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Exploring Sources of Sex Education in African American Females: A Qualitative Study

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By

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AbayomiOluwaranmilowo!

Sincerely

Oluwakemi Olurotimi

Dedication

…it is not of him that willeth, nor of him that runneth,

but of God that sheweth mercy.

Romans 9:16

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Abstract

According to the Centers for Disease Control (2009), there is a growing concern for the rate of mortality and prevalence of STIs and unwanted pregnancies among African American women, yet traditional interventions have failed. The purpose of this qualitative study is to explore the sources of sex education in African American females and their subsequent sexual behaviors (partners and use of contraception), including the use of available sexual health resources. Semi-structured interviews were conducted with 16 African American young women to identify and understand current sources and preferences for sexual health and pregnancy prevention information. Interviews provide a more detailed data that allows for new and better understanding of sexual health education among women of color. Most of our participants reported parents as their most preferred source of STI and pregnancy prevention information. Participants also reported peers as their least preferred source of sex information but most preferred for information about the emotional consequences of sex. We also address the perception of our participants towards formal sex education, menarche (first menstruation) and sexual assault. The information about the difference between peer and parental sources of sex education in this study will provide a better understanding of the disparity of STI prevalence and offer to develop culturally competent sex education content.

Keyword: African American females, adolescent, sex education, peers, *parents*

Introduction

There is a widespread development of STIs and STDs across racial and ethnic groups. However, African Americans report more than eight times the rate of chlamydia, over 20 times the rates of gonorrhea and close to 26 time the rate of syphilis compared to Euro Americans (CDC, 2009). In the US, African Americans women make up 12% of the female population but over 60% of the women diagnosed with AIDs. (Jemmott, Jemmott & O'Leary, 2007).

In a study by Forhan et al., (2009), female participants between the ages of 14 to 19 participated in the National Health and Nutrition Examination Survey. Each participant went through a standard physical examination, provided sexual history information and submitted a biological specimen. In this study, "sex" referred to vaginal, anal or oral sex and Participants were deemed "sexually experienced" if they have ever had sex. Forhan et al. (2009) found a substantial racial disparity in STI rates among female adolescents. The most prevalent STI was the Human Papillomavirus Infection (HPV) (30% of their participant population) followed by chlamydia infection (15% of the participant population). Prevalence for some of the infections was similar amongst non-Hispanic whites and Mexican Americans but higher among non-Hispanic black participants. Specifically, black participants were more likely to have one of the five STIs tested for in the study. The authors stated that although STI prevalence among adolescents of all races and ethnicities were a cause for concern, increased efforts should be directed towards members of all subpopulation, to ensure that they have equal opportunities for sexual health.

Understanding Adolescent Romantic Relationships

Romantic relationships are more prevalent in adolescents in the US than has been commonly assumed with more than half of the adolescent population reporting to have had a romantic relationship in the past six months (Cavanaugh & Blanchard-Fields, 2018). With more inclusive definitions of a romantic relationship, there is a higher number of adolescents reporting to have had a romantic relationship. In a report by De Meyer et al. (2017) over 30% of 13-year-old 54% of 16-year-olds and nearly 80% 18-year-olds reported that they had a romantic relationship in the past six months. Usually, by middle adolescence, most people have been involved in one form of romantic relationship or the other.

The concern for adolescent relationships arose as a response to the maladaptive and negative behaviors associated with dating. Consequently, more recent researchers have expanded their research on adolescent romantic relationships in several regards (Deptula, Henry &Schoent, 2010; Arnett, 2014; Wang, Stanton, Deveaux, Li, Koci, & Lunn, 2014). Currently there is an emphasis on the quality of these adolescent relationships, including the positive and negative possibilities for these adolescents. The research questions have become more inclusive of the processes relating to most adolescent relationships and the subsequent qualities of these relationships (e.g., cognition, intimacy, perception, and emotion). Also, the research methods have switched from being reliant on surveys and questionnaires to including detailed interviews, observational methods and so on (Giordano, 2003; Udry, Joyner &Carver,2003). Despite the attempts to become more inclusive and diverse, the research still excludes some cultural, socioeconomic, racial and sexual diversity.

Acquiring knowledge about sex is a continuous process that commences in childhood and extends across the lifetime of an individual (Bleakley, Hennessy, Fishbein & Jordan, 2009). Fasula and Miller (2006) found 47% of high school students have engaged in sexual intercourse before graduation and 7% initiated sexual intercourse before 14 years of age. There is a major ethnic and racial differentiation in age at first intercourse (Park, McCoy, Erausquin, Bartlett, 2018). According to the CDC (2009), observations across racial groups show that 66% of African- American adolescents are sexually active in comparison with 40 % of Euro Americans and 49 % of Hispanic Americans. African American teenagers engage in sexual activities earlier than peers from other racial groups (CDC, 2009) and have more sex partners (Lanier, Stewart, Schensul & Guthrie, 2018). A study by Cavazos-Rehg et al. (2009) also stated that African American were more likely to initiate sexual intercourse by the age of 15 compared to Euro American, Hispanic Americans and Asian American who waited longer to have intercourse. Because African American adolescents become involved in high- risk sexual behaviors more than other ethnic groups, they face a heightened risk for adverse consequences including pregnancy, when compared to other racial groups (Hoskins & Simons, 2015).

Comprehensive vs. Abstinence Programs

The high risk for HIV and other sexually transmitted infections among African Americans is well documented. According to Kirby and Larris (2009), some research suggests that behavioral interventions can decrease the rate of self- reported risk behaviors linked with HIV. The transmission of HIV is tied to unprotected sex. Subsequently, behavioral interventions aimed at reducing the cases of HIV must include

a strategy to reduce unprotected sex. According to Jemmott, Jemmott, Braveman and Fong (2005), this can be achieved in two ways: an abstinence approach or a comprehensive (safe- sex) approach. The abstinence approach emphasizes reducing the frequency of pre-marital sexual intercourse while the comprehensive approach is concerned with increasing the rate of condom use.

There is still an ongoing debate among advocates, experts, and educators on which method is most effective for adolescents. (Kholer, Manhart & Lafferty, 2008). Because adolescents often lack the cognitive tools to make informed decisions about their sexual behaviors, the abstinence-only approach might appeal to parents and educators. The abstinence-based program proposes that abstinence from sexual intercourse is the only way for youths to avoid the risks of unwanted pregnancy and STDs. (Bader, 2005; Perrin & Dejoy, 2003; Underhill,Montgomery & Operario, 2007). Introducing condoms and other methods of contraception reduces risks, so abstinence-only curriculums are mostly referred to as “risk avoidance” or “risk elimination” programs, while comprehensive sex curriculum is referred to as “risk reduction” programs (Kirby, 2008).

Comprehensive sex education programs emphasize abstinence and also encourage the use of condoms and other contraceptives for those who engage in sexual intercourse. According to Beh and Diamond (2006), a comprehensive approach to sex education can both delay the initiation of sexual intercourse and increase contraception use for those who choose to become sexually active. A comprehensive approach to sex education can have a more significant impact on the numbers of unwanted pregnancies and STIs in adolescents compared to abstinence-based programs.

Researchers in favor of abstinence-based programs (Bader, 2005; Perrin & Dejoy, 2003; Santelli, Ott, Lyon, Rogers, Summers & Schleifer, 2006), argue that comprehensive sexual education sends a confusing message to adolescents. For example, a comprehensive sex program encourages adolescents to abstain from sex and still practice safe sex. Without appropriate guidance some adolescents may be confused on how to make the decision to abstain or practice safe sex. Furthermore, it can hinder the progress that it is supposed to make with alleviating the rates of STIs and unwanted pregnancies in youths. These researchers also argue that if the messages to the adolescents on sexual activities are focused on abstinence, it could have a greater impact on the rates of teenage pregnancy and STI rates compared to comprehensive sex programs.

Supporters for comprehensive sex education (Kirby & Laris, 2009; Kohler et al., 2008; Robin et al., 2004) argue that the message of their program is neither confusing nor misleading. Instead, the comprehensive curriculum has a bigger impact on teenagers than abstinence-only programs. According to Shepard, Sly and Girard (2017), adolescents who received abstinence-only education had reduced favorable attitudes toward condom use and were more likely to have unprotected sex compared to those who received comprehensive sex education, putting them at greater risk for STIs and unwanted pregnancies.

The debate surrounding which approach to sex education is most effective is important in the U.S for several reasons. First, according to the CDC (2010), three in ten girls get pregnant once before they turn 20. Teenage pregnancy is especially common amongst African American females. The U.S has one of the highest rates of teenage

pregnancies in developed countries, taxpayers, teen parents, and the infants involved bear the cost of unintended pregnancies (Beh & Diamond, 2006; Dailard, 2002; Sonfield, & Gold, 2001; Vedung, 2017.)

