EXPLORING PARENTAL PERCEPTIONS CONCERNING SEXUAL COMMUNICATION BETWEEN SUB-SAHARAN AFRICAN IMMIGRANT PARENTS AND THEIR CHILDREN

By

Kwame Owura Frimpong

Liberty University

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree Doctor of

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Abstract

Sub-Saharan African families experience communication barriers due to factors such as sexual silence, cultural taboos, and shame, preventing them from having sexual health communication with their children. The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their pre-adolescent children concerning sexuality and sexual practices. While numerous researchers have demonstrated efficiency in audience-specific interventions, the literature reflects little attention to African immigrants, specifically Sub-Saharan immigrants. The research questions addressed perceptions of influences of a decision to discuss issues relating to sex and sexuality with their children, attitudes about their self-efficacy in parent-child communications about sex, and communication barriers based on cultural taboos and belief systems. Data collection was by individual interviews of 12 Sub-Saharan immigrant adults having resided in the United States for 10 years or more. Inductive analysis of qualitative data revealed communication barriers due to cultural beliefs, cultural taboos, and shame. In addition, another barrier identified was parents' lack of knowledge concerning sexual health. Findings indicated acculturation presented challenges to many immigrant parents. However, most parents indicated an interest in sex education training to be well prepared to talk with their children on sexual health matters. These results may inform the counseling profession on strategies for providing counseling services to Sub-Saharan immigrants. Counselors should be knowledgeable of cultural differences and ready to help immigrant parents who struggle with initiating a parent-based sexual health conversation. It will also help to improve parent-child sexual health communication

Keywords: Immigrants, parent-child conversations, cultural shame, sexual health

Dedication

To my wife Mary, my three children, and my grandchildren. Thank you for all your love and support. I also dedicate this work to all the parents in the diaspora, who toil day and night to see their children succeed.

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CHAPTER ONE: INTRODUCTION

Sex education has been widely researched, and studies have indicated sex education helps prevent children and adolescents from engaging in risky sexual behaviors (Gabbidon & Shaw-Ridley, 2018; Koren, 2019; Motsomi et al., 2016; Noe et al., 2018); however, challenges exist concerning sexual communication between parents and children, especially among immigrant families from diverse cultures. Regardless of their cultural origin, children have the natural tendency to exhibit "childhood culture" (Kincheloe, 1998, pp. 169-175). These two cultures (the childhood culture of the child and their parents' culture) lead to complex and stressful parenting for African immigrant families (Amayo, 2009), often rendering parenting ineffective. Studies have indicated that effective parent-child communication is a bedrock for building a child's sense of self-worth, impacting their resilience to resist peer pressure for sexual promiscuity, preventing unplanned pregnancy, sexually transmitted diseases, and school dropout (Hacker et al., 2000).

Studies have identified that cultural and communication barriers hinder conversations between parents and adolescents regarding sexual health education (Holman & Kellas, 2018). Parent-child interventions have been highlighted as a means of improving parent-children sexual-related communication (Coakley et al., 2017). The likelihood of teens who receive sex education to resist pressure for sexual risk behavior is higher than their peers who do not receive such education (Hacker et al., 2000; Albert, 2010). However, sub-Saharan parents face barriers to communicating sexually related communication to their children (Ojo et al., 2011). In 2010, the Centers for Disease Control and Prevention (CDC) reported that consequences of unprotected sexual intercourse with multiple partners to a teenager include sexually transmitted infections (STIs), human immunodeficiency virus (HIV), acquired immune-deficiency syndrome (AIDs), and unintended pregnancy. Furthermore, the CDC (2013) report showed six sexually

risky behaviors under surveillance in the United States. Moreover, other risky behaviors among teenagers included inadequate physical activity, alcohol use, illicit drug and tobacco use, behaviors leading to unintentional injury and violence, and unhealthy dietary behaviors are other risk behaviors (CDC, 2013). The rate at which sexually risky behavior predisposes adolescents to unintended health outcomes is growing fast and is a considerable concern in the United States (Ogunnowo, 2016). For example, in a 2013 survey of high school adolescents in the United States, the CDC (2014) reported that approximately 47% had ever had sexual intercourse, 34% had experienced sexual intercourse during the previous 3 months and, 41% of these individuals did not use a condom the last time they had sex. Also, 15% had sex with four or more people during their lives, whereas 22% who are sexually active had ever been tested for HIV (CDC, 2014, p. 43). Parent-child communication is a critical component to combat sexually risky behaviors.

The term immigrant embraces an array of foreign nationalities, cultures, and ethnicities (Alegría et al., 2017). Immigrant families, specifically Sub-Saharan African families, experience cultural barriers, such as shame, preventing sensitive conversations (Christensen et al., 2017). Culturally appropriate and skill-based approaches can help families with communication, and parental education can help support discussions with children concerning sexual health (Gabbidon & Shaw-Ridley, 2018). Counselors can help parents reduce barriers based on cultural or religious shame concerning sexuality and provide parents the training needed for effective sex education (Ussher et al., 2017). By conversing with Sub-Saharan African immigrant families, researchers can understand the needs of first-generation parents concerning strengths and weaknesses of parental conversations on sexual health with youth effectively.

This chapter presents an introduction to the important components of this research study. Research was needed to understand Sub-Saharan African immigrant families facing challenges associated with sexual shame. The sections within this chapter include information on the background of the problem, problem statement, purpose statement, the significance of the study, research questions, definitions, and summary.

Background to the Problem

Researchers have found that United States immigrant parents often experience uncertainty when considering how to engage in a conversation about sexuality (Christensen et al., 2017). A parent's level of confidence in discussing sexuality can also affect the quality of a conversation and the appropriate amount of time to cover the topic. Christensen et al. (2017) found that many immigrant parents face cultural, traditional, or religious barriers, preventing meaningful conversations on sexuality. These barriers may include sexual shame, which includes feeling awkward or embarrassed about the topic, lack of knowledge, and even cultural or religious restrictions on the topic's appropriateness (Agbemenu et al., 2016; Christensen et al., 2017).

According to Gabbidon et al. (2017), adolescents, ages 15 to 25, account for half of the estimated 20 million new sexually transmitted diseases occurring annually within the United States. The reports concerning adolescents contracting sexually transmitted diseases present the importance of sex education, which has been widely researched and proven to help prevent children and adolescents' from engaging in risky sexual behaviors (Gabbidon & Shaw-Ridley, 2018; Kajula et al., 2014; Koren, 2019; Motsomi et al., 2016; Noe et al., 2018). However, challenges exist concerning sexual communication between immigrant parents and their children.

As a potential barrier to communication, sexual shame is often associated with desires or sexuality perceived as off-limit topics for discourse among immigrant families (Clark, 2017). A standard definition of sexual shame does not currently exist (Kyle, 2013). However, sexual shame was defined by Kyle (2013) using an adaptation of the definition of shame proposed by Brené Brown (2007). Kyle (2013) noted sexual shame is the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging due to our current or past sexual thoughts, experiences, or behaviors. To further understand the impact of shame on sexual communication, it is vital to understand its definition. Gordon (2018) explained that sexual shame is a shame associated with a strong view of an individual's sexual identity, attractions, feelings, and behaviors. Parker and Thomas (2009) noted that shame often produces an overall sense of badness or worthlessness. Shame can have an impact on mental health (Parker & Thomas, 2009), and many individuals who have experienced sexual shame may avoid counseling or therapy, which could deprive the individuals of mental health services that could prove beneficial (Hutchinson & Dhairyawan, 2018; Ussher et al., 2017). As in many U.S. immigrant families, sexual shame may result from family culture or beliefs (Christensen et al., 2017). In many families, parents shape the faith and values of their children. Values are often modeled, and permissible and non-permissible forms of conversation concerning sexuality are taught (Volk et al., 2016).

A conceptual foundation for the study was needed to help support research components that can help with exploring the parental conversations about sexuality among immigrant families. The social cognitive theory (SCT) was used to emphasize the role of social and cultural factors that can influence behavior, motivation, learning, and self-regulation (Schunk &

DiBenedetto, 2020). Exploring clients' culture and cultural challenges can help identify needed supports (Beck, 2016).

For immigrant parents to be effective in providing sexual health education to their children, parental training may be essential (Ussher et al., 2017). Exploring parental perceptions concerning sexual communication between immigrant parents and their children may help counselors understand parental needs for successful communication. For a parent-child sexually related conversation to be successful, culture cannot be avoided. Culture plays a significant role in learning about sexuality, and culture may impact the sexual self (Dune & Mapedzahama, 2017). For example, culture may influence an individual's sexual identity, attitudes, and behaviors (Robinson et al., 2002). Many researchers have highlighted that parent-child intervention improves parent-children sexual-related communication (Coakley et al., 2017). According to Miller et al. (2011) and Wycoff et al. (2008), conversations increase adolescent knowledge level about sexual health topics and increase higher self-efficacy levels to communicate and increase the frequency of communication with their children.

