintain the integrity of both paradigms while investigating the same concept (parent-child relationships, religiosity, spirituality, and sexual health) from two different perspectives. The selection of the complementary stance has led to the decision to apply a sequential explanatory design for the current study.

Appendix B

Demographics

1. Are you:
   Male
   Female
2. How old are you? _____
3. Do you live in the City of Atlanta?*
   Yes
   No
4. What neighborhood do you spend the majority of your time?
   Vine City
   English Avenue
   Pittsburgh
   Washington Heights
   Boulevard Heights
   Other: _____

Sexual Behavior

The next sets of questions are about your knowledge of your adolescent's behavior to people of the opposite sex.

1. In the past year have your adolescent hugged anybody that was not a family member?
   Yes
   No
2. In the past year, for someone that they have romantic feelings for, has your child held hands with someone with that person?
   Yes
   No
3. In the past year, for someone that your child has romantic feelings for, has your child spent time alone with that person?
   Yes
   No

For someone that your child has had romantic feelings…..

1. In the past year have your child kissed that person?
   Yes
   No
2. In the past year, has your child been kissed by anybody?
   Yes
   No
3. In the past year have they cuddled?
   Yes
   No
4. In the past year have they lain down together (with their clothes on)?
   Yes
   No

5. To your knowledge has your child ever had sexual intercourse? This is when a guy puts his penis in a girl's vagina.
   Yes
   No
6. How old do you think they were when they first started having sex? ____
7. Do you know if your son or daughter is using condoms?
   Yes
   No
   Not sure
8. Do you know if your son or daughter is using other type(s) of protection? (Check all that apply)
   Pill or Depo
   Withdrawal
   Spermicide
   None
   Other
   Not sure
9. To your knowledge, has your child ever had oral sex? Oral sex is when one person puts their mouth on someone else private parts.
   Yes
   No
   Not sure

Parental Background

1. Which is the highest education level that you have completed?
   Some Grade School
   Finished the 8th Grade
   Some High School
   GED / High School Diploma
   Some Technical School
   Technical School Graduate
   Some College
   Associates Degree
   Bachelor's Degree
   Some Graduate Work
   Advanced Degree
2. Which of the following best describes your marital status?
   Never married to my child's biological/adopted parent
   Currently married to my child's biological/adopted parent
   Divorced or separated
   Divorced and remarried
   Widowed or Widower
3. Who is the person (who lives in your house) who knows what your child is doing most of the time? (Choose one)
   Me
   Their other parent (father or mother)
   Another Relative

Sister or Brother
Other

Parental Monitoring Assessment (PMA)

4. Indicate if you never, rarely sometimes or always

I know where my child is after school
If my child is going to be home late, he/she is expected to call me to let me they will be late.
My child tells me who they are going to be with before they go out.
When my child goes out at night, I know where they are.
My child talks to me about the plans they have with their friends.
When my child goes out, I ask them where they are going.

Discipline

5. Indicate if you usually, sometimes, rarely, or never

Yell or scream at your child?
Ground or restrict your child privileges?
Discuss with your child why what they did was wrong?
Stop talking to your child?
Threaten to throw your child out of the house?
Not do anything (meaning you do not give a punishment)?
Discuss what your child should have done?

QPR-Parent

Indicate: None of the time, a little of the time, some of the time, most of the time, or all of the time
I show my child that I am proud of him or her
I take an interest in my child's activities
My child can count on me to be there when he or she needs me
My child and I talk about the things that really matter
My child is comfortable sharing his or her thoughts and feelings with me
Even if my child knows I'd be disappointed, he or she can come to me for help with a problem

1. I consider my child and I to be:

Very close
Close
Somewhat close
Not very close
Not close at all

Sexual values and beliefs

Rate your thoughts on the following statements: Strongly disagree, disagree, neutral, agree, or strongly agree