Second, middle schools and high schools across the nation use either abstinence-only curricular, a comprehensive approach, or no sex education. In school districts across the U.S, more than 70% have a policy to teach sexuality education (Landry, Darroch, Singh, & Higgins, 2003; Sonfield & Gold, 2001).The others leave the decision to teach or not to teach sex education to the individual schools. In districts that have the policy to teach sex education, a vast majority require that the various schools teach an abstinence-only curriculum. More than half of these schools promote abstinence-only programs as the preferred option for sexuality education (Sonfield & Gold, 2001)

Currently, the majority of the sex education programs taught in schools were developed sometime around the 1990s during a period of intense debate amongst many local communities and state capitals (Landry et al., 2003). These programs also do not include information for same-sex relationships and activities, are still outdated and ineffective.

Third, the Federal government spends over 100 million dollars annually to provide abstinence-only sex education to American youths (Beh & Diamond, 2006; Vedung, 2017).

A meta-analysis by Kirby (2008) explored the impact of youth abstinence programs and found that abstinence-only curricula had no effects on initiation of sex, age at initiation of sex, abstinence in the previous 12 months, number of sexual partners, or condom use during sexual intercourse. The meta-analysis included 56 reviews of

abstinence and comprehensive sex education programs. They were selected based on the assessed impact of the curricular employed. One of the studies in the meta-analysis was by Trenholm, Devaney, Fortson, Quay, Wheeler and Clark (2007). The study used an experimental design to measure the impact of postponing sexual involvement with a five-session curriculum focused on delaying the initiation of sex. Tenholm et al. (2007) collected survey responses of over 2000 adolescents with an average age of 16.5 years four to five years after they received the abstinence training in an 8th-grade class. The results found no significant positive effects on age of initiation of sexual intercourse, the risk of unwanted pregnancies and unprotected sex. Another study in the meta-analysis by Clark, Trenholm, Devaney, Wheeler and Quay (2007), collected survey responses from over six hundred adolescents two years after they received an abstinence-only program in middle school. The abstinence curriculum was a 7.5-hour curriculum aimed at increasing knowledge and awareness of pregnancy and STI risks. Like the Tenholm et al. (2007) study, the program had no impact on perceived consequences of pre-marital sex. It also did not delay initiation of sexual intercourse. However, participants expressed views that were more supportive of abstinence.

According to Kirby (2008), abstinence programs were methodologically much weaker than comprehensive sex education studies. These studies employed quasi-experimental designs with comparison groups that were not always well matched, they sometimes had high attrition rates, they measured program impact for a shorter period, and their statistical analyses were not always as strong as those in the comprehensive sex education studies were. In comparison, the author found evidence for the effectiveness of comprehensive sex education programs. In fact, 15 out of 32 (47%) of the programs in

the selected 48 studies for the meta-analysis delayed the initiation of sexual intercourse, and none hastened initiation. Specifically, 6 out of 21 (29%) reduced the frequency of sexual intercourse, and none increased frequency. Furthermore, 11 out of 24 (46%) reduced the number of sexual partners. One program out of 24 (4%) increased the number of sexual partners. Additionally, 15 out of 32 (47%) of the evaluated programs increased condom use. Four out of nine (44%) increased contraceptive use, but one program out of nine (11%) decreased it. Finally, 15 out of 24 (62%) reduced sexual risk-taking through a combination of changes in multiple behaviors. Overall, the results of the study provided evidence that most abstinence programs were ineffective. This, however, does not justify why these programs are grossly popular in several school districts till today. On the other hand, the meta-analysis found results favoring comprehensive sex education programs, especially with increasing abstinence and improving other sexual behaviors in adolescents. Almost half of the studies in the meta-analysis delayed initiation of sex, and at least 25% reduced the number of sexual partners. Thus, when comparing the effectiveness of sex education programs, comprehensive sex education might be favorable. It is noteworthy that the source of sex education is important in determining subsequent sexual behaviors (Hoskins & Simons, 2015; Fasula & Miller, 2006) in young adults.

Social and Ethnic Factors Influencing STI and Unwanted Pregnancy Rates

STIs and teenage pregnancy are contributing factors to the high mortality rates among young women and adolescents in the US (Health and Human Services, 2016). Despite the attempts of several programs at reducing risky sexual behaviors in youths, understanding some of the social and ethnic-related factors has been ignored among these

groups. Understanding factors such as beliefs about the contraceptive use (Mellanby, Newcombe, Rees, & Tripp, 2001) and level of parental involvement (Upadhya & Ellen, 2011) can be enlightening in identifying risky sexual behaviors.

To understand what influences sexual activity or pregnancy risk at different stages of adolescence, Upadhya and Ellen (2011) explored whether social differences in the number of adolescent pregnancies varies with each level of adolescent years, i.e., early, middle or late adolescence. The study analyzed responses to a cross-sectional survey conducted by the Center for Disease Control related to pregnancy and reproductive health in a nationally representative sample of women and men of reproductive age. The results of their study indicated an overall increase in the rates of pregnancies across racial groups, i.e., from early to late adolescence. However, the rates of pregnancy were higher amongst African American women compared to others. Their study also confirmed that the level of education significantly influenced the age of first pregnancy in African American girls. It should be noted that although the low level of education correlated with early pregnancy, African American females with a higher level of education were also at risk for an unplanned pregnancy but at an older age (post-adolescence). Simply put, the level of education among African American women can influence when an unplanned pregnancy occurs, but it may not prevent it from happening. Also, women who reported that their mother had less than a high school degree were also at risk for an early unplanned pregnancy. Upadhya and Ellen (2011) concluded that factors related to social disadvantage contribute significantly to teenage pregnancy in early adolescent years more than in later adolescence in African American women. They also stated that social disparities do exist in adolescence among adolescents of color and must be

addressed. They suggested that the reason why teens from minority backgrounds might be at risk for early sexual activities and teenage pregnancy revolves around family, peer and educational influences. Currently, there is no known strategy to explore how people from minority backgrounds prefer to have this crucial information delivered or how socio-cultural factors could dampen the effects of potential projects addressing the issue.

The Relationship between African American Beliefs and Sexual Health

Another issue influencing the prevalence of STIs among African Americans is belief/ superstition. Given the differences in HIV rates in African Americans compared to other ethnicities, it is important to identify factors that contribute to high-risk sexual behavior. Some conspiracy beliefs held by some African Americans include beliefs that HIV is a human-made virus, birth control is the government's way of reducing the Black population and so on (Bogart & Thornburn, 2005). Usually, conspiracy beliefs include a wide scale of discrimination by either the government or health care system against a group of people.

Herek and Glunt (1991) conducted a series of phone interviews regarding this issue and discovered that African Americans and Euro Americans differed in their willingness to trust the government and scientific authorities. In their study, African Americans were more likely to agree that there were government held secrets concerning HIV and AIDS. Also, they were more likely to believe that AIDS could be spread through mere contact (touching, holding hands, etc.) and that the disease is being used to promote hatred of minority groups by the government. Furthermore, Black men were closer to estimating their high risk for the virus while black women underestimated their risk of infection. This is interesting, given the over-representation of African American

women amongst the population of those who have AIDS in the U.S. Participants were mostly undereducated people within inner-city areas. However, education and socioeconomic status do not mitigate this effect and it has been this way for a long time because Klonoff and Landrine (1999) found similar findings with their suburban participants. In a survey of randomly selected middle and working class participants living in suburban California, they found that a significant number of participants endorsed the idea of HIV as an artificially created virus designed by the government to annihilate the black population. Interestingly, the majority of those who endorsed the AIDS- conspiracy were more likely to be college graduates than high school graduates. This point of view is not limited to undereducated and poor African Americans. Conspiracy beliefs concerning HIV/AIDS and birth control among African Americans play an important role in increasing or decreasing sexual risk behaviors within the population. It is important, therefore, to consider this socio-cultural factor in a disease prevention intervention.

A Case for Sexual Empowerment

Women in low power relationships are also at a higher risk of STIs (Pulerwitz, Amaro, Gortmaker, DeJong & Rudd, 2002). According to Mcnair and Prather (2004), the sex-ratio imbalance in the African American community increases the difficulty women have in discussing and bargaining for condom use with their partners. There are less African American males in the US population, compared to females (US Census, 2016). The disparity in numbers between the number of males and females in the population results in fewer available partners, which means that African American women experience less interpersonal power in relationships (McNair & Prather, 2004). Low

power in relationships has been implicated in lower condom use, lower education, and low relationship satisfaction in women of color (Pulerwitz et al., 2002). It means that women in low power relationships are less likely to speak up for themselves or discuss sexual health/ protective methods with their partners. This could explain why African American women remain a group at risk for STIs. Some women experience issues in their relationships that challenge their ability to protect their sexual health (Katz & Sutherland, 2017). For example, Abel and Fitzgerald (2006) found that some women experience the shame of asking a partner to use a condom. They conducted in-depth interviews with 42 young people concerning the importance of condom use. The result showed that females were embarrassed to introduce condoms to their partners because of the possibility of being perceived as inexperienced by their sexual partners. The attitudes of men towards sexual health also influence the perceived low power that these women feel in their relationship. For instance, Geter and Crosby (2014) conducted a cross-sectional study of 561 young black men. The result shows that nearly 50 % of the participants had refused to wear a condom when asked by their females' partners.