Statement of the Problem

Despite past studies that have been conducted on sexuality and youth health, there remains a gap in research that explores how Sub-Saharan African immigrant culture and sexual shame may affect teen sexuality (Gabbidon et al., 2017). For many immigrant families, culture presents sexual shame or other barriers to effective sexual communication (Noe et al., 2018). Regnerus (2005) noted that religion could often influence the beliefs of sexual activities and attitudes. Sexual silence, cultural taboo, and a high level of religiosity can create shame associated with initiating sexually-related conversations with children, including adolescents (Gabbidon et al., 2017). However, when parents are knowledgeable or trained about how to

discuss sexuality-related topics with children, a reduction in shame may be possible (Jerman & Constantine, 2010), and meaningful conversations can occur. Therefore, it was necessary to explore the perceptions of Sub-Saharan African immigrant parents to identify a lack of effective resources and parent training to help overcome cultural barriers to discussing sexuality-related topics with their children.

Parents find it difficult to initiate sexually-related conversations with children in most sub-Saharan countries due to sexual silence and cultural taboo. The cultural belief that sex education would promote promiscuity and premature exposure to sexual activity is very strong (Asekun-Olarinmoye et al., 2009). This research elicited the experiences of Sub-Saharan parents who want to educate their children about sexual health. However, the parents find themselves between two cultures, making it difficult to offer meaningful sexual communication with their children. As indicated by Viruell-Fuentes (2007), improper acculturation can negatively affect the well-being of immigrants and adversely affect their health outcomes (Viruell-Fuentes, 2007). This study also explored the impact of the acculturation process on Sub-Saharan parents and their experiences with parenting in the United States.

While many research studies have been conducted on sexual shame and its negative impact on individuals, there is limited research about parental perceptions of barriers to initiating sexual health conversations between immigrant parents and their children. A fundamental process to convey values, beliefs, and expectations, communication is essential to effective parenting (Jerman & Constantine, 2010). Studies have confirmed that cultural barriers to communication can interfere with engaging in sexual health conversations (Christensen et al., 2017; Roudsari et al., 2013; Thompson et al., 2015). For example, researchers of health and human development, Jerman and Constantine (2010), discussed factors that make sexual

conversations difficult, including developmental concerns, embarrassment, parents' knowledge, and comfort level. Similarly, Malacane and Beckmeyer (2016) found four major barriers between parent-adolescent sex communication, including limited sexual health knowledge, perceptions of adolescents' readiness for sex, parental comfort with discussing sex, and demographic factors. Motsomi et al. (2016) discussed additional barriers between parents and adolescents regarding conversations on sexuality, such as adolescent misperceptions that guardians do not want to discuss sexual activities with them, a strong belief system of parents or guardians, myths that adolescents are too young, and cultural and religious beliefs.

According to Gabbidon et al. (2017), study findings have indicated that some teens have engaged in sexual intercourse before conversing with a parent on sexuality. This finding supports the need for early parental discussions on sexuality. Lebese et al. (2010) noted minimal or absent dialogue about sexual health between parents and teenagers (aged 13 to 19 years old). Lebese et al. explained how culture is a major challenge to sexual health dialogue. As dialogue is needed among younger adolescents, this study may increase immigrant parental awareness of the benefits of having sexual conversations with their adolescent children. Additionally, an exploration of immigrant parental perceptions may identify communication barriers with sensitive topics. The problem was parental communication barriers (e.g., sexual shame, taboos) of Sub-Saharan African immigrant families may generate interference in meaningful sexual conversations with adolescents ages 10-16 years old. For the purpose of this study, culture is defined as the customs, identities, and behavior of a particular nationality of people sustained through communication, actions, and interactions (Martinovski, 2018).

Purpose of the Study

The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Examining immigrant families living in the United States and understanding the impact of sexual shame on providing sexual health education to their preadolescent children is beneficial to counselors working with diverse families. Due to the different variations of cultures within cultures, providing a one-size-fits-all solution may not be helpful (Szlachta, 2015). The study helped explore how perceptions of cultural barriers mediate Sub-Saharan immigrant parent sexual conversations. Potential perceived barriers included a) sexual shame, b) knowledge about sexuality, c) attitudes and beliefs, d) parental style, e) acculturation, and f) gender (father and mother).

Thus, this researcher aimed to explore perceived struggles to provide a baseline framework to improve conversations concerning sex education within Sub-Saharan African immigrant families. The researcher aimed to identify the communication needs of Sub-Saharan African immigrant parents concerning the benefits of sexual conversations and meaningful communication with their adolescent children. Results from this study might provide counselors with the information needed to address the cultural barriers of Sub-Saharan African immigrant families concerning sexual shame, enabling parents to instigate a discussion on sexuality.

Research Questions

This study used a phenomenological qualitative research method. A phenomenological approach (Creswell & Creswell, 2017) was used to gather the perceptions of Sub-Saharan

African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. The following research questions were used in this study.

RQ1: What are the perceptions of Sub Saharan immigrant parents concerning the influences of a decision to discuss issues relating to sex and sexuality with their children?

RQ2: What are the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality?

RQ3: What are the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief systems?

Limitations and Delimitations

Limitations are a part of every research design (Creswell & Creswell, 2017). For this qualitative study, limitations included the sample population. Many quantitative studies involve large populations and random sampling (Creswell & Creswell, 2017); however, time and resources are a limitation and do not support a large-scale research study. Delimitations are research components that are within the researcher's control (Theofanidis & Fountouki, 2018). Delimitations included a smaller sample size restricted to the geographical location of the researcher. Having a geographically restricted population prevents generalizability but could still yield essential data important to the field of counseling and parent-child communications of sexuality. Another delimitation is the types of families that were the focus of the study. A focus on Sub-Saharan African immigrant families was appropriate as the purpose of the study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices.

Operational Definitions

The following terms are relevant to the dissertation study. The following terms represent barriers to conversations on sexual health and sexual topics of discussion that were the focus of the data analysis.

1. *Cultural taboo* – Taboos are beliefs of a specific culture or group that present contempt for certain topics, actions, or ideas that lead to shame, stigmatization, and isolation (Goldschmidt-Gjerløw, 2019). Many individuals of these cultures will avoid social reactions identified as taboo and comply with the norm keeping certain ideas silenced. In the context of this study, cultural taboos have been identified as a potential barrier to parent-child communications (Gabbidon et al., 2017).
2. *Culture*- the customs, identities, and behavior of a particular nationality of people sustained through communication, actions, and interactions (Martinovski, 2018).
3. *First-generation immigrants*- individuals born in one country (outside of the United States) who migrated to the United States (Alegría et al., 2017).
4. *Outcome expectancy*- In the context of this study, outcome expectancy is defined as the parents' expectation about the outcomes associated with talking with their adolescents about sex-related topics (Bandura, 1997).
5. Outcome expectation- In the context of this study, outcome expectation means a judgment of the likely consequences that result from the performance of a behavior (Bandura, 1997).
6. *Self-efficacy*- In the context of this study, self-efficacy means confidence in performing a behavior (Bandura, 1997).

7. *Sexual communication barriers*- Barriers to sexual health communication between immigrant parents in their adolescents may include sexual silence, cultural taboo, and a high level of religiosity can create shame associated with initiating sexually-related conversations with children, including adolescents (Gabbidon et al., 2017). In the context of this study, sexual communications are related to the sexual outcome expectancy scale.
8. *Sexual shame*- Kyle (2013) noted sexual shame is the intensely painful feeling or experience of believing we are flawed and the focus of the study therefore unworthy of acceptance and belonging due to our current or past sexual thoughts, experiences, or behaviors. As the purpose of the study is to investigate sexual shame, this operational definition is essential to the context of the Sub-Saharan African immigrant population.
9. *Sexual silence*- Sexual silence is a lack of conversations, or silence, around sexuality and relationships (Konkle-Parker et al., 2018). Sexual silence has been associated with the sexual shame associated with initiating sexually-related conversations with children (Gabbidon et al., 2017).
10. *Sexual topics*- Sexual topics are part of the focus of the sexuality scale. Topics of discussion center on sexual health, growth, and development. Topics may include sexual maturity, puberty, the life cycle, sexual intercourse, misconduct, or disease (DiLorio, 2013).
11. *Sub-Saharan African*- According to Amadi (2012), Sub-Saharan Africa represents a region of the African continent south of the Sahara Desert, including the eastern, central, southern, and western regions. Sub-Saharan Africa is viewed as Black Africa based on its predominantly Black population. Christianity is prominent in sub-Saharan Africa;

however, religion overlaps with other traditional religions and mythologies (Amadi, 2012). Sub-Saharan immigrant families are the focus of this study.