It is important for people not to have sex before they get married
Having sex should be viewed as just a normal and expected part of dating relationships
It is against my values for my teen to have sexual intercourse while they are an unmarried teenager
Teens who have been dating the same person for a long time should be willing to go along and have sex if their partner wants to
It is all right for teenagers to have sex before they're married if they are in love
Having sex is something only married couples should do.
I think it is OK for adults my age to have sex whither or not they are married
People who do not want to have sex should have the right to say NO
My child's sexual values and beliefs agree with my values and beliefs

Religiousness/Spirituality

1. How often do you pray privately in places other than at church or synagogue?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never
2. How often do you watch or listen to religious programs on TV or radio?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never
3. How often do you read the Bible or other religious literature?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never
4. How often are prayers or grace said before or after meals in your home?
   At all meals

Once a day
At least once a week
Only on special occasions
Never

5. I try hard to carry my religious beliefs over into all my other dealings in life.
   Strongly agree
   Agree
   Disagree
   Strongly disagree
6. I try hard to carry my spiritual beliefs over into all my other dealings in life.
   Strongly agree
   Agree
   Disagree
   Strongly disagree
7. How often do you go to religious services?
   More than once a week
   Every week or more often
   Once or twice a month
   Every month or so
   Once or twice a year
   Never
8. Besides religious services, how often do you take part in other activities at a place of worship?
   More than once a week
   Every week or more often
   Once or twice a month
   Every month or so
   Once or twice a year
   Never
9. What is your current religious preference?
10. To what extent do you consider yourself a religious person?
    Very religious
    Moderately religious
    Slightly religious
    Not religious at all
11. To what extent do you consider yourself a spiritual person?
    Very spiritual
    Moderately spiritual
    Slightly spiritual
    Not spiritual at all

Sexual Health Communication

In the last year, how much information did you share with your child about:

Amount of time they shared with you in the last year

...contraception/preventing pregnancy?
...sexually-transmitted diseases (STDs)?

...HIV/AIDS?
...ways to protect yourself against STDs and HIV/AIDS?
...condoms specifically?
...postponing or not having sex?
...peer pressure and sexual pressure from dating partners?
...how to resist sexual pressure from peers and dating partners?

Housing

1. In the past 3 months, were you homeless at any time? That is, you slept in a shelter for homeless people, or on the streets, or another place not intended for sleeping?
2. Have you changed homes in the past year?
3. How many times have you changed homes in the past five years?
   Never
   1 or 2 times
   3 or 4 times
   5 or 6 times
   7 or more times

Economic Status

1. In the past 12 months, did you or anyone you live with receive any money or services from any of the following? (Check all items that apply OR check "NO") (Check all that apply) *
   Welfare (including TANF (Temporary Assistance to Needy Families) or SSI)
   Food stamps
   WIC (Women, Infants and Children)
   Section 8 housing (housing subsidies)
   No, none of the above
2. Do you have a job for which you are paid?
3. How many hours per week do you usually work at your job?
4. How much do you make per hour?

Adolescent Survey

Demographics

1. Are you:
   Male
   Female
2. How old are you?
3. Who do you live with?
   Alone
   Mother and Father
   Mother
   Father
   Mother & romantic partner
   Father & romantic partner
   Another relative
   Other

4.What is the last grade you completed in school?
   6th grade or less
   7th grade
   8th grade
   9th grade
   10th grade
   11th grade
   12 grade
   Graduated High School or GED

Sexual Behavior

The next sets of questions are going to ask you about your behavior towards someone of the opposite sex. Please keep in mind that your answers are completely confidential.