Katz and Sutherland (2017) surveyed 146 women investigating the extent of partner interference with contraception use before sex. The results found that women who reported low power in their relationships were more likely to experience abuse from their partners. Also, they report higher cases of coercive sex, psychological distress and substance abuse with their partners. In addition, Guteierrez, Oh, and Gilmore (2000), found a correlation between low power and disempowerment for girls and risk, especially in African Americans. Girls who have low power in their romantic relationships are less able to engage their partners in STI related protective behaviors. A woman's inability to

initiate discussions concerning condom use might be as a result of fear of conflict which could lead to an end of her romantic relationships (Raj, Silverman & Amrao, 2000).

Sex Education Programs for African Americans

Although quite limited, research for sources of sexual education indicated that individual reading, online sources and peers were the highest rated sources overall in adolescents and college-age students (Bleakley, Hennessy, Fishben & Jordan, 2009). Interestingly, the predilection for sex education sources by adolescents' themselves has been grossly ignored in the literature (Somers & Surmann, 2004). Resources that are devoted to sex education programs also need more ethnic diversity (Lyles et al., 2007). A meta-analysis by Beatty, Wheeler, and Gaiter (2004) found that potentially helpful research to African Americans is limited either by exclusion or underrepresentation of the African American population.

Furthermore, Borawski, Trapl, Adams-Tufts,Hayman and Lovegreen (2009) investigated the effectiveness of named “Be Proud! Be Responsible!” by Jemmott et al. (1998) which was created for Black male youths in non-school settings. According to the researchers, many schools adopted the program with little empirical evidence for its effectiveness in school settings. In the replication, five pairs of large urban and suburban high schools were paired by socioeconomic status and racial composition. One of the paired schools adopted the sex education program while its control adopted a health promotion curriculum with emphasis on nutrition, stress reduction, and physical activities. The primary aim of the study was to determine the effectiveness of the sex education program when taught within a high school health curriculum by a school representative. They also investigated the effectiveness of the program on Euro American

youths as well as African American suburban males. Because the program was initially created for black males in inner city areas, the authors hypothesized a significant effect on urban black male adolescents than among suburban female of Caucasian adolescents. The curriculum included a total of six 1- hour modules incorporating a variety teaching styles including group discussions, interactive exercises, and videos and so on. Although the program discussed safe- sex to an extent, the curriculum emphasized an abstinence-first approach. Overall, students involved with the sex education program reported having gained significant knowledge about STDs and condoms than the control group. The program also had a significant impact on sexual behaviors in male adolescent students (both Caucasian and African American) but not for females in the study. According to the authors, this program proved ineffective as far as sex education in Black female adolescents is concerned.

Another study evaluated the efficacy of an intervention to reduce sexual behaviors and HIV in African American adolescent girls (DiClemente et al., 2004). The study included over 522 sexually experienced African American girls who visited four community health clinics in the southern US. There were two conditions in the study. The first condition was a 4-hour long interactive HIV intervention implemented every Saturday at the clinics. The study implemented the use of African American health and peer educators. The peer educators helped to create group norms which supported HIV prevention. In the second condition, another set of participants received a 4-hour interactive group session emphasizing exercise which was also admitted on Saturdays. After six months, the participants' self- reported their condom use, subsequent sexual behaviors and were given vaginal swabs to test for STIs. The result of the study showed

an increase in condom use in the intervention group compared to the health group. The researchers also found that participants in the HIV group demonstrated higher scores on the HIV prevention knowledge test. The study, however, found an increase in sexual partners in the HIV group and that girls in the group reported higher confidence in getting a partner compared to the health group. There was also no significant difference in chlamydia or gonorrhea incidence tested by the vaginal swabs at the post intervention examination. While this study proved effective, it conducted with sexually experienced girls in the southern US. This may question its promise of generalizing to inner-city youths in other parts of the country. Since the study only focused on sexually experienced girls who already had children, it does not address the issue of initiation of sexual intercourse at an early age. However, this is the only study that shows some promise of the effectiveness of tailored sex education for at-risk African American girls.

Parental Involvement on Subsequent Sexual Behavior

There are limited studies are addressing the issue of sex education from an ethnic perspective. Hence, there is limited work linking the source of sex education to subsequent sexual behaviors in ethnic youths. Lee, Tran, Thoi, Chang, Wu, and Trieu (2013) provided evidence that there is a relationship between the source of sexual education and the age of sexual debut in Asian cultures. According to the authors, the limited literature focused on examining parental attitudes toward sexuality and sex education in Asian cultures have hinted that most parents prefer not to discuss the topic with their adolescent children. Some Asians Americans believe that schools should teach sex education and approve of sex education curriculum even with limited knowledge of what it contains. In Asian cultures, parents seldom discuss sex with their adolescent

children and a common misconception is that STI prevalence rate is none existent within the culture. In Lee et al. (2013), Asian American adolescents rated schools as their most preferred source of sex education and rated parents as the least preferred source. It is not surprising that they might avoid the topic altogether to avoid the associated discomfort. In general, when it comes to sex talks in Asian American families, the focus is mainly on abstinence (Kim, 2009) and to delay the age of sexual debut. In Lee et al. (2013), Asian American girls who reported receiving primary sexual education from parents reported having sex later than those who did not. Evidence for the importance of the source of sex education given culture is not just limited to Asians.

Another study found a relationship between maternal communications about sex-related issues and adolescent sexual behaviors in Jamaican mothers and daughters (Hutchinson, Kahwa, Waldron, Brown, Hamilton, Hewitt & Jemmott, 2012). In this study, the researchers sought to identify ways in which urban Jamaican mothers could influence their adolescent daughters' beliefs and behaviors concerning sex. According to the authors, the rate of STIs in the Jamaican and Caribbean regions are similar to those of African Americans in the US. In fact, despite the prevalence of HIV, some Jamaican adolescents continue to underestimate their risk of contracting the virus. According to Nicholls, McLean, Henry & Camara (2000), the majority of the HIV transmission in the Caribbean occurs by heterosexual contact and women make up more for more than half the population of those who are affected. The region now ranks second to sub-Saharan Africa regarding HIV and AIDS prevalence (USAID, 2010). According to Olukoga (2004), the risk of an HIV infection in female adolescents in two to three times higher

compared to males. Babies are born HIV-infected, making it the second leading cause of death in children aged one to four years old.

The age of first sexual intercourse in Jamaican adolescent is also very early. In males, the mean age is about 12 years old, and by 14, over 13% of girls are already sexually active. According to Olukoga, (2004), these adolescents seem to have sexual intercourse early and usually have multiple sexual partners. Adolescent boys report having some three to four sexual partners and girls are more likely to have two before the age of 18. Johnson et al. (2004) explained that it is normal for Jamaican youths to expect an STI when they engage in sexual activities as long as it is curable. Also, they report less condom use and experience high rates of teenage pregnancies. Factors such as substance abuse, socioeconomic status, education level and most importantly, the source of sex education influence the rates of STIs and STDs in both Jamaican and US African American adolescents. Since mothers are supposed to be one of the most influential people in adolescent lives, particularly girls, Hutchinson et al. (2003) sought to examine how mothers might influence their adolescent daughters' sexual risk-taking behaviors and beliefs. The study which involved a semi-structured focus group with Jamaican girls between the ages of 14 to 18 and their mothers. Overall, mothers and daughter agreed on the importance and potential influence of a close mother-daughter relationship. Specifically, having a good relationship with the child makes it easier to discuss sex-related topics. However, only a small number of mothers expressed having a close relationship and extensive discussion about sex with their daughters. The daughters in the study reported modeling their mother's sexual behaviors concerning men. Additionally, those who reported a close relationship with their mothers were more likely to delay

sexual activities until later in life compared to those who did not report such close relationships. Furthermore, mothers who modeled a negative maternal sex role had daughters with a higher risk for STD and unwanted pregnancies compared those who were a more positive role model.

The results of the studies in this section indicate a need for parents to be included in their children's sex education because this can affect their subsequent sexual attitudes including their beliefs about STDs, STIs, and pregnancies. It is unfortunate that African American girls as a subgroup are particularly at a higher risk for the majority of STIs and STDs. As mentioned earlier, the prevalence rate for STDs like HIV is significantly higher amongst African American girls compared to their Caucasian and Hispanic counterparts.

Summary

In summary, the rates for STI and unwanted pregnancies in African American females is the highest compared to Euro Americans and Hispanic Americans (CDC, 2009). This problem is compounded by the fact that, no known research acknowledges some of the socio-cultural factors (e.g., beliefs, disempowerment, socio-economic status and so on) that might be contributing to how African American females receive and use sex education. Understanding these factors can be enlightening in the process of uncovering risky sexual behaviors. According to Jemmott et al., (2007), increased efforts should be directed towards members of all subpopulation to ensure that they have equal opportunities for sexual health. Although limited, some studies in other cultures similar to African American cultures that have found a relationship between the source of sex education and subsequent sexual behaviors in adolescents (Lee et al., 2013; Hutchinson et al., 2003). The purpose of this study is to examine the effect of source of sex education

on subsequent sexual behaviors in African American females. We investigated the preferences for the source of sexual health information, pregnancy prevention, and sexual education. We also examined the efficacy of parental involvement with semi-structured interviews with African American female participants.