Theoretical Framework

When synthesizing past empirical research studies to answer new questions, using a theoretical basis similar to that of studies examined is appropriate. The social cognitive theory (SCT) is often used to explore behaviors, experiences, and emotions (Schunk & DiBenedetto, 2020). As the focus of this study was on understanding the common concerns among Sub-Saharan African immigrant parents and their understanding of effective measures to initiate conversations about sexuality and sexual health, a theoretical basis using SCT was appropriate.

The social cognitive theory emphasizes the significant role of social factors that impact an individuals' behavior, motivation, learning, and self-regulation (Schunk & DiBenedetto, 2020). Bandura (1989) was the originator of the social cognitive theory, and the theory was developed when societies were less diverse. However, the SCT has been used as a basis in many cultural studies examining motivation by reviewing an individual's agency and self-efficacy. Past studies that have used the SCT as a theoretical basis have indicated that self-efficacy may be influenced by cultural variables (Bandura, 1989). Many researchers have used the SCT to explore behavioral and environmental influences on an individual's perceptions (Schunk & DiBenedetto, 2020).

Many studies with a focus on diverse cultures and immigrants have used the SCT as a theoretical basis. For example, Garcia et al. (2019) used SCT as a basis to study how immigrant parents communicate career development. Dutta (2018) conducted a study on Bengali parents that immigrated to Canada. Dutta (2018) used SCT to examine how acculturation and immigration influenced Bengali parenting, considering past cultural differences in gender

equality. Another study by Peacock-Chambers et al. (2017) used SCT to explore how self-efficacy influenced immigrant parents' home learning environment. As many studies have effectively used SCT as a basis for conducting research with immigrant parents and families of diverse cultures, SCT was an appropriate theoretical framework to use for this conceptual analysis.

Significance of the Study

Although cultural and religious beliefs have been identified as possible barriers to communication (Ussher et al., 2017), a lack of information exists in literature concerning sexual shame and Sub-Saharan African immigrant parents' attitudes, knowledge, and comfort in having a conversation with their adolescent children concerning sexuality and sexual practices. Based on a review of past studies, some factors that can reduce perceived barriers to sexual health conversations include culturally appropriate and skill-based approaches (Gabbidon & Shaw-Ridley, 2018) and parental education to support discussions with children concerning sexual health (Jerman & Constantine, 2010). Ussher et al. (2017) indicated that counselors could help parents reduce their feelings of cultural or religious shame concerning sexuality. While extensive research has been conducted regarding sexual shame and communication barriers regarding conversations about sexuality, there are gaps in the literature concerning exploring parental perceptions concerning the barriers to initiating sexual conversations among immigrant families (Farringdon et al., 2014).

According to Guilamo-Ramos et al. (2011), pre-adolescence is the most appropriate time for parents to begin sexual health conversations with their children, in that the children have not become sexually active. Despite the growing number of studies focused on the effectiveness of interventions for parents, few studies have focused on culture and counselor-led parental

interventions (Christensen et al., 2017). Because very few studies have proven higher outcomes of initiating meaningful sexual health conversations by using interventions, researchers have recommended counselor-led parental interventions to promote education on sexual health (Othman et al., 2020).

Studies on parent-child sexual health conversations present the effectiveness of parent interventions (Alcalde & Quelopana, 2013; Dune & Mapedzahama, 2017). Parent-child interventions that are culturally specific and geared toward specific cultural issues have a higher likelihood of a positive outcome (Wight & Fullerton, 2013). Wight and Fullerton (2013) explained this positive outcome could be related to the improvement of parent-child communication. Culturally specific interventions have several benefits and are successful based on science and cultural relevancy (Castro et al., 2004). A culturally specific community develops a sense of ownership with the intervention, adoption, and participation in the intervention (Castro et al., 2004). Moreover, the Centers for Disease Control and Prevention (CDC) recommends specific interventions aimed at the family level are essential to supplement community efforts and health systems to target youth (Centers for Disease Control and Prevention, 2014). The findings from this study provide educational recommendations that could help promote healthy conversations about sexuality between immigrant parents and their adolescent children. As noted by Wight and Fullerton (2013), healthy conversations can result from improved parent-child communication.

Organization of Remaining Chapters

Chapter One presents the background of the problem, the purpose of the study, the research questions and hypotheses, limitations, operational definitions, theoretical framework, and the significance of the study. Chapter Two presents a literature review. This review helps

identify and focus on factors relevant to the purpose of the study. A review of the literature helps explore culturally focused parental conversations with adolescent children concerning sexuality and sexual practices. An exploration of barriers to parental conversations on sexual topics is also included. Chapter Three includes the methodology for the study. The research design and approach include information such as instrumentation, sample population, data collection, and data analysis. Chapter Four presents the findings from the analysis of the data, and Chapter Five concludes the study with results and recommendations.

Chapter Summary

The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. A qualitative approach was used to explore potential barriers to parental conversations. This study's findings could benefit counselors who work with immigrant parents of adolescents who may experience sexual shame and face communication difficulties. The following chapter presents the literature review to support the research design and purpose.

CHAPTER TWO: LITERATURE REVIEW

Overview

Culture impacts sexuality, and studies have indicated that several factors contribute to the development of young people's sexual health, including family structure, family connectedness, parental monitoring (Dilorio et al., 2003). Due to limited research about the African immigrant population, it is challenging to recognize what this immigrant population may need and how they are coping (Ogunnowo, 2016). Parents' attitudes and values are essential to helping young people with sexual health. Researchers have supported the claim that parents and caregivers serve as the foundation for children's sexuality and sexual development (Volk et al., 2016).

Sexual shame for many U.S. immigrant families may result from family culture or beliefs (Christensen et al., 2017). However, this study addresses the gap in research concerning how Sub-Saharan African immigrant culture and sexual shame affect teen sexuality (Gabbidon et al., 2017). The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices.

This chapter provides a review of relevant research that provides foundational support. This chapter includes information on the theory that supports the conceptual foundation. For this study, a conceptual foundation supported research components that address parental conversations about sexuality among immigrant families. Similar research has used SCT to focus on the cognitive, behavioral, and social aspects of participants. A section on related literature is also be provided.

Conceptual Framework

In the field of counseling, psychology and research-based theories serve as a basis for therapeutic services (Rad et al., 2018). A conceptual framework based on theory supported this study to investigate sexual shame and the effect of a two-hour parent workshop on Sub-Saharan African immigrant parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Behaviors, experiences, and emotions play a significant role in parenting; therefore, this study used Bandura's (1989) social cognitive theory (SCT) to examine Sub-Saharan African immigrant parents' and their attitudes towards initiating conversations about sexuality and sexual health.

Social cognitive theory, developed by psychology professor Albert Bandura, suggests a framework for understanding how individuals are shaped by their environment (Schunk & DiBenedetto, 2020). Processes such as observational learning and modeling influence behavior and self-efficacy. Specifically, Bandura (2001) explained how economic conditions, socioeconomic status, and educational and family structures affect behavior. These societal factors also influence aspirations, self-efficacy, and personal standards. The SCT emphasizes the role of social factors have on an individual's behavior, motivation, and learning (Schunk & DiBenedetto, 2020).

Although Bandura (1989) developed the social cognitive theory when cultures were less diverse, the SCT has served as the basis for cultural studies examining the influence of behavior and self-efficacy. For example, Garcia et al. (2019) used SCT to study how immigrant parents hold conversations about careers. Dutta (2018) conducted a study on Bengali parents that immigrated to Canada. Dutta (2018) used SCT to examine gender equality and how acculturation and immigration parenting. As many studies have effectively used SCT to research

immigrant parents and families of diverse cultures, SCT is an appropriate theoretical framework for this conceptual framework. To explore behaviors, experiences, and emotions, SCT is a preferred theoretical framework (Schunk & DiBenedetto, 2020). This framework was used to shape the meaning of the study and created the lens for the themes, codes, organization, and findings of participants' experiences. As noted in the literature, SCT asserts that people learn from their own experiences and by observing other people's experiences (Kelder et al., 2015).

Gap in Literature

A study on African immigrant health in the U.S confirms that African immigrants are the least studied immigrant group (Omenka et al., 2020). Moreover, while numerous researchers have demonstrated audience-specific interventions' efficiency, studies that target African immigrants are scarce (Maibach & Parrott, 1995). There is support for this statement, as Lindstrom et al. (2019) argued that while parents' role in adolescent health has been well studied, culturally-based studies among African immigrants have little to no research support. A study by Agbemenu, Terry, Hannan, Kitutu, and Doswell (2018) presented a study about African immigrant mothers and daughters, yet also shared within their results that existing research is limited. The literature gap related to African immigrants' sexual health is supported by recognizing the limited studies on early and middle childhood development among immigrant families (Gassman-Pines & Skinner, 2018) and limited research on the impact of acculturation on immigrant children's sexuality (Ogunnowo, 2016). Thus, Kingori et al. (2018) recommended the need for future research to help better serve the African immigrant population. Parent-child sexual communication is critical during pre-adolescence, impacting sexual identity and understanding relationships. However, there is a gap in the literature assessing the changers, barriers, and effectiveness in parent-child conversation concerning

sexual health (Grossman et al., 2018). There are very limited studies regarding sex education among African immigrants. Particularly, parent-child conversations on sexual health are rare (Agbemenu et al., 2016). More information is needed on supporting African immigrant parents with considerations towards culture, religion, traditions, and mental health.