1. In the past year have you hugged anybody that was not a family member?
   Yes
   No
2. In the past year have you held hands with someone you had romantic feelings?
   Yes
   No
3. In the past year have you spent time alone with someone you had romantic feelings?
   Yes
   No
4. For someone that you have had romantic feelings, in the past year have you kissed that person?
   Yes
   No
5. In the past year, have you been kissed by anybody?
   Yes
   No

6. For someone that you have had romantic feelings, in the past year have you cuddled?*
   Yes
   No
7. For someone that you have had romantic feelings, in the past year have you lain down together?
   Yes
   No
8. For someone that you have had romantic feelings, in the past year has someone put their hands under your clothing?
   Yes
   No
9. Have you put your hands under someone else's clothing?
   Yes
   No
10. Have you been undressed with your [private parts] showing with someone that you have romantic feelings?
    Yes
    No
11. Have you touched or fondled someone's private parts?
    Yes
    No
12. Has someone (that you wanted to touch you) touched or fondled your private parts?
    Yes
    No
13. Have you ever had sexual intercourse? This is when a guy puts a penis in a girl's vagina.
    Yes
    No
14. How old were you when you willingly had vaginal sex for the first time?
15. The very last time you had sex; did you use a condom to prevent STDs or pregnancy?
    Yes
16. No
17. The very last time you had sex, what other type(s) of protection did you use? (Check all that apply) (Check all that apply)
    Pill or Depo
    Withdrawal
    Spermicide
    None
    Other
18. In your entire life, how many people have you had vaginal sex with?
19. In the past 30 days, how many times have you had vaginal sex?
20. Have you had vaginal sex in the past 30 days?
    Yes
    No

21. In the past 30 days, how many people of the opposite sex have you had vaginal sex with?
22. Out of the times that you had vaginal sex, in the past 30 days, how many times did you use a condom?
23. How many times did you have sex in the past 30 days while using alcohol?
24. How many times in the past 30 days did you have sex while high on drugs?
25. How many times in the past 30 days was your sex partner high on alcohol?
26. How many times in the past 30 days was your sex partner high on drugs?

Parental Background

1. What is the highest education level that your mother/mother figure completed?
   Some Grade School
   Finished the 8th Grade
   Some High School
   GED / High School Diploma
   Some Technical School
   Technical School Graduate
   Some College
   Associates Degree
   Bachelor's Degree
   Some Graduate Work
   Advanced Degree
   I do not know
2. What is the highest education level that your father/father figure completed
   Some Grade School
   Finished the 8th Grade
   Some High School
   GED / High School Diploma
   Some Technical School
   Technical School Graduate
   Some College
   Associates Degree
   Bachelor's Degree
   Some Graduate Work
   Advanced Degree
   I do not know
3. Which of the following best describes your parents' marital status?
   My parents were never married to each other.
   My parents are currently married to each other.
   My parents are divorced or separated, neither has remarried.
   My parents are divorced and one or both of my parents has remarried.
   One or both of my parents is deceased
4. Who is the person (who lives in your house) who knows what you are doing most of the time? (Choose one)
   Mother
   Father
   Another Relative

Group home super
Sister or Brother
Other

Parental Monitoring Assessment (PMA)

The next sets of questions are about your parents or the people that you consider your primary caregivers. This is the person who lives in your house that knows what you are doing most of the time. Please answer the questions as honestly as you can.

1. Indicate: Never, rarely, sometimes, most of the time, or always

My parents know where I am after school.
If I am going to be home late, I am expected to call my parent(s) to let them know.
I tell my parent(s) who I am going to be with before I go out.
When I go out at night, my parent(s) know where I am.
I talk with my parent(s) about the plans I have with my friends.
When I go out, my parent(s) ask me where I am going.

Discipline

Think of the person that is your primary caregiver (parent/guardian) and answer the following questions about that person. When you have done something wrong, how often does this person

2. Indicate: Usually, sometimes, rarely, or never

Yell or scream at you?
Ground you or restrict your privileges?
Discuss with you why what you did was wrong?
Stop talking to you?
Threaten to throw you out of the house?
Not do anything (meaning you don't get punished)?
Discuss what you should have done?

Mother Questions

The following Questions are about your relationship with your mother or a mother figure.

1. I will answer the following questions about my,
   Mother
   Mother figure
2. If you answered Mother Figure in the previous question, my mother figure is my
   Aunt
   Cousin
   Sister
   Grandmother

QPR-Mother

The next set of questions asks you about your relationship with your female Parent (i.e. mother or whoever takes care of you).