METHOD

Participants

Participants in this study were 16 African American college-aged women from the University of Central Oklahoma and the research team's social network. The mean age of the population was 23 years old, with a range of 17-30 years old. The initial sample of participants was recruited through using the University of Central Oklahoma (UCO) SONA recruiting systems. Thirty-five participants volunteered but only sixteen participated in the study. Fifteen participants did not show up for their scheduled appointment without notifying researchers, two participants rescheduled but withdrew due to medical emergencies. One person did not meet the ethnicity requirement and one did not meet the gender requirement of the study. Participants met either on campus or at a location of their choosing. The majority chose to meet on the UCO campus with the interviewer. All participants received and signed a copy of the IRB approved informed consent and audio release form.

Procedure

Interviews were digitally-recorded by the principal investigator and a volunteer research assistant who was a first-year counseling graduate student. To ensure that the interviews were conducted in the same format, the principal investigator frequently met with the volunteer research assistant and the faculty advisor to check for interviewing consistency styles. The interviews were semi-structured and conducted one on one with each participant. The study used an interview guide which included questions about menstruation, first sexual experience, first contact with any form of sex education, parental approach to discussing sex (See Appendix A). Questions also addressed peer

approach to discussing sex and the type of knowledge obtained from those interactions and preferred sources for sex information and sexual health. The interviews were designed to encourage interviewees to explore and describe their experiences. Given the nature and sensitivity of this study, participants were provided with a list of counseling services within the area, in case they experienced any anxiety or became upset during the interview. Also, participants were regularly assured of the confidentiality of their responses to foster open and honest discussion. This study aimed to explore the sources versus preferred sources for sex education in African American females and more specifically:

- What were the sources of sex information inquiry?
- Where and how would these women have preferred to obtain this information?
- Is there a disparity in perceived accuracy towards sex information received from peers compared to those received from parents?

Data Analysis

This study employed the use of qualitative methodology to understand the participants' perspective comprehensively. According to Rubin and Rubin (1995), Qualitative interviews can help the researcher to see and understand that which is often overlooked via quantitative methodology. Interviewing allows for the researcher to reach across racial, socioeconomic, national, occupational and gender barriers. By using in-depth interviews, the researcher can explore a great deal of experience with the problem of interest. Also, listening carefully to the participants allows researchers to extend their intellectual and emotional reach across different barriers compared to quantitative analysis. Using a qualitative approach allowed the participants' multiple emotions,

complex reactions, and attitudes towards sex education for African American females, emerge from their recorded response, rather than organizing their answers into already existing categories (Yin, 2017). We used descriptive analysis via SPSS to calculate the mean of age of participants, mean age of menstruation and the mean age of sexual intercourse initiation. There were assumptions on how participants might respond to the questions. First, we assumed that most participants would prefer peers as sources of sex education over parents based on findings supporting peer-based sex education (DiClemente et al., 2004; Jemmott et al., 1998). Another assumption was that some African American females would prefer their primary source of sex education to be from a close family member, e.g., parents, aunts, grandparents and so on. This assumption was based on the collectivist nature of African American culture compared to Caucasians who are more individualistic (Xie, Leong & Feng, 2008; Brewer & Gardner, 1996; Markus & Kitayama, 1991). According to Hines and Boyd-Franklin (2005), the culture of African Americans is rooted in kinship bonds/networks similar to African cultures. As such, it is not uncommon to find members of extended families actively involved in the lives of adolescents To develop rapport with participants, the interview questions began with demographic questions to make them comfortable. As recommended by Lincoln and Guba, (1985) each theme in the results of this study is described in sufficient detail through with the reader can evaluate the extent to which conclusions are drawn how transferable the results are to different settings, time, situations and individuals.

As a measure of consistency, the researchers independently evaluated all the transcribed scripts, to identify emerging themes. We met to discuss general patterns and responses. The faculty mentor also independently evaluated the scripts and reported

themes as well. In total, we analyzed 71 pages of raw data with an average response of five pages per participant.

RESULTS

The mean age of initial sexual intercourse in the participants was 15 years of age. The mean age of first menstruation was 11 years of age. The data analysis generated several themes. Instead of forcing the responses into categories, we allowed several themes to emerge from the data and named them accordingly. In total, four themes emerged relating to the source of and preference of sex education. The last theme centered participants who were survivors of sexual assault and how they responded to the incident.

Theme 1: Parents/Family

Participants in this study frequently referred to parents as their most preferred source of sex education. However, the preference for the content of the information varied among participants. Ten participants stated that they would have preferred to learn about pregnancy and STIs and STDs prevention primarily from their parents. When asked about how they would have preferred to learn about sex, some of their responses include:

> "Um, I think I would have wanted to learn from my parents. I'm not sure how that conversation would have been but I would have been more knowledgeable about condoms and getting pregnant."*27-years-old, married, graduate student*

> "I wish my parents had told me that you could get pregnant (laughter) and you can get STD's and having sex can kill you." *20-years-old, single, college sophomore*

> "…I wish I learned about it (STD) and protection from someone close that I trust instead of hearing it from others. So like my aunties or mom." *19-years-old, college freshman*

> "I wish they had said (my family), um like what sex is and how to prevent yourself from getting an infection and how to prevent pregnancy…" *23-years old, single, college senior*

Three participants responded to the question of how they would have preferred to learn about sex by stating that they would have preferred to learn about some of the emotional consequences of engaging in sexual activities from their parents. Some of their responses include:

> "Honestly, I did not know what I was getting into. That stuff (sex) would make you crazy if you are not ready. I wish my mom had told me that sometimes guys love you before sex and drop you after like it was nothing. I was out here thinking we was going to get married and stuff (laughter)"*20-years-old, college sophomore*

> "Um, I mean it would've nice if my mom gave me an outline of a few things… I guess the difference of how a guy is afterwards. How he is towards you (after sex). Just the basic outline." *18-year-old, single, college freshman*

> "Um, I think I wish my sister would have told me to be careful who I give myself to some men just want one thing." *21-years-old, single, college year sophomore*

A majority of participants also stated that parents and family members were often reluctant to discuss topics surrounding the issue of sex. As a result, they were less likely to initiate a conversation until after their daughters' first menstruation or after an unwanted pregnancy had occurred. For example, when asked about when they first discussed sex with their parents or family members, some participants replied:

> "Never, I just told them I was pregnant. They didn't talk about it with me either… I was 17 and pregnant."26-years-*old, college graduate*

> "I mean we really didn't discuss that with them. My mom put me on birth control after I got my period."23-year-*old, single, college junior*

> "That's a funny question! Um, all they said really was, they said, "stay away from sex"! I was 18, and I was already having sex. Yeah, that came a little too late, didn't it (laughing)?" *24-year-old, committed relationship, graduate student*

In this study, the mean age for parent initiation of sex conversation in participants was 15 years of age.

Theme 2: Peers

Participants frequently referred to peers as their least preferred source of sex education. The majority described their peer as unreliable sources of sex education. When asked about what they wish their peers would tell them about sex, participants either described their peers as incapable of properly educating them on the issues of STI and pregnancy prevention or preferred that their peer educated them on the emotional consequences of sex in addition to boosting their self-confidence. Some of their responses include:

> "I wish my peers warned me to stay away from boys who strictly just want a sexual relationship. There is nothing much I can say I wanted my peers to tell me because everyone is still learning about STD and pregnancy- They've got kids they didn't plan for anyway so. I just don't think they really know what to do for diseases and pregnancy." *19-years-old, college freshman*

> "I wished that they would have told me that just because the dude is cute does not mean that he wants you for you, or he's just your friend, or that he just wants it. I wish they were more honest like that. Like, "Girl, he don't want you. He wants Evette. Stuff like that." *21-years old, college sophomore*

> "I know my friends don't know nothing about HIV and stuff. Them b**** be ignorant when it come to that type of stuff, excusing my cussing (laughter)… I know if I don't know, they don't know so I don't think they have nothing to tell me. But I wish they told me about them dudes though like how they just do you and leave like take advantage of you and stuff…" *20-years-old, college sophomore*

Compared to parents, conversations about sex occurs earlier in peers. Some of them reported having their first conversation about sex with their peer as early as nine years old.

Theme 3: Perception of sex education programs

This theme emerged from a category of questions relating to how participants learned about sexual health and pregnancy prevention. While some of them listed sex-ed classes as a source of information, there were mixed reports concerning the usefulness of information, the content of the information, how frequent it was presented to them and the motivation to use the information they received. Most participants mainly stated that sex-ed in formal settings did not meet their specific needs.