Search Strategy and Criteria

Finding literature to support the focus and purpose of a research study is essential. For this study, the literature review included searches of academic databases. Databases available through the Liberty University library were used, including APA PsycNET, CINAHL Plus, Consumer Health Complete, JSTOR, ProQuest Central, and PsycArticles. ERIC, Google Scholar, and PubMed were also used to locate relevant published research from credentialed sites. The selection of articles was based on inclusion criteria. Criteria for inclusion included research relevant to the primary topics of African immigrants, sexual health, and cultural barriers to parent conversations on sexual health. Research articles and excerpts from books were considered adequate if historically or theoretically significant or currently published within the past 5 years. Old articles that could be represented by more recent research without historical significance were excluded from the study.

Identifying potentially relevant data included using specific searchers using Boolean operators, truncation searching, keywords, and phrase searching to narrow the results of the search. The keywords and phrases used for searching literature included *sexual health, adolescents, parent communication and sexual health, barriers to parent conversations, cultural barriers, African immigrants and parenting, counseling and sexual health,* and *culturally*

sensitive interventions. All relevant results meeting the criteria were included as empirical support for the purpose of the study.

Related Literature

A review of empirical research that is current or historically significant provides support for the basis of this research (Creswell & Creswell, 2017). Information is presented that is relevant to the purpose of the study, investigating sexual shame and the effects of a parent workshop on Sub-Saharan African immigrant parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. The following sections present information on sexual health and adolescents, sexual health risks for youth, sexual health and parenting, culture and sexual health, cultural barriers, African immigrant culture and sexuality, sexual shame, counseling clients of different cultures, counseling and sexual health, and culturally sensitive interventions.

Sexual Health and Adolescents

Sexually risky behavior in the United States is high, prompting a need to educate parents on the critical role they play in helping their children with sexual health issues (Centers for Disease Control and Prevention, 2013). There are numerous benefits of talking to preadolescents regarding sexual health, including protecting them from potential negative consequences (Wilson et al., 2010). An individual sense of sexual embodiment stems from one's understanding and experiencing the world from the location of one's sexual body (Ussher et al., 2017). Sexual reproductive health is paramount to the quality of life encompassing physical, emotional, mental, pleasurable and safe sexual experience (World Health Organisation, 2009).

The developmental stages of children and youth can often determine how parents feel about having sexual conversations. As children develop into adolescents, a new set of challenges

arise between them and their parents. Thus, parents must change their approach regarding sexual conversations (Grossman et al., 2018). A lot of research on sexual health centers on adult-child communication. However, studies show that young couples struggle to communicate about sex. Barriers include the feeling of uncomfortableness, fear about upsetting their partner, leading to unwanted sexual experiences and depressive symptoms (Little et al., 2011).

African American girls experience a high level of pregnancy rates and acquisition of sexually transmitted infectious diseases compared to their non-Hispanic, White counterparts (Grigsby, 2018). There are several elements that contribute to the rate of African Americans high pregnancy rate, including (a) authoritarian parental style and behavioral control with minimal negotiation (Heller & Johnson, 2010; Hill & Tyson, 2008), and (b) the lack of research to understand African American communication pattern and styles with early adolescent girls (Aronowitz & Eche, 2013; Cornelius, 2008). Researchers have confirmed that research is limited relating to African American father-son communications on sexual health (Randolph et al., 2017). Consequently, this lack of transfer of information may contribute to a high level of sexually transmitted infections. The likelihood for young African American males to have sex before 13 years old is higher (13.9%) compared to their White counterparts (3.9%: Centers for Disease Control and Prevention [CDC], 2012).

Child development from early to middle adolescence is a critical period for how parents talk to their children regarding sexuality. Often, the responsibility of sexual health and sex education is passed on to public school educators. Teachers in the United States who teach sexuality often run into a conflict among immigrant families whose view on sex education is different (Szlachta, 2015).

Sexual Education

According to Hall et al. (2019), almost all U.S. students (97%) have received some variation of sex education before the age of 18. However, the type of sex education varies depending on the state, as state educational departments delegate the curriculum. Hall et al. (2016) explained that, in the United States, sex education is primarily focused on abstinence as a primary means of prevention, and in-depth discussions on sexual health are brief, as the sex education curriculum has to compete with other teen health concerns such as substance use, suicide, and bullying. Hall et al. (2019) noted that public schools are regarded as the primary platform for presenting sex education, as many parents are uncomfortable talking about sexuality and sexual health. Research Toor (2016) conducted a study on attitudes towards sexual education among teachers and parents. Toor found that male teachers had a more positive attitude towards sex education than female teachers. Toor (2016) also noted that highly educated parents had a more positive attitude towards sexual education than parents with less education.

Although many public-school systems offer educational programs that introduce sexual health and sexuality (Hall et al., 2019), many students are not getting much-needed guidance and support from their parents. Parent communication is essential to reinforcing the necessary information presented in the school system (Jerman & Constantine, 2010); however, many parents of diverse backgrounds face challenges in initiating conversations about sexuality. Culture and ethnicity are important factors to consider when examining why some parents struggle to initiate conversations about sexuality.

Agbemenu et al. (2018) conducted a study on African immigrants in the United States, examining how culture impacts communication with children concerning sexual health. Agbemenu et al. noted that African immigrants are often hindered by their culture, myths, and

taboos when faced with having conversations about reproductive health concerns. In another study on cultural influences, Gabbidon and Shaw-Ridley (2018) studied Haitian and Afro-Caribbean mothers concerning sexual conversations. Gabbidon and Shaw-Ridley shared that Haitian mothers were more reluctant to have sexual conversations with their children than Afro-Caribbean mothers; however, both groups studied shared religious and cultural upbringing that created barriers hindrances to initiating conversations. Many participants in Gabbidon and Shaw-Ridley's (2018) study shared their religious beliefs in abstinence. So, instead of parental conversations on sexuality and sexual health, many participants that held strong religious convictions on abstinence before marriage only talked about abstinence.

In a study on Hispanics and parental conversations on sexuality, McKee and Karasz (2006) found that, while highly respected compared to other cultures, Hispanic mothers are the primary communicators to parental conversations on sexuality. However, due to religious and cultural traditions, many Hispanic mothers only have conversations on the basics of sexuality and the consequences of risky sexual behaviors (McKee & Karasz, 2006). Compared to European Americans, many minority cultures are rooted in religious and cultural traditions that present barriers to open and confident conversations with children concerning sexuality and sexual health (Agbemenu et al., 2018; Gabbidon & Shaw-Ridley, 2018; McKee & Karasz, 2006).

Sexual Health Risks for Youth

In all cultures, the preadolescent years are a critical period for addressing sexual health issues. Adolescents face particular health risks and need education on sexual health. Preadolescents account for 23% of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth (Patton et al., 2009). Annually, 16 million births occur to young

women aged 15–19 years, representing 11% of all births (Sawyer et al., 2012). Approximately 2.5 million births occur to girls aged 12–15 years in low-resource countries each year, of which around a million births occur to girls younger than 16 years in Africa (Neal et al., 2012). Moreover, early childbearing is linked with higher maternal mortality and morbidity rates (Blanc et al., 2013; Ganchimeg et al., 2014; Nove et al., 2014;) and increased risk of induced (mostly illegal and unsafe) abortions (Shah & Åhman, 2012). Complications with childbearing and maternal issues constitute the leading cause of death among adolescent females (Patton et al., 2009; World Health Organization, 2012). Shame may also factor in how adolescents communicate sexual health concerns. For children who are sexually traumatized, there is comfort in talking about their ordeal. Traumatized children may feel powerless to even open up and discuss their ordeals (Hlavka, 2017; Weiss, 2010).

Sexual Health and Parenting

Parents-child sexual health communication should occur in every family (Harris, 2016), given the high occurrence of sexually transmitted diseases that occur. Researchers indicate that adolescents ranging in age from 15 to 25 years account for half of the estimated 20 million new sexually transmitted diseases occurring annually within the United States (Gabbidon et al., 2017). Parents play a critical role in children's sexuality. Parents are the child's primary sexual socializing agent, whose supervision impacts the child's sexual attitudes. Moreover, children's beliefs on sexuality are impacted by parents' supervision and monitoring (Gabbidon & Shaw-Ridley, 2019).