My mother respects my feelings.
I feel my mother does a good job as a mother.
I wish I had a different mother.
My mother accepts me as I am.
I like to get my mother's point of view on things I am concerned about.
I feel it's no use letting my feelings show around my mother.
My mother can tell when I am upset about something.
Talking over my problems with my mother makes me feel ashamed or foolish.
My mother expects too much of me.
I get upset easily around my mother.
I get upset a lot more than my mother knows about.
When we discuss things, my mother cares about my point of view.
My mother trusts my judgment.

1. I consider my mother / mother figure and I to be:
   Very close
   Close
   Somewhat close
   Not very close
   Not close at all

Father Questions

The following Questions are about your relationship with your father or a father figure.

1. Is your father or a father figure (uncle, grandfather, etc.) a part of your life?
   Yes
   No
2. I will answer the following questions about my,
   Father
   Father figure
3. If you answered Father Figure in the previous question, my father figure is my
   Uncle
   Cousin
   Brother
   Grandfather
   Male mentor

The next set of questions asks you about your relationship with your male Parent (i.e. father or whoever takes care of you).

My father respects my feelings.
I feel my father does a good job as a mother.
I wish I had a different father.
My father accepts me as I am.
I like to get my father's point of view on things I am concerned about.
I feel it's no use letting my feelings show around my father.
My father can tell when I am upset about something.

Talking over my problems with my father makes me feel ashamed or foolish.
My father expects too much of me.
I get upset easily around my father.
I get upset a lot more than my father knows about.
When we discuss things, my father cares about my point of view.
My father trusts my judgment.
My father has her own problems, so I don't bother her with mine.

Oral Sex

1. In the past year, have you had oral sex? Oral sex is when you put your mouth on someone else private parts.
   Yes
   No
2. How old were you the first time you willingly performed oral sex on some of the opposite sex?
3. In your entire life, how many people of the opposite sex have you performed oral sex on?
4. In the past 30 days, how many times have you performed oral sex?
5. In the past 30 days, how many people of the opposite sex have you performed oral sex on?
6. How many times did you use a condom in the last 30 days when you performed oral sex?

Sexual Values and Beliefs

Rate your thoughts on the following statements:

It is important for me not to have sex before I get married
Having sex should be viewed as just a normal and expected part of teenage dating relationships
It is against my values for me to have sexual intercourse while I am an unmarried teenager
Teens who have been dating the same person for a long time should be willing to go along and have sex if their partner wants to
It is all right for teenagers to have sexual intercourse before they're married if they are in love
Having sexual intercourse is something only married couples should do.
I think it is OK for kids my age to have sex
People who do not want to have sex should have the right to say NO
My sexual values and beliefs agree with those of my parent(s).

Religiousness/Spirituality

1. How often do you pray privately in places other than at church or synagogue?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never

2. How often do you watch or listen to religious programs on TV or radio?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never
3. How often do you read the Bible or other religious literature?
   More than once a day
   Once a day
   A few times a week
   Once a week
   A few times a month
   Once a month
   Less than once a month
   Never
4. How often are prayers or grace said before or after meals in your home?
   At all meals
   Once a day
   At least once a week
   Only on special occasions
   Never
5. I try hard to carry my religious beliefs over into all my other dealings in life.
   Strongly agree
   Agree
   Disagree
   Strongly disagree
6. I try hard to carry my spiritual beliefs over into all my other dealings in life.
   Strongly agree
   Agree
   Disagree
   Strongly disagree
7. How often do you go to religious services?
   More than once a week
   Every week or more often
   Once or twice a month
   Every month or so
   Once or twice a year
   Never
8. Besides religious services, how often do you take part in other activities at a place of worship?
   More than once a week
   Every week or more often
   Once or twice a month

Every month or so
Once or twice a year
Never

9. What is your current religious preference?
10. To what extent do you consider yourself a religious person?
    Very religious
    Moderately religious
    Slightly religious
    Not religious at all
11. To what extent do you consider yourself a spiritual person?
    Very spiritual
    Moderately spiritual
    Slightly spiritual
    Not spiritual at all

Sexual Health Communication

In the last year, how much information did you share with your child about:

	Amount of time they shared with you in the last year
...contraception/preventing pregnancy?	
...sexually-transmitted diseases (STDs)?	
...HIV/AIDS?	
...ways to protect yourself against STDs and HIV/AIDS?	
...condoms specifically?	
...postponing or not having sex?	
...peer pressure and sexual pressure from dating partners?	
...how to resist sexual pressure from peers and dating partners?	