Concerning formal sex education, some of the participant responses include:

> "Well I think how I learned about sex was pretty good, I mean sex education at school open the door to making it easier to discuss sex with my parents. But if that's only where I learned, I would have been doomed! They only taught in 6th grade. Thank God my parents stepped in when I talked to them." *22-years-old, college senior*

> I actually like it in the classroom setting, because you are around people that are your age, and you are around people that might be going through the same things as you or the same questions going through your mind. I do like the classroom setting if I can say". I just wish they taught it more often instead of just 5th grade. *27-years-old, college graduate.*

Some participants who reported school sex education as their primary source of sex education stated that the information they received was not sufficient to prepare or protect them against STI, STD, and unwanted pregnancies. A participant stated:

> "I am not sexually active, but I feel like I need more information other than what they have in books and sex class."

Another one stated

> "It's really just like the videos don't tell you anything it's just the basic of the – what leads up to that (STDs) and all that stuff. It gives me a little bit of information, but I don't think it's enough." *20-years-old, college sophomore*

Participants acknowledged a lack of motivation to use the resources they were given. The lack of motivation was due to the timing of the information and a lack of follow up. One of them said

> "Yeah. Everyone goes through the 7th-grade video that shows you diseases and stuff, I cared for about a day and not anymore. It did not help at all."*18-year-old, college freshman*

Participants also expressed having little to no information but were also not certain about where to get information about them. This was either a function of their sexuality or access to resources. One participant who identified as a lesbian said:

> "I don't know (what to do if I were to have sex). I've never really thought about it like that. It's only male and female stuff that's all you hear. I guess I'm screwed"*19-years-old, college freshman*

Theme 4: Menstruation

Menstruation emerged as a theme because, in our participants, it marked the beginning of womanhood and usually for some, it was marked the initiation of conversation about sex with their parents or family.

> "I would say it wasn't terrible. I think I was about 13. I was at home, and my mom was there. Uh, I knew what it was, but she kind of gave me the break down and gave me the pad."

> "Um, gosh. I don't know, it was just expected. I already knew that it was going to happen. I already knew what to do so I was just like ok I started my menstrual. My mom said I am a woman now, it is what it is."*30-years-old, graduate student*

> "Oh yeah. I was 15 then. I remember I was bathing when I just saw something drop. I was like "what's this?". Then, I called my older sister, and she started preaching. "Don't move close to boys," "Don't touch a guy or you'll become pregnant," "You've started menstruation." I'm like "menstruation, what's that?". Then taught me about what happens. I got pads that day. I only did it for like five days, but they helped me with pads for the next three months because I did not know how to use it."*17-years-old, college freshman*

> "Yes. I was 11. When it came, it was just like normal. I was happy about it. I don't know why. I was happy that it came. It was just normal, I guess"17-*year old, college freshman*

Participants frequently reported being unprepared for their menarche (first menstruation)

> "Um, let's see, I was 11 and I started at school, so I was freaking out. I had a clue of what it was because one of my friends had hers a month before. She had white pants on so she soaked her pants and her seat." *19-years-old, college freshman*

> Um let's see I was 13, um it kind of snuck up on me. It was like randomly I had a period one day. I said Oh, it's blood down there…" *25-years-old, college graduate*

> "I was ten years old, and I was at school. I went to the bathroom, and suddenly, there was blood everywhere. I was very innocent, and I was very young, I didn't know what to do because my mom hadn't spoken to me about it." *26-years-old, graduate student*

Some participants, however, reported feelings of shame and as such, did not tell anyone or waited until later to inform their mothers

> "Um, first menstrual? That was a while ago (laughter) um it was scary because I was not sure what it was. I went to the restroom, and I was freaking out. I was wondering where it came from. I was really ashamed because I thought I could get pregnant. I did not tell anyone." *24-years-old, college graduate*

> "Huh, well before I started my menstrual period I actually never knew anything about it. So I went to the bathroom to pee and just saw some red thing come out. Before then a girl started hers and refused to get out the seat because her pants were soaked in blood. Same thing happened to me too. People told me if you don't start a period you won't be able to have kids, so I knew a little about it before mine." *25-years-old, college graduate*

> "Oh god, I went in the bathroom and peed, and blood came out, and then I told my momma, and she didn't care. So, I was freaking; I thought I was dying so I wrote myself a letter and wrote everybody else a letter." *23-years-old, college junior*

Theme 5: Sexual Assault

It is interesting to note the attitudes of our participants towards sexual assault although it was not one of the focuses of this study. Six of the participants admitted to being sexually assaulted; however, none of them reported the incident. Some of them decided to avoid talking about it and did not acknowledge it was sexual assault. None sought counseling or professional help and declined it when the researchers offered the option to them. All of them except one did not inform a family member and personally held themselves responsible for the incident. Four of them said it was a mistake and one person attempted to press charges but withdrew for personal reasons. The men in question were either close relatives, boyfriends, or friends. Two participants became pregnant as a result of the incident; one opted for an abortion while the other had a miscarriage. There was only one case where the accused was a 27-year-old stranger. All six participants admitted that the incident might have negatively affected their confidence in selecting prospective partners and their attitudes towards STI, STD, and pregnancy in general.

DISCUSSION

Similar to studies other studies, (CDC, 2009; Cavazos-Regh et al., 2009; Furstenberg et al.,1987), our study found that participants engaged in sexual intercourse were more likely to have done so at an earlier age. Sexually active participants in our study had their first sex intercourse between the age of 13 and 17. This is about the same time menarche happens. It is therefore important that African American females receive sex education early to not only help them prepare for sex but to also anticipate and prepare for menstruation.

The results of this study provide insight into how African American females learn and may prefer to receive information on topics of sex. Unlike the study by Lee et al. (2013), our participants frequently mentioned parents/ family members as their most preferred source of sex education compared to peers, schools and other sources. Studies show that the fact that African Americans and Asian Americans both have collectivistic cultures(Xie, Leong & Feng, 2008; Brewer & Gardner, 1996; Markus & Kitayama, 1991). However, the preferences for sources of sex education information differed with our participant sample from traditional samples. This difference can be attributed to the kinship bonds and networks that exist in African American culture, which is similar to that of Africans (Hutchinson et al., 2012). Also, Euro American dominated studies on adolescent sexual behaviors listed reading and peers as the highest source of sex education and as such, interventions have been created to these effects and generalized to all groups of adolescents (Bleakley, Hennessy, Fishben & Jordan, 2009). Participants in our study however listed school and peers as their primary source of sex education with preference for parents. Similar to Hines and Boyd-Franklin (2005), participants in our

study reported having very active extended families. In some cases, aunts, uncles, and grandparents were responsible for the upbringings of some of our participants. About ten participants reported that their grandmothers helped them prepare for their first menstruation. Also, they also mentioned that aunts and sisters were often involved in their sexual learning experience. When asked about where they received information concerning sex outside of school, some participant responses included the following:

> "I guess from like my aunts because they talk about their men and their sex lives." *22-years-old, a college senior*

> "My sister had a lot of boyfriends, and she talked about them a lot. I mean A LOT! So I guess I picked up on a thing or two". *17-year-old college freshman*

Based on the study by DiClemente et al. (2004) and Jemmott et al. (1998), we expected that most participants would prefer peers are their most preferred source of sex education. This assumption was also rooted in the evidence for peer-based sex education similar to the findings of Jemmot et al. (1998). On the contrary, participants' mostly preferred to learn about sex primarily from their parents/family compared to other sources.

A very interesting finding from our study was the difference we found between peers and parents as sources of sex education. Participants in our studies stated that they would much rather learn about STI and pregnancy prevention information form their family and learn about the emotional consequences resulting from sexual behaviors. Specifically, they were more interested in learning to cope with negative emotions that come from some sexual experiences (e.g., feeling sexually exploited, emotional detachment from their partner and the possible end of a relationship). This indicates that our participants often experience low power in their relationships and could be at risk for

STIs and unwanted pregnancies according to Geter and Crosby (2014). Some of our participants also reported unwillingly engaging in sexual intercourse and other sexual activities without protection, at the request of their partners. For example, a participant stated:

> "… He (sexual partner) kinda talked me into giving him oral sex, but I honestly did not want to do it. I felt disrespected, but I did not say anything. I did it anyway. I mean we had sex, but he did not use a condom, and I didn't have my pills. I cried after I told him not to, but he did anyway."*27-year-old, college graduate.*

Only a few participants in our study attested to having a relationship with their family/parents, comfortable enough to discuss sex. This missing relationship was expressed by stating that they preferred to have learned from their parents and feelings of regret for not doing so. For example, some participants stated that some of the mistakes they made especially with an unwanted pregnancy, could have been avoided if they had discussed had a close relationship with their families, especially with a female family member.

> "I wish I had learned about condoms. I didn't know about using condoms that's how I got pregnant. Or what you could get (from unprotected sex), I had to learn the hard way." *25-years-old, college graduate*

> "…I wish I learned about it (STD) and protection from someone close that I trust instead of hearing it from others. So like my aunties or mom." *20-years-old, college sophomore*

This finding is similar to the results of Hutchinson et al. (2012) who stated that having a good relationship with the child makes it easier to discuss sex-related topics. However, only a small number of mothers expressed having a close relationship and extensive discussion about sex with their daughters.