Parents and caregivers serve as the foundation for children's sexual development (Volk et al., 2016). However, one challenge for parents is the content of the sexual conversation with children. Sexual health is broad, and parents alone cannot teach everything to their children.

Therefore, parents must know what to say or not (Pineda et al., 2019). Another challenge for parents is the frequency of sexual health conversations. Besides the content as a barrier to parents, sometimes struggles include how often they should engage in sexual health communication with children. Harris (2016) argued that "The quality of the parent-child relationship is key in promoting good parent-child sexual communication" (p. 200). Research by Somers et al. (2019) indicated that "higher frequencies of conversations about sexual activity often result in more conversations focusing on scenarios and tools for handling sexual situations" (p. 225).

Studies show that factors such as family structure, family connectedness, parent monitoring, and parent's attitudes and values are essential to help young people have meaningful conversations about sexual health (Dilorio et al., 2002; Fullerton, 2004; Lezin et al., 2004, Miller et al., 2001). Researchers have confirmed the importance of parent-child communication on sexual health, noting conversations help reduce risky sexual behaviors (Holman & Koenig Kellas, 2018). Family communication regarding sexually related topics has a positive effect on teenagers and helps prevent participating in risky sexual behaviors (Frederico et al., 2019). Timing and approach to sexual health conversations can be complicated. The time that parents choose to discuss sexual health with their children may pose a barrier for their adolescent children. Parents who are eager to teach sexual health to their children face another barrier regarding the content of the message; what to say and how to say it (Holman & Koenig Kellas, 2018). If conversations are infrequent, narrow, and occur beyond a meaningful age, the conversation loses its effectiveness (Noe et al., 2018). However, parents face barriers preventing them from having meaningful communication. Barriers such as parents' lack of accurate

information, discomfort in talking about sex, and the perception that children are not ready to talk about sex are a few examples (Malacane & Beckmeyer, 2016).

The dynamics of parent-child communication are essential to conversations that reduce risky sexual behaviors. Adolescents sometimes do not like to talk to their parents about sexuality due to fear of accusations. Often parents will accuse their children of doing something wrong whenever they attempt to ask questions regarding sexuality (Kajula et al., 2014). Adolescents also struggle when discussing sexuality with their parents. Barriers include feelings of embarrassment, discomfort, and trust issues (Afifi et al., 2008).

Parental conversations also vary on the gender of the parent and the gender of the child. Some families feel the parent of the same gender should educate children on sexual health, behavior, and risks (cite). Mothers are often researched as the parent responsible for initiating or forbidding conversations on sexuality. The emphasis on the responsibility of the mother is also highlighted in evidence of limited studies regarding the involvement of fathers in educating their children regarding sexual health (Coakley et al., 2017).

While previous research has focused on parents and adolescents, little information exists concerning children and parental communication about sexuality (Moncloa et al., 2012). Many sexual health conversations should begin before puberty and adolescence. Studies show that immigrant parents of young children continue to struggle to provide sexual health education. Moreover, a gap exists in literature concerning parental communication with preadolescents (Christensen et al., 2017).

Culture and Sexual Health

Immigrant families in the United States represent various cultures and religions of the world. In 2017, there were 44.4 million recorded immigrants living in the United States, making

up 13.6% of the nation's population (Radford & Noe-Bustamante, 2019). With such a large presence in the United States, the culture of immigrant families is essential to understand when considering the sexual health needs of a diverse population.

There are very limited studies on early and middle childhood developmental periods in literature among immigrant families (Gassman-Pines & Skinner, 2018). However, culture plays a significant role in sexually related communication with children. Cultural factors that impact parental communication on sexuality include the belief that sex is shameful (Romo et al., 2010), parental embarrassment (Campero et al., 2010), or a parent's lack of education to speak to discuss sexuality (Campero et al., 2010). The Hispanic population is the largest and most rapidly growing minority group in the U.S (Census Bureau, 2014). At approximately 56 million, the Hispanic population in the United States is projected to increase to approximately 77 million by the year 2030 (Census Bureau, 2014). Religion plays a huge role in the Hispanic culture. Studies also show that first-generation immigrant Hispanic parents give a little freedom to their U.S. children than they would in their native country. However, many of them do not agree or support the liberal ideas of the United States. Consequently, making it difficult to have a meaningful sexual health conversation (Gonzalez & Méndez-Pounds, 2017).

Parents of Latin American descent are hesitant to have a sexually-related conversation with their children. One of the main barriers is the belief that the promotion of abstinence is the best sex education (Campero et al., 2010). In Latin American culture, for example, families discourage communication concerning sexuality (Amaro et al., 2001; Arreolla, 2010). Other immigrant parents also struggle when talking to children regarding sexual health. Haitian mothers reported high levels of discomfort when initiating sexual health conversations with their

children. Many Haitian parents considered parent-child talk on sexual health as taboo or forbidden (Gabbidon & Shaw-Ridley, 2018).

In cultures where conversations on sexuality and sexual health are forbidden, many girls and young women face experiences of shock when they reach puberty. For example, studies confirm that across cultures, certain refugee women report that they had no knowledge regarding menstruation prior to menarche, and most women reported no understanding of pregnancy until pregnant with their first child (Metusela et al., 2017). Consequently, a lack of knowledge and information leads to health issues. Some women describe their menarche as a painful experience, including bleeding that was concealed and kept secret and experiencing frightening or shocking feelings of anxiety on wedding nights (Metusela et al., 2017).

Acculturation is a complex process; each family member processes acculturation differently. Due to barriers in communicating sexual health to children, in some cultures, parents use religious instruction as a tool to teach their children rather than use direct communication (Nundwe, 2012). A strong or strict Christian view could sabotage a meaningful sexual health conversation with children. Haitian Christian mothers struggle in this area (Gabbidon & Shaw-Ridley, 2018). Thus, making it more difficult for immigrant families and sexually related conversations due to religious and cultural beliefs (Ogunnowo, 2016). Acculturation poses challenges for immigrant parents, making it difficult to have meaningful sexually related communication with their children. Moreover, the generational gap between immigrant parents and their children can be exacerbated by parent-child differences in acculturation. Thus, making conversation on sexual health more challenging (Meschke & Dettmer, 2012).

Cultural Barriers

Understanding the cross-cultural construction of sexuality is critical as it relates to sexual communication within immigrant families. Without a good understanding of the role of culture and sexuality, it may be confusing for first and second generations of immigrants receiving one message from parents and another from school (Dune & Mapedzahama, 2017). Immigrant families continue to struggle when seeking health services, specifically related to sexuality. More culturally secure services are highly recommended (Rad et al., 2018).

While mothers in the Hispanic community are the sole ones responsible for sexual health communication, there are barriers, including the perception that talking to their children about sexuality will make children curious (McKee & Karasz, 2006). The feelings of embarrassment are another huge barrier to initiating sexually related topics. Hispanic daughters reported experiencing conversations that were the wrong timing; they felt that either they were too old to talk about sex or too young (McKee & Karasz, 2006).

Cultural and religious barriers make it difficult to offer sexual health education to Somali immigrants (Pavlish et al., 2010). Somali immigrants that are refugees in the United States are at high risk of poor sexual health (Afable-Munsuz & Brandis, 2006). Another major issue for Somali women is female circumcision. Girls between the ages of 5 and 8 are circumcised to discourage premarital sex. However, female circumcision is linked to sexual and reproductive issues such as long labor, postpartum hemorrhage, and newborn death (Borkan, 2010; Lazarus et al., 2006). Studies show that there are barriers in the African immigrant families that impact meaningful parent-child conversation. Among the barriers are taboos, embarrassment, lack of information, and the lack of preparation on the side of the parents (Agbemenu et al., 2016). There are cultural reasons why some immigrants may be reluctant to seek out professional

counseling to help with having parent-child conversations about sexuality. In a study conducted by DeJong and El-Khoury (2006), researchers agreed that cultural taboo and shame prevent many families from making any effort to seek professional help.

African Immigrants

Researchers Salami et al. (2017) conducted a study examining African immigrants and changes and challenges to their parenting styles and traditions. Salami et al. found that some of the biggest challenges to parenting among African immigrants involved acceptable discipline practices (i.e., physical punishment may be a tradition in one's native country), embedding cultural and religious practices in U.S.-born children, and accessing needed support services from the community. A study by Agbemenu et al. (2018) examined barriers to parental conversations on the sexuality of immigrants from African nationalities. Agbemenu et al.'s study focused on African immigrants regarding the influence of culture on their perceptions of reproductive health related to parent-child conversations on sexuality. Agbemenu et al.'s study shared how, currently, there are approximately 1.7 million documented African immigrants in the United States. Moreover, according to Agbemenu et al. (2018), there are no studies on mother-daughter reproductive health communications in the African immigrant population living in the United States. Agbemenu et al. also noted that counselors would find it challenging to help the African immigrant population due to the lack of existing information on parental conversations on sexual health. Agbemenu et al. highlighted the importance of how mothers communicate with their preadolescents, especially concerning sexual health and sexual risks.