Appendix C

Parental & Adolescent Interview Guide

Thank you again for agreeing to participate in my one on one parental interview. As I stated earlier I am a doctoral student in the College of Public Health at the University of Georgia. The purpose of this interview is to examine the parent-child relationship. In addition to gathering information on the familial relationship I am also interested understanding how the family relationship helps reduce risky behavior. Today I will be asking you questions about your experiences. As we discussed this is a completely voluntarily interview and you may stop that interview at any time. Please feel free to skip any question that you may not want to answer. I will be using your response to make suggestions to community organizations.

Family of origin (Parents only)

Research question: How does the parents' familial history affect their relationship with their child?

I understand that our personal history can influence the way we view the world. Because of that ….

1. Can you describe to me your family of origin? By family origin, I mean the people that were in your household.
2. Who would you consider to be your primary caregiver? This would be the person that took care of your emotional and physical needs.
3. Can you describe to me in detail what your relationship was like with your primary caregiver prior to entering adolescences?
   Probe: Communication? Time together?
4. After you entered adolescences, was there a shift in your relationship?
   Can you describe to me in detail what shifted in your relationship?

We first talked about your personal background and your relationships now I would like to talk about your relationship with your child.

Parent child relationship

Research question: What are the key factors in the parental-child relationship that moderate risky-sexual behavior?

1. Can you describe to me your current household?
2. Can you describe to me what your relationship with your child/parent was like prior to them entering adolescences? Communication? Time together?
3. Can you describe to me the first time that you realized that your child had entered the stage of adolescences? For the adolescent: Can you describe to me the first time that you realized that you were a teenager?

4. Have there been any shifts in your relationship since she/you has/have entered adolescence? If so, can you describe to me what those shifts have been?

Discipline

I understand that there can be challenge times in parenting/ within your relationship with your parent. For the next set of questions, I would like to gain a greater understanding of how you deal with those challenges.

1. Do you have house rules? Can you describe to me what those house rules maybe?
2. How do you enforce the rules?/ How does your parent enforce the rules?
3. Can you tell me about a time that your child/you did not follow the rules? How did you respond/ how did your parent respond?
4. If there could be one thing that you could change about your/your parents discipline style what would that one thing be?

As I stated at the beginning of the interview I am interested in understanding the connection of the parent-child relationship and sex education. For the next set of questions, I would like to talk about how you communicate sexual health education.

Sexual Communication

1. Have you talked to your teenager about sex?/ Has your parent talk to you about sex? If so when did you first start talking to him/her about sex?
2. Can you describe to me how the first conversation went?
3. Can you describe to me some of the topics you covered?
4. Can you describe to me some of the challenges that you may have with continuing the discussion of sex with your child/parent?

Sexual Health Values and Beliefs

1. Can you describe to me in your own words what is sex?
   Probe: Can you tell me, what is your knowledge? What do you know? What do you think sex is?
2. Can you describe to me your beliefs about teenagers and sex, sexuality, and physical involvement?

Religion and Spirituality

1. If you can describe to me in your own words, how would you define religious or spiritual beliefs?
2. Thinking about your religious or spiritual beliefs, how do you feel they inform your decision making as a parent/teenager?
   How do your beliefs inform the choices that you make? Sex? Dating?

Program Creation

Finally, please imagine that I gave you a million dollars and you could create the best sexual health program in the world. What would you put in that program for parents?

Thank you for participating in the study!