Furthermore, our study found that majority of parents waited until after menstruation to initiate sexual conversations with their children. While parents might experience discomfort discussing the topic of sex with their children, it seems discussing menstruation can mitigate this discomfort. However, this means that the child has to wait longer in a case of delayed menarche, at which point might be too late given the early initiation of sexual intercourse in African American girls. This may suggest a need for the development of family-based sex education interventions focused on equipping African American parents with tools to initiate sex conversations at an earlier age. In our study, some participants who stated that family members were their primary source of education discussed having a more favorable experience learning about sex and preparing for their first sexual experience.

Our participants initiated a conversation about sex as early as age nine with their peers. It would be easy to assume that at this age children are not so aware of the issue of sex. However, this is not the case. Some of our participants report receiving sexual education information from school as early as the 5^{th} grade, which is usually before the age of menarche. The lack of follow up either by parents or schools after dissipating this information could be doing more harm than good because it initiates sex conversation and leaves subsequent assumptions to the minds of naive ten and eleven-year-olds.

In general, the majority of participants in our study expressed mixed feelings concerning the sex education programs they were exposed to (which were majorly unfavorable). It might be important to add here that we included three LGBTQ+ participants in this study and all of them stated that formal sex education did not cater to their need especially as LGBTQ+ individuals of color. Some participants, however,

regarded formal sex education as a facilitator for initiating sex conversations with their parents. Most participants addressed the issue of consistency as a major problem with formal sex education. They expressed that they only received this information once usually between 5th and 7th grade. Only one participant reported voluntarily enrolling in a class that emphasized sexual education in college. Participants also acknowledged a lack of motivation to use the resources they were given. This may be because of the timing of the information compounded by a lack of effective follow up with African American parents. Other participants, especially those who identified as members of the LGBTQ+ community simply stated that they had little or no formal sex education to prepare them for subsequent sexual encounters.

Although menarche marked the beginning of sex conversations with our participants and their parents, they described feelings of unpreparedness and shame concerning the experience. For many of them, neither formal sex education, parent conversation nor peer interactions, prepared them for menstruation. Some of them reported being embarrassed and ashamed of their menstruation. The feeling of embarrassment mostly came from being unprepared especially for those who started their first period in public with no protection for their clothing. Shame, on the other hand, came from the bullying some of them had to endure because of this public mishap.

Finally, the last theme in this study addressed the issue of sexual assault. Six of our participants confirmed that they had been sexually assaulted. More alarming was the fact that except one, none of them reported the incident. A common subtheme on the issue was that of self-blaming. All six of them were willing to take the blame and thus refused to turn their perpetrators to the appropriate authorities. Five of these women were

molested by a familiar offender (i.e., they knew the person) who was either an intimate partner (boyfriend), close friend or relative. The last case was the only one in which the perpetrator was a complete stranger to them. According to Black et al. (2011) nearly 1 in 5 African American women in the US, have experienced rape at some point in their lives. At approximately 22% of the reported rape cases in the US, African American report the second highest cases of rape next to Native Alaskan women. Despite their alarming numbers, Black et al. (2011) state that rape cases remain underreported in the US, a factor that is evident in our participants.

We recognize that the small sample size of this study might be a cause of concern for its generalizability. However, this study addresses serious issues affecting African American women – an often-underrepresented group in sex educational research. As such, its results should not be dismissed. The data analysis generated several themes from participants. One was concerning the difference in sources and preference for sources of sex education; another was on the difference between the preferred content of sex education depending on whether it was from a peer or a parent. We also discussed the how our participants perceived formal sex education, attitudes towards menarche and lastly, sexual assault.

LIMITATIONS AND FUTURE IMPLICATIONS

Participants in our study frequently described parents/family as their most preferred sources of sex education. Specifically, as sources of STI and pregnancy prevention. They also described peers as their least favorite source of sex education, however, most preferred for education on negative emotions/emotional consequences of sex. We recognize that the opinions of our participants might not be a representation of all African American females in the US. However, no known studies have addressed the differences between parents and peers as sources of sex education in African Americans. Also, no known research has addressed the negative emotions that African American females might face after intercourse initiation.

Future studies targeting African American females may benefit from developing interventions that include parents/family members in adolescent sexual learning. Peer-based sex intervention targeted towards African American females may also benefit from educating young women on some of the negative emotions they might experience after sex which could leave them at risk for depression, anxiety, low power in future relationships and so on.

Participants in our study also described formal sex education as seriously ineffective towards their needs (e.g., LGBTQ+), inconsistent and limited. Future research can benefit from including age-appropriate formal sex education consistently at different stages of adolescent development and specifically strive to include LGBTQ+ individuals of color. Also, since we only had three LGBTQ+ individuals in our study, we recommend the need for further research in this regard particularly with developing culturally competent research for people of color.

Furthermore, a few participants in our study listed faith-based organizations (churches) as their preferred source of sex education. Future research should consider exploring the content of sex education in a faith-based organization and consider developing appropriate content.

A majority of our participants reported being unprepared for menarche. Some of them also described menarche as the beginning of intuition of sex conversation with their parents. Also, some of them discussed experiencing feelings of shame and embarrassment as a result of accidents resulting from unpreparedness and lack of information. Sex education intervention should look into menarche as a segue into sex conversation with parents of African American females and also create premenstrual education to create a better menarche experience for young girls.

Six of our participants self-identified as survivors of sexual assault but refused to report or seek out help even after it was offered to them. None of them informed their parents or family members except two who became pregnant as a result. Future prevention efforts should consider beginning early by promoting healthy, respectful relationships with African American families by fostering healthy parent-child relationships and developing positive family dynamics and emotionally supportive environments. According to Black et al. (2011), emotionally supportive environments create a strong foundation for children, help them to adopt positive interactions based on respect and trust, and foster effective and non-violent communication and conflict resolution in their peer and dating relationships.

Also, five of these women were sexually assaulted by a familiar offender (i.e., they knew the person) who was either an intimate partner (boyfriend), close friend or

relative. The last case was the only one in which the perpetrator was a complete stranger to them. As a result, it is equally important to continue addressing the beliefs, attitudes, and messages that are deeply embedded in our social structures and that create a climate that condones sexual violence and intimate partner violence. This has been implicated in low relationship power in African American females. Although they were not willing to discuss their experience, it is possible that these women were reluctant to disclose their victimization for a variety of reasons including self-shaming, embarrassment, fear of retribution from perpetrators, or a belief that they may not receive support from law enforcement. This factors could contribute to the feelings of low power they reported in our study. Future studies should consider including training efforts focused on empowering young girls to protect themselves and boost confidence.

Despite the promising result of our study, it is not without its limits. A major limitation of this study is its sample size. We experienced a high attrition rate with participants during the data collection process. The level of attrition in our study could be attributed to simultaneous studies running at the UCO psychology lab at the time of this research. Participants may have decided to participate in another less time-consuming study since all studies offered the same number of credit. Hence, the result of our study could differ slightly with a different population. We also were not able to include as many LGBTQ+ individuals because we had a low representation in our study. However, our LGBTQ+ participants included one lesbian, one bisexual, and one who self identified as queer. Their responses provide insight to some of the struggles of LGBTQ+ individuals of color and may be beneficial to future studies.

References

Abel, G., & Fitzgerald, L. (2006). 'When you come to it you feel like a dork asking a guy to put a condom on': Is sex education addressing young people's understandings of risk?. *Sex Education*, *6*(02), 105-119.

Arnett, J. J. (2014). Adolescence and emerging adulthood. Upper Saddle River, New Jersey: Pearson Education Inc.

Bader, E. (2005). Abstinence-only education. Z Magazine Online, 18(1), 7.

Bandura, A., & Walters, R. H. (1977). Social learning theory. Stanford, Carlifonia: Stanford University.

Beatty, L. A., Wheeler, D., & Gaiter, J. (2004). HIV prevention research for African Americans: Current and future directions. *Journal of Black Psychology*, *30*(1), 40-58.

Beh, H. G., & Diamond, M. (2006). The failure of abstinence-only education: Minors have a right to honest talk about sex. Colum. J. Gender & L., 15, 12.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., & Stevens, M. R. (2011). The national intimate partner and sexual violence survey: 2010 summary report. *Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 19, 39-40.*

Bleakley, A., Hennessy, M., Fishbein, M., & Jordan, A. (2009). How sources of sexual information relate to adolescents' beliefs about sex. *American journal of health behavior*, *33*(1), 37-48.

Bogart, L. M., & Thorburn, S. (2005). Are HIV/AIDS conspiracy beliefs a barrier to HIV prevention among African Americans?. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *38*(2), 213-218.

Borawski, E. A., Trapl, E. S., Adams-Tufts, K., Hayman, L. L., Goodwin, M. A., & Lovegreen, L. D. (2009). Taking Be Proud! Be Responsible! to the suburbs: a replication study. *Perspectives on sexual and reproductive health*, *41*(1), 12-22.