Agbemenu et al.'s (2018) findings indicate the existence of communication barriers in the African immigrant population, including a lack of knowledge among the adolescents about menstruation and pregnancy prevention, religiosity, previous reproductive health communication

with their parents, and cultural norms. However, Agbemenu et al. shared that many immigrant mothers were interested in getting additional help with parent-child communications. The mothers felt that U.S. society was permissive and accepting of overt sexual behaviors and practices, something that is contrary to their country of origin (Agbemenu et al., 2018). This study, among others, presents how various sensitive topics (i.e., religion, sexuality, marriage, or gender roles) are still considered taboo among the immigrant populations.

Sub-Saharan African Immigrants

The study examined Sub-Saharan parents' experiences of sexual health communication with their children using the lens of SCT. The study targeted African immigrant families from Sub-Saharan countries, which comprises approximately 48 independent countries located south of the Sahara Desert (Pariona, 2017). As of 2018, more than 2 million immigrants from Sub-Saharan Africans live in the United States, representing just 4.5% of the country's 44.7 million immigrants, and the population is rapidly growing (Echeverria-Estrada & Batalova, 2019). Furthermore, the sub-Saharan region is known to be one of the most ethnically diverse groups globally (Pariona, 2017).

The Sub-Saharan region (see Figure 1) is made up of countries and territories that are fully or partially lie south of the Sahara and are separate from North Africa (Pariona, 2017). While the Northern part of the African region consists of countries and territories considered a part of the Islamic region or League of Arab States (Pariona, 2017). These two regions are separated by the Sahara Desert, which is not habitable (Pariona, 2017). While Sub-Saharan Africans speak multiple languages, they also share cultural commonalities such as common patriarchy, communal tradition, and identity (Pariona, 2017; Ruzicki, 2010). The most populated cities of the Sub-Saharan immigrants are New York City and Washington, D.C., metropolitan

regions, followed by Minneapolis and Dallas (Echeverria-Estrada & Batalova, 2019). Although Maryland, Texas, New York, California, New Jersey, Atlanta, and Minnesota are also home to more than 100,000 Sub-Saharan African immigrants (Anderson, 2017). Sub-Saharan Africans speak 17 multiple languages (Pariona, 2017). The Sub-Saharan-born immigrants are the fastest-growing segment of the U.S. Black population compared to other immigrant groups (Echeverria-Estrada & Batalova, 2019). Moreover, the Sub-Saharan population increased by 52% between 2010 and 2018, surpassing the 12% growth rate of the general immigration population to the United States (Echeverria-Estrada & Batalova, 2019).

Figure 1

Sub-Saharan Regions

Note. Image sourced from Creative Commons site Wikimedia Commons.

African Immigrant Culture and Sexuality

Immigrants from Africa are not homogenous, and they come from diverse cultures with different cultural beliefs and taboos (Kingori et al., 2018). According to the Pew Research

Center (Anderson, 2017), the number of African immigrants living in the United States in 2015 was 2.1 million. Furthermore, African immigrants had the fastest growth than other major immigrant groups who migrated to the United States since 2013. The migration policy of 2017 reported approximately 4.4 million Caribbean immigrants residing in the United States, accounting for 10% of the nation's 44.5 million immigrants (Zong & Batalova, 2017). Although there is a gap in the literature concerning African immigrant parent-child communication, other studies indicate that sex education is crucial as it helps prevent children and adolescents from engaging in risky sexual behaviors (Frederico et al., 2019; Gabbidon & Shaw-Ridley, 2018; Koren, 2019; Noe et al., 2018).

Most cultures in Africa consider sexual health conversations with children taboo. Asekun-Olarinmoye et al. (2009) indicated that parent-child communication is forbidden in Nigeria of West Africa. Another study conducted by Agbemenu et al. (2018) on African immigrants in the United States explored the impact of culture on parent-child communication. Agbemenu et al.'s study showed that culture, myths, and taboos prevent many African immigrants from having a meaningful conversation on sexual health with their children.

Culture plays a significant role in the communication of sexual health with children. Moreover, cultural factors that impact communication on sexuality include the belief that sex is shameful (Romo et al., 2010), parental embarrassment (Campero et al., 2010), and parents' lack of education to discuss sexuality (Campero et al., 2010). It is crucial to understand the cross-cultural construction of sexuality related to sexual communication within African immigrant families. A lack of communication can confuse first- and second-generation immigrants due to school teachers and families being given different messages on sexual health to children (Dune & Mapedzahama, 2017). Due to the limited knowledge of research in the African immigrant

acculturation, knowledge about how families cope and the impact acculturation has on the youth as it relates to sexuality is not known (Ogunnowo, 2016). Many African immigrant families experience a conflict of beliefs between U.S society's view on sexual behavior and the family's culture.

There is a clash between African immigrant parents who adhere to their traditional customs and their children who embrace the dominant Western values. Moreover, there is very limited knowledge about how families and youth handle the clash (Choi & Harachi, 2008). For example, among Nigerian families, youth are torn between their own native culture and the popular culture of the United States (Ogunnowo, 2016). Families may experience stress due to the impact of merging two cultures. Due to the merging of both African culture and U.S. culture, African families face complex and stressful parenting (Amayo, 2009). Consequently, parental stress influences parent-child communication on sexuality (Ogunnowo, 2016).

Parental Communication Style

Some key concepts to consider related to Sub Saharan parents and their conversations with children concerning sexuality is communication style. Communication style varies by culture and social settings, and parental communication style plays a huge role in children's ability to conform to societal norms (Baumrind, 1967). Studies have identified that parents' lack of communication skills can cause their children to shy away from talking with parents about sexual matters, while parents who communicate well with their children experience less reservation (Afifi et al., 2008). Baumrind (1967) proposed three types of parenting styles, including (a) authoritative, (b) authoritarian, and (c) permissive. For example, Peterson (2007) and Sneed (2008) argued that parents with a directive communication style (authoritative) and able to clearly state their sexual expectation of their children lead a positive parent-child

relationship and less risky sexual behavior. Dissimilarly, the authoritarian parental style does not make room for open discussions, and children cannot ask questions (Heller & Johnson, 2010). Each parenting style differs based on effectiveness and their respective impacts on obedience and responsibility on a child's character and obedience.

The Authoritative Parent

The authoritative parental style is where parents rationalize directives to a child, explaining reasons behind demands, disciplines, policies, and values in a nonjudgmental atmosphere. Authoritative parents make room for mistakes; however, they use power when necessary, and they maintain control while setting rules for the development of the child's conduct (Baumrind, 1978, p. 245). Authoritative parental style produces a positive outcome in a child's development (Baumrind, 1991) and also generates warmth and affection (O'Reilly & Peterson, 2014), differing greatly from the authoritarian parenting style.

The Authoritarian Parent

The authoritarian parenting style values and focuses on obedience. Punitive is a preferred choice for parenting. This type of parenting style uses forceful measures regardless of what the child thinks. Parents of the authoritarian style exercise control in such a way as to restrict the child autonomy because due to the notion that children are self-willed and strong, thus the need to bend their will through authorities such as the church, school, and parents (Baumrind, 1967, p. 890). Studies have shown that the authoritarian style tends to be one-sided from parent to child, parents have high expectations, and while children may be obedient, the children's self-esteem and moral reasoning (values and ideas about sexuality) is relatively lower (Richardson & Schuster, 2003). Authoritarian parents rarely talk to their children; they talk at them (Haffner, 2008).

Permissive Parents

Permissive parents (Baumrind, 1967) or indulgent parents (Richardson & Schuster, 2003) present characteristics of permissive styles, including parents who are not demanding, have low demands of responsibility or lack parental oversight (Baumrind, 1967; Richardson & Schuster, 2003). Permissive parents avoid punitive measures and allow children to engage in unacceptable activities and indulge in impulsive behaviors. These children are often neglected, and their emotional needs are not attended to (Richardson & Schuster, 2003). The literature indicates a correlation between a permissive parenting style and children's sexual risk behaviors. For example, Okhakhume (2014) conducted a cross-sectional study of 194 pupils from three high schools in Ibadan, Southwest Nigeria. Findings revealed the outcome of a permissive parenting style. The goal of the study was a correlation of three variables of parenting styles, self-esteem, and parental involvement to adolescent sexual behavior. The findings presented 98% of adolescents whose parents utilize a permissive parenting style reported low self-esteem and more sexually risky behaviors (Okhakhume, 2014).