Brewer, M. B., & Gardner, W. (1996). Who is this" We"? Levels of collective identity and self representations. *Journal of personality and social psychology*, *71*(1), 83.

Cavanaugh, J. C., & Blanchard-Fields, F. (2018). Adult development and aging. Cengage Learning.

Cavazos-Rehg, P. A., Krauss, M. J., Spitznagel, E. L., Schootman, M., Bucholz, K. K., Peipert, J. F., ... & Bierut, L. J. (2009). Age of sexual debut among US adolescents. *Contraception*, *80*(2), 158-162.

Centers for Disease Control. (2009). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, National Survey of Family Growth 2006–2008 [Online]. (Accessed Nov 14, 2017)

Centers for Disease Control.(2010). Trends in the prevalence of sexual behaviors—National YRBS: 1991–2009 [Online]. (Accessed January 19, 2018). http://www.cdc.gov/HealthyYouth/yrbs/pdf/ us_sexual_trend_yrbs.pdf http://www.cdc.gov/nchs/data/series/sr_23/sr23_030.pdf

Clark, M. A., Trenholm, C., Devaney, B., Wheeler, J., & Quay, L. (2007). Impacts of the Heritage Keepers® Life Skills Education Component. *Mathematica Policy Research*, 1.

Dailard, C. (2002). Abstinence promotion and teen family planning: the misguided drive for equal funding. The Guttmacher Report on Public Policy, 5(1), 1-3.

Deptula, D. P., Henry, D. B., & Schoeny, M. E. (2010). How can parents make a difference? Longitudinal associations with adolescent sexual behavior. *Journal of Family Psychology*, *24*(6), 731.

De Meyer, S., Kågesten, A., Mmari, K., McEachran, J., Chilet-Rosell, E., Kabiru, C. W. ... & Michielsen, K. (2017). "Boys should have the courage to ask a girl out": Gender norms in early adolescent romantic relationships. *Journal of Adolescent Health*, *61*(4), S42-S47.

DiClemente, R. J., Wingood, G. M., Harrington, K. F., Lang, D. L., Davies, S. L., Hook III, E. W. ... & Hardin, J. W. (2004). Efficacy of an HIV prevention intervention for African American adolescent girls: a randomized controlled trial. *Jama*, *292*(2), 171-179.

Fasula, A. M., & Miller, K. S. (2006). African-American and Hispanic adolescents' intentions to delay first intercourse: Parental communication as a buffer for sexually active peers. *Journal of Adolescent Health*, *38*(3), 193-200.

Forhan, S. E., Gottlieb, S. L., Sternberg, M. R., Xu, F., Datta, S. D., McQuillan, G. M., ... & Markowitz, L. E. (2009). Prevalence of sexually transmitted infections among female adolescents aged 14 to 19 in the United States. *Pediatrics*, *124*(6), 1505-1512.

Furman, W. & Wehner, E. A. (1997). Adolescent romantic relationships: A developmental perspective. *New directions for child and adolescent development*, *1997*(78), 21-36.

Furstenberg Jr, F. F., Morgan, S. P., Moore, K. A., & Peterson, J. L. (1987). Race differences in the timing of adolescent intercourse. *American Sociological Review*, 511-518.

Geter, A., & Crosby, R. (2014). Condom refusal and young Black men: the influence of pleasure, sexual partners, and friends. *Journal of Urban Health*, *91*(3), 541-546.

Giordano, P. C. (2003). Relationships in adolescence. *Annual review of Sociology*, *29*(1), 257-281.

Gutiérrez, L., Oh, H. J., & Gillmore, M. R. (2000). Toward an understanding of (em) power (ment) for HIV/AIDS prevention with adolescent women. *Sex Roles*, *42*(7-8), 581-611.

Health and Human Services. (2016). Trends in Teen Pregnancy and Childbearing 2016 [Online]. (Accessed Sept 10, 2017) Retrieved from: https://www.hhs.gov/ash/oah/adolescent-development/reproductive-health-and-teen-pregnancy/teen-pregnancy-and-childbearing/trends/index.html

Herek, G. M., & Glunt, E. K. (1991). AIDS-related attitudes in the United States: A preliminary conceptualization. *Journal of Sex Research*, *28*(1), 99-123.

Hines, P. M., & Boyd-Franklin, N. (2005). African American families. *Ethnicity and family therapy*, *3*, 87-100.

Hoskins, D. H., & Simons, L. G. (2015). Predicting the risk of pregnancy among African American youth: Testing a social contextual model. *Journal of Child and Family Studies*, *24*(4), 1163-1174.

Hutchinson, M. K., Jemmott, J. B., Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother–daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: a prospective study. *Journal of adolescent health*, *33*(2), 98-107.

Hutchinson, M., Kahwa, E., Waldron, N., Brown, C., Hamilton, P. I., Hewitt, H. H. ... & Jemmott, L. (2012). Jamaican mothers' influences of adolescent girls' sexual beliefs and behaviors. *Journal of Nursing Scholarship*, *44*(1), 27-35.

IBM Corp. (2015). IBM SPSS Statistics for Windows [Computer Software]. Armonk, NY: IBM Corp.

Jemmott III, J. B., Jemmott, L. S., & Fong, G. T. (1998). Abstinence and safer sex HIV risk-reduction interventions for African American adolescents: a randomized controlled trial. *Jama*, *279*(19), 1529-1536.

Jemmott, J. B., Jemmott, L. S., Braverman, P. K., & Fong, G. T. (2005). HIV/STD risk reduction interventions for African American and Latino adolescent girls at an adolescent medicine clinic: a randomized controlled trial. *Archives of pediatrics & adolescent medicine*, *159*(5), 440-449.

Jemmott, L. S., Jemmott III, J. B., & O'Leary, A. (2007). Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. *American journal of public health*, *97*(6), 1034-1040.

Johnson, N., Mullings, A. A., Harvey, K. M., Alexander, G., McDonald, D., Smikle, M. F. ... & Christie, C. D. (2004). HIV seroprevalence, uptake of interventions to reduce mother-to-child transmission and birth outcomes in greater Kingston, Jamaica. *The West Indian medical journal*, *53*(5), 297-302.

Katz, J., & Sutherland, M. A. (2017). College Women's Experiences of Male Partner Contraceptive Interference: Associations with Intimate Partner Violence and Contraceptive Outcomes. *Journal of interpersonal violence*, 0886260517715600.

Kim, J. L. (2009). Asian American women's retrospective reports of their sexual socialization. *Psychology of Women Quarterly*, *33*(3), 334-350.

Kirby, D. B. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior. *Sexuality Research & Social Policy*, *5*(3), 18.

Kirby, D., & Laris, B. A. (2009). Effective curriculum-based sex and STD/HIV education programs for adolescents. *Child Development Perspectives*, *3*(1), 21-29.

Klonoff, E. A., & Landrine, H. (1999). Do blacks believe that HIV/AIDS is a government conspiracy against them?. *Preventive Medicine*, *28*(5), 451-457.

Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of adolescent Health*, *42*(4), 344-351.

Landry, D. J., Darroch, J. E., Singh, S., & Higgins, J. (2003). Factors associated with the content of sex education in US public secondary schools. Perspectives on Sexual and Reproductive Health, 35(6), 261-262.

Lanier, Y., Stewart, J. M., Schensul, J. J., & Guthrie, B. J. (2018). Moving beyond age: An exploratory qualitative study on the context of young African American men and women's sexual debut. *Journal of racial and ethnic health disparities*, *5*(2), 261-270.

Lee, C., Tran, D. Y., Thoi, D., Chang, M., Wu, L., & Trieu, S. L. (2013). Sex education among Asian American college females: Who is teaching them and what is being taught. Journal of immigrant and minority health, 15(2), 350-356.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Newbury Park, Carlinornia: Sage.

Lyles, C. M., Kay, L. S., Crepaz, N., Herbst, J. H., Passin, W. F., Kim, A. S., ... & Mullins, M. M. (2007). Best-evidence interventions: findings from a systematic review of HIV behavioral interventions for US populations at high risk, 2000–2004. *American journal of public health*, *97*(1), 133-143.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, *98*(2), 224.

Martino, S. C., Elliott, M. N., Corona, R., Kanouse, D. E., & Schuster, M. A. (2008). Beyond the "big talk": The roles of breadth and repetition in parent-adolescent communication about sexual topics. *Pediatrics*, *121*(3), e612-e618.

McNair, L. D., & Prather, C. M. (2004). African American women and AIDS: Factors influencing risk and reaction to HIV disease. *Journal of Black Psychology*, *30*(1), 106-123.

Mellanby, A. R., Newcombe, R. G., Rees, J., & Tripp, J. H. (2001). A comparative study of peer-led and adult-led school sex education. *Health Education Research, 16*(4), 481-492.

Nicholls, S., Mc Lean, R., Henry, K. T., & Camara, B. (2000). Modeling the macroeconomic impact of HIV/AIDS in the English speaking Caribbean. *South African Journal of Economics,* 68(5), 405-412.

Olukoga, I. A. (2004). Epidemiologic trends of HIV/AIDS in Jamaica. *Revista Panamericana de Salud Pública, 15,* 358-363.