Parenting in Sub Saharan Countries

Authoritarian parenting is common in most Sub-Saharan countries (Akanbi et al., 2013). Parenting is rooted in strong cultural beliefs, with parents utilizing various control strategies in making sure that children obey their parents (Baumrind, 1967; Maccoby & Martin, 1983). Various studies have indicated that authoritarian parenting is the dominant style across Sub-Saharan countries. For example, studies by Akkuş et al. (2017) and Bukuluki (2013) indicated that collective cultural values are characterized by corporal punishment, high demands and low responsiveness, high parental expectation with low feedback and nurturance, and strict obedience to elders with harsh punishment when children fail to comply. Even in some cases, corporal

punishment has resulted in child abuse (Akinmode & Adegunloye, 2011). While most Sub-Saharan parents adopt an authoritarian style, there are exceptions. For example, parents from countries such as South Africa and Zimbabwe are authoritative (Roman et al., 2015), and their parental style affects parent-child communication on sexual matters. However, parenting style is not the only thing that researchers say impacts Sub-Saharan immigrant parents' child communication on sexual health. Gender also plays a huge difference in parent-child communication on sexual matters.

Gender Roles

Depending on the culture, the gender of a parent can have an influence on parent-child relationships and conversations. Namisi et al. (2013) agreed that both childrens' and parents' gender influences parent-child communication. Studies have shown a correlation between fathers who discuss sexuality with their children and responsible sexual behavior (Bowling & Werner-Wilson, 2000). In addition, research confirms that fathers are a valuable tool in minimizing sexual high-risk behaviors in children (Haffner, 2001). A Fathers contribution to sex education has been linked to their sons' sexual attitudes and behaviors (Burns & Caldwell, 2016; Namisi et al., 2013). Furthermore, researchers continue to show an increase in awareness of the critical role of fathers in sons' sex education (Baker et al., 2018; Dilorio et al., 2006). For example, father absenteeism is linked to teens' sexually risky behaviors and pregnancy (Ellis et al., 2003), indicating the critical role of fathers in children's sexual health. However, Sub-Saharan fathers play a minimal role in parent-child conversations on sexual health and behaviors. For example, African American female teenagers are more likely to discuss sexual health matters with their mothers than their male counterparts (Dilorio et al., 1999). This situation is also true for Sub-Saharan fathers and male communication on sexuality. For example, Nigerian males are less

likely to discuss sexuality with their parents (Biddlecom et al., 2009). Although mothers often offer children advice and provide nurturing, fathers play a huge role in communicating sexual health with their children.

Attitudes of African Immigrant Parents

Zunich (2012) explained how parenting attitudes present a social influence that children are exposed to early in life. The attitudes of parents serve as a foundation for the behavior of their children. Sorbring et al. (2015) shared parental attitudes towards adolescent sexuality are associated with the sexual activities and behaviors of youth. Sorbring et al. (2015) conducted a study of 496 families using a questionnaire to determine relationships between parental attitudes and online sexual activities of youth. Sorbring et al. (2015) found that parents' attitudes differed depending on parents' gender and the age of the children. Parenting style and rules were linked to parental attitudes of adolescent online sexual activities. However, this study was not reflective of immigrant parents. Agbemenu et al. (2018) examined the influence of African immigrant mothers and their daughter's reproductive health education. Among African immigrants, Agbemenu et al. (2018) defined "cultural attitudes as mothers' views on reproductive health issues, such as abstinence until marriage and no girl-boy relationships until college or until daughters were in their late teens" (p. 703). Immigrant parental attitudes came from cultural experiences that mothers were exposed to growing up. Researchers noted that cultural taboos influence parental attitudes, even if the parents do not believe the taboos. Agbemenu et al. (2018) found that taboo concerning having conversations about sexual intercourse was the most common among African immigrant mothers, and this taboo led to an overemphasis on abstinence.

Sexual Shame

In the field of counseling, shame and guilt are sometimes confused (Parker & Thomas, 2009); however, differing components can help distinguish shame from guilt. Parker and Thomas (2009) noted that shame often precedes guilt, and shame is often an overall feeling of badness or worthlessness. Sexual shame is the association of desires or sexuality that are perceived as topics that are off-limits for discourse (Clark, 2017). As shame has an impact on mental health (Parker & Thomas, 2009), counselors need to recognize the difference between feelings of shame and guilt. According to Gordon (2018), "sexual shame may be defined as shame that is caused by negative evaluations of one's sexual identity, behaviors, attractions, thoughts, or feelings" (p.107). There are several issues associated with sexual shame and individuals who experience sexual shame face potential deprivation of mental health services that could prove beneficial (Hutchinson & Dhairyawan, 2018; Ussher et al., 2017).

Sexual shame is a real issue among many cultures and religions; however, there is a gap in the literature concerning the feeling of shame as it relates to sexuality and parental conversations concerning sexuality (Dune & Mapedzahama, 2017; Kyle, 2013; McKee & Karasz, 2006). Culture plays a huge role in developing attitudes and beliefs (Graham & Hudley, 2005). In some African cultures, any form of sexual health communication is considered off-limits (Clark, 2017). There is also cultural silence and sexual shame, which inhibit African immigrant parents from initiating sexual health conversations with their children (Gabbidon et al., 2017; Mollon, 2005). The root cause of sexual shame associated with initiating sexual health communication includes how, in some cultures, children cannot know about sexuality, childhood sexual abuse, growing up in an extremely religious environment, and menstrual shame (Kyle,

2013; Ussher et al., 2017). Also, due to sexual silence, girls who experience first-time menstruation often experience feelings of shame and shyness (Ussher et al., 2017).

Due to sexual silence and cultural taboos, while menstruation is a natural reproductive process, it is associated to shame in certain cultures. Thus, it cannot be seen, discussed, or acknowledged (Kissling, 1996). Moreover, menstrual attitudes affect sexual behavior (Rempel & Baumgartner, 2003). For example, in one study, individuals reporting more comfort with conversations on menstruation have a higher awareness of sexuality than those who were not comfortable conversing (Rempel & Baumgartner, 2003). Schooler et al. (2005) confirmed that sexual shame associated with menstruation could impact women's general approach to sexuality. Because menstruation is connected to the overall attitude of sexuality, sexual shame and silence influence the belief system of girls as it relates to sexuality (Schooler et al., 2005). For counselors working with clients who experience sexual shame (religious or cultural), diverse background knowledge is necessary.

War and Albert (2013) argued that societal silence on issues related to sexuality and the limitations of appropriate words in an indigenous language contribute to sexual silence, which in turn creates sexual shame. Another cause of shame associated with discussing sexually related topics is personal experiences with sexual abuse. According to Hlavka (2017), "youth who feel emasculated and are concerned that they will be scrutinized or humiliated are often too embarrassed or ashamed to disclose" (p. 498). Children who have been sexually abused experience shame, guilt, and worthlessness. Furthermore, perpetrators induce blame and stigmatization. Thus, abused children find it difficult to trust or discuss their ordeals with someone (Gibson, 2016). Professional counseling services are needed for more diverse cultures. Without a good understanding of the client's shame as it relates to culture, counselors will not be

effective in working with the intercultural population. Furthermore, the cycle of shame will continue if research is not conductive to help develop a culturally sensitive treatment (Hosken, 1993).

Counseling Clients of Different Cultures

As the United States becomes increasingly diverse, the need for counselors to know how to offer therapy to people from different cultures and religious backgrounds is critical. One cannot overemphasize multiculturalism as a vital component of society, and if a counselor is not willing to address issues of religion and culture, they will miss a vital aspect of their client's life (Cashwell & Young, 2011). Just as culture is important for counselors to understand, religion is also essential to developing good counselor-client relationships. For example, over the years, Islam has been one of the fastest-growing religions in the United States, now second to Christianity (Cashwell, 2011). According to Hamdan (2007), about seven to eight million Muslims live in the United States, with a corresponding need for counseling services.

Presenting a challenge to counselors, many immigrants face a great deal of prejudice (Cashwell, 2011). Due to the different beliefs and cultural values that characterize different faith religions, there are codes of ethical requirements that must be adhered to when practicing competent faith counseling. Cultural awareness may help counselors not impose personal religious or faith-based values on clients from different religions and cultures. Without considering the religious background of the client, a counselor can harm the client. According to the American Association of Christian Counselors, "while Christian counselors may expose clients and/or the community at large to their faith orientation, they do not impose their religious beliefs or practices on clients" (AACC, 2014, p. 26).

According to the Ethics Desk Reference for Counselors (2015),

> Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature. (p. 16)

Moreover, counselors should avoid imposing their faith values on the clients when practicing competent counseling with clients of various cultural and faith backgrounds. Furthermore, therapists should see that they are not being influenced by their attitudes and biases (McGoldrick et al., 2005). For assistance with working with diverse and multiple cultures, counselors can reference the *Ethics Desk Reference for Counselors*, which states that

> Counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law (Barnett & Johnson, 2015, p. 66)

Counseling and Sexual Health

Immigrants struggle to find available resources for dealing with sexually related communication barriers with their children (Ogunnowo, 2016). Currently, there are few counseling centers in the United States that help immigrant families. In light of the struggles facing immigrants regarding acculturation and sexual communication, counselors who are trained are needed to help. However, with no counseling centers to meet the specific needs of immigrants, families face stressful parenting challenges (Ogunnowo, 2016).