Park, E., McCoy, T. P., Erausquin, J. T., & Bartlett, R. (2018). Trajectories of risk behaviors across adolescence and young adulthood: the role of race and ethnicity. *Addictive behaviors*, *76*, 1-7.

Perrin, K. K., & DeJoy, S. B. (2003). Abstinence-only education: How we got here and where we're going. Journal of public health policy, 24(3-4), 445-459.

Pulerwitz, J., Amaro, H., Jong, W. D., Gortmaker, S. L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS care, 14*(6), 789-800.

Raiford, J. L., Seth, P., & DiClemente, R. J. (2013). What girls won't do for love: human immunodeficiency virus/sexually transmitted infections risk among young African-American women driven by a relationship imperative. *Journal of Adolescent Health*, *52*(5), 566-571.

Raj, A., Silverman, J. G., & Amaro, H. (2000). The relationship between sexual abuse and sexual risk among high school students: Findings from the 1997

Massachusetts Youth Risk Behavior Survey. *Maternal and child health journal*, *4*(2), 125-134.

Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., ... & Pappas-Deluca, K. (2004). Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *Journal of Adolescent Health*, *34*(1), 3-26.

Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, California: Sage.

Santelli, J., Ott, M. A., Lyon, M., Rogers, J., Summers, D., & Schleifer, R. (2006). Abstinence and abstinence-only education: A review of US policies and programs. Journal of Adolescent Health, 38(1), 72-81.

Shepherd, L. M., Sly, K. F., & Girard, J. M. (2017). Comparison of comprehensive and abstinence-only sexuality education in young African American adolescents. *Journal of adolescence*, *61*, 50-63.

Somers, C. L., & Surmann, A. T. (2004). Adolescents' preferences for source of sex education. *Child Study Journal*, *34*(1), 47-60.

Sonfield, A., & Gold, R. B. (2001). States' implementation of the section 510 abstinence education program, FY 1999. Family Planning Perspectives, 166-171.

Stanger-Hall, K. F., & Hall, D. W. (2011). Abstinence-only education and teen pregnancy rates: why we need comprehensive sex education in the US. PLoS One, 6(10), e24658.

Stevens, R., Gilliard-Matthews, S., Nilsen, M., Malven, E., & Dunaev, J. (2014). Socioecological factors in sexual decision making among urban girls and young women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *43*(5), 644-654.

Trenholm, C., Devaney, B., Fortson, K., Quay, K., Wheeler, J., & Clark, M. (2007). Impacts of Four Title V, Section 510 Abstinence Education Programs. Final Report. *Mathematica Policy Research, Inc.*

UCO SONA systems. (2018). Psychology Department Research Participation System [Computer Software]. Retrieved from https://uco.sona-systems.com/main.aspx

Udry, J. R., Joyner, K., & Carver, K. (2003). National estimates of adolescent romantic relationships. In *Adolescent romantic relations and sexual behavior* (pp. 37-70). Psychology Press.

Underhill, K., Montgomery, P., & Operario, D. (2007). Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review. Bmj, 335(7613), 248.

Upadhya, K. K. & Ellen, J. M. (2011). Social disadvantage as a risk for first pregnancy among adolescent females in the United States. *Journal of Adolescent Health*, *49*(5), 538-541.

U.S. Census. Quick Facts United States. 2016. [Online]. Retrieved from: https://www.census.gov/quickfacts/fact/table/US/PST045216

Vedung, E. (2017). *Public policy and program evaluation*. Routledge.

Wang, B., Stanton, B., Deveaux, L., Li, X., Koci, V., & Lunn, S. (2014). The impact of parent involvement in an effective adolescent risk reduction intervention on sexual risk communication and adolescent outcomes. *AIDS Education and Prevention*, *26*(6), 500-520.

Yin, R. K. (2017). Case study research and applications: Design and methods. Thousand Oaks California: Sage.

Xie, D., Leong, F. T., & Feng, S. (2008). Culture- specific personality correlates of anxiety among Chinese and Caucasian college students. *Asian Journal of Social Psychology*, *11*(2), 163-174

APPENDIX A

Interview Questions

Participants can choose to opt out at any time.

- Introduction questions. E.g., tell me about yourself, what is your major? Etc.
- What was your first menstruation (period) experience like?
- How old were you when you had your first menstruation experience?
- What were your first experiences with sexuality (intercourse, masturbation, heavy petting with a partner, etc?)
- What were your experiences with oral sex?
- What do you consider the worst sexual experience you have had in your life?
- Have you engaged in any sexual activities in the past six months? E.g., oral sex (giving or receiving), anal sex, etc.
- What were some sexual activities have you engaged in within the past six months?
- Have you ever been raped?

Important questions

- Do you identify as a member of the LGBTQ+ community?
- *(If Yes to the above)*What do you identify as?
- How do you practice safe sex?
- How old were you when you first discussed sex with your family?
- How old were you when you first discussed sex with your peers?
- How many times have you discussed sex with your family?
- How many times have you discussed sex with your peers?
- How have you prevented unwanted pregnancies?
- How did you get to know about your pregnancy prevention method?

- How did you prepare for your first sexual experience?
- How did you discuss pregnancy prevention with your family?
- How do you discuss sexual health with your family?
- How did you discuss pregnancy prevention with your peers?
- How do you discuss sexual health with your peers?
- How would you have preferred to learn about sex?
- What do you wish your family had told you about sex?
- What do you wish your peers had told you about sex?
- Do you feel anything was neglected in this discussion? Would you like to add/share anything?

Ask for follow up approval

APPENDIX B

UNIVERSITY OF Central Oklahoma

UCO IRB Number _____
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UNIVERSITY OF CENTRAL OKLAHOMA
INFORMED CONSENT FORM

Research Project Title: Exploring the source of sex education in African American females: A qualitative study

Researcher (s): Dr. Lorry Youll, Oluwakemi Olurotimi

A. **Purpose of this research:** This qualitative study wishes to explore the relationship between the source of sex education particularly in African American females and their subsequent sexual behaviors (partners and use of contraception), including use of available sexual health resources. The research questions are proposed to provide answers pertaining to the preferred sources of sex education, contraceptive uses, including the difference in roles between peer sources of sex information/education and the role of parental sources of sex information/education.
B. **Procedures/treatments involved** The privately conducted interviews will last for approximately 1-hour, be audio taped and transcribed. The, participants will be informed of the purpose of the study, the procedures involved, that their participation in the study is voluntary and that they may choose to withdraw from the study at any time.
C. **Expected length of participation:** 60 Minutes
D. **Potential benefits:** This study will help to expand our understanding of sexual behaviors in African American females by exploring youths' approach to sexual education. The latter point is an important contribution because existing studies on African American female sexual health have not explored perspectives of adolescents on peer versus parental sources of sex education
E. **Potential risks or discomforts:** Due to the nature of this study, participants might experience some discomfort disclosing their sexual history.
F. **Medical/mental health contact information (if required):** UCO Center for counseling and well-being,405-974-2215
G. **Contact information for researchers:** oolurotimi@uco.edu, lyoull@uco.edu
H. **Contact information for UCO IRB:** irb@uco.edu
I. **Explanation of confidentiality and privacy:** Your identity as a participant will remain confidential during and after the study.
J. **Assurance of voluntary participation:** Participation in the study is voluntary and you may choose to withdraw from the study at any time.

AFFIRMATION BY RESEARCH SUBJECT

I hereby voluntarily agree to participate in the above listed research project and further understand the above listed explanations and descriptions of the research project. I also understand that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty. I acknowledge that I am at least 18 years old. I have read and fully understand

UNIVERSITY OF Central Oklahoma

UCO IRB Number _____
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this Informed Consent Form. I sign it freely and voluntarily. I acknowledge that a copy of this

Informed Consent Form has been given to me to keep.

Research Subject's Name: _____

Signature:

Date: _____

This project has been approved by the University of Central Oklahoma Institutional Review Board (#17120).

Approved
SEP 21 2017
UCO IRB

Approval
SEP 20 2018
Expires

APPENDIX C

Consent & Recording Release Form
Title of Study: Exploring Sources Of Sex Education In African American Females: A Qualitative Study
Principle Investigator: Oluwakemi Olurotimi
Co-Principle Investigator: Dr. Lorry Youll

I understand and consent to the use and release of the recording by university of central Oklahoma. I understand that the information and recording is for research purposes only and will not be released for other purposes. Once the study has concluded the recordings will be kept for not more than three years. Recordings will be kept in a password protected computer. Once the project has concluded the recordings will be deleted and scrubbed from the hard drive.

I understand that participation in this study is voluntary and I agree to immediately raise any concerns or areas of discomfort during the session with the researcher.

Please sign below to indicate that you have read and you understand the information on this form and that any questions you might have about the session have been answered.

Date:_____
Please print your name:_____
Please sign your name for audio release:_____
Please sign your name for consent for audio recording:_____

Approved
SEP 2 1 2017
UCO IRB

Approval
SEP 2 0 2018
Expires