Researchers argue that more research is needed to better understand how sexuality is understood across and within cultures. Counseling parents on issues such as adolescent health and sexuality should be based on background and recognition of specific cultural values and beliefs. Moreover, it is clear in the literature that the Western expectation and approaches to sexual health are still limited (Dune & Mapedzahama, 2017).

Based on a review of past studies of sexual shame as a barrier to parent-child conversations, some factors that can reduce sexual shame include culturally appropriate and skill-based approaches (Gabbidon & Shaw-Ridley, 2018) and parental education to support discussions with children concerning sexual health (Jerman & Constantine, 2010). Researchers indicated that counselors help parents reduce feelings of cultural or religious shame concerning sexuality and provide parents the training needed for effective sexual conversations (Ussher et al., 2017). Ussher et al. (2017) noted that counselors use cultural discourses and practices to provide resources to non-native families to help address sensitivity to language and other potential barriers to sexual health.

Whitfield (2017) highlighted a lack of research about parental intervention and cultural sensitivities being used by clinicians who work with refugees in the United States. Counselors offering effective therapy to immigrant populations as it relates to sexuality, establishing cultural intervention, and being family-centered is critical (Whitfield, 2017). Considering the cultural context of a family is essential to effective counseling. Therefore, sexual discussions that include the cultural context have a positive impact on the outcome (Rodgers et al., 2018). Researchers have confirmed that parents have great difficulty bringing up the issue of sexual health with their children. However, counselor-led training can help parents become better communicators.

According to Christensen et al. (2017), educating immigrant parents can make them feel more comfortable.

Culturally Sensitive Interventions

For a parent-child sexually related conversation to be successful, culture cannot be avoided. Culture plays a significant role in sexuality. Culture impacts one's sexual self. For example, culture could be the underlying influencer on an individual's sexual identity, attitudes, behaviors (Robinson et al., 2002). Researchers have highlighted and recommended future studies to examine immigrant parent-child sexual health interventions with culturally sensitive strategies (Alcalde & Quelopana, 2013). In other countries, parental-based interventions still lack cultural sensitivity. For example, due to the role culture plays in sexuality, the Eurocentric framework method of teaching sexuality and sexual health is limited. Thus, a more culturally sensitive component is needed in a family-based sexual health discussion (Dune & Mapedzahama, 2017).

The profession of counseling faces a need for cultural diversity and culture-based interventions. In society today, the likelihood for a counselor to encounter a client from another culture is very high. In 2018, the Migration Policy Institute reported that 88% of children of immigrant families were born in the United States. In 2018, The Pew Research Center reported that African immigrants make up 39% of the foreign-born Black population (Anderson & Lopez, 2018). Similarly, Mexicans and Latin Americans make up one-fourth of the immigrant population (Radford & Noe-Bustamante, 2019). Thus, counseling that is culturally sensitive to the needs of immigrant culture is paramount in offering effective treatment.

Parent-child sexual health intervention has been widely researched. However, what makes an intervention effective needs to be examined. Factors including settings, the target group, and intensity are critical to evaluate the effectiveness of intervention (Wight & Fullerton,

2013). Researchers have conducted a meta-analysis of various studies to determine the most effective intervention for parental communications and conversations on sexuality and sexual health. Santa Maria et al. (2015) reviewed 28 empirical studies concerning parental interventions and their outcomes. Moreover, Santa Maria et al. argued that different theoretical bases produce different outcomes. For example, planned behavior produces high outcomes for understanding adolescent and parent behaviors and, similarly, the social cognitive theory effectively informs intervention components, methods, and applications.

Social Cognitive Theory

Counselors seeking a theoretical-based intervention could consider using models based on the social cognitive theory. The social cognitive theory is preferred since it helps parents increase their understanding of the pressures of teenagers, improves parental communication, and helps children resist sexual pressures to reduce risky behaviors (Blake et al., 2001). As noted by Schunk and DiBenedetto (2020), SCT can help researchers with examining perspectives that are related to behavioral and environmental influences.

Health Belief Model

The health belief model (HBM) is a tool many counselors use to explain and predict health-related behaviors. The tool can help counselors develop counselor-led parenting workshops or trainings that may help immigrant families address cultural barriers. The HBM may also be used by counselors to help immigrant parents initiate meaningful conversations with their children concerning sexual health and behaviors. Through counselor-led interventions, parents increase their comfort level with a high level of positive outcome expectation (Barr et al., 2012).

The Ecological Model

To determine the multiple levels and interacting determinants of sexual health, the ecological model is highly recommended (Bronfenbrenner, 1979; Svanemyr et al., 2015). The ecological model identifies the multiple levels of factors that influence behaviors such as knowledge, attitudes, and beliefs. These three factors are common barriers to immigrant parent conversations on sexual health. Recognizing the ecological factors that influence health behaviors can help counselors develop interventions that address cultural knowledge, attitudes, and beliefs.

PEN 3

According to Iwelunmor et al. (2014), the PEN-3 Cultural model helps identify intervention points of entry. The model includes three domains, (a) cultural identity, (b) relationships and expectations, and (c) cultural empowerment. The acronym PEN stands for the three areas of focus for each of the three domains. PEN stands for Person, Extended Family, and Neighborhood in the cultural identity domain; Perceptions, Enablers, and Nurturers in the relationship and expectation domain; and Positive, Existential, and Negative in the cultural empowerment domain (Iwelunmor et al., 2014). When researching sexual health within immigrant families from different cultural backgrounds, the PEN-3 model is preferred. The model can be used by counselors to focus on culture in the study of health (Airhihenbuwa, 1989; Airhihenbuwa, 1995).

Each of these models presents a research-based option that counselors could use to develop a plan to work with immigrant families. Interventions that are culturally based may provide the most effective solutions to promote parent-child communication concerning sexual health.

Counselor-Led Parenting Workshops

When seeking measures to implement effective parental interventions, a synthesis of data is an appropriate method for evaluating various cultures with counseling interventions. Counselor-led interventions are common in counseling to help educate parents of diverse backgrounds on specific topics (Kamangu et al., 2017). Conducting a meta-analysis of 11 studies examining parent-child sexual health communication interventions, Santa Maria et al. (2015) found "barrier-reducing interventions, such as self-paced ones, hold promise for the dissemination of parent-based interventions, have been reported to be acceptable to minority families" (p. 10). Santa Maria et al. (2015) explained effective interventions promoted comfort levels with having sexual health conversations.

Parent communication is essential in helping young adolescents understand the consequences of risky behaviors (i.e., pregnancy, STDs, and drug addiction). Research studies that have examined the benefits of parental communication have indicated that conversations between parents and their children can help increase positive sexual behaviors (Pariera & Brody, 2018). Diiorio et al. (2003) noted that the benefits of parent communication concerning sexual health include adolescents that will delay intercourse, practice safe sex, have fewer sexual partners, and have positive views on sexual health. Pariera and Brody (2018) stressed a need for identifying resources that can help parents have meaningful conversations with their children, noting many parents wait until it is too late to have conversations about sexual health. Pariera and Brody (2018) and McKee and Karasz (2006) shared the content of parent-child conversations is essential to how youth perceive sexuality. Researchers have expressed how parents do not know how to begin a conversation with their children (Pariera & Brody, 2018), or

they focus on the basics of risks and do not discuss more intimate details (McKee & Karasz, 2006).

Some parents may benefit from counselor-led workshops or training that would provide education on how to initiate conversations with young adolescents and what topics to cover. Santa Maria et al. (2017) shared recommended counseling talking points that address both adolescents and parents. Santa Maria et al. (2017) noted the benefits of counseling both the parent and child on sexual health issues and concerns. However, to provide the most effective counselor-led interventions, understanding cultural differences can help counselors working with parents of diverse cultural backgrounds have meaningful conversations about sexual health and sexuality. Counselors should, therefore, be aware of cultural traditions and practices (Kamangu et al., 2017). Counselors should also be ready to offer help to immigrant parents who struggle with initiating a parent-based sexual health conversation (Soto et al., 2018).

First-Generation Immigrants and Shifting Views

Counselors have played a role in helping parents of strict cultural traditions address the sexual health needs of their youth (Sinai & Shehade, 2019). Sinai and Shehade explained how their research participants, Muslim Arab school counselors, highlighted the importance of promoting sex education. However, Sinai and Shehade found that the counselors of their study often had to refrain from engaging in sexual health topics that were prohibited due to religion or considered taboo in Arab society. Similarly, researchers have noted that many sub-Saharan immigrants come to the United States rooted in their home country traditions, including taboos and myths (Agbemenu et al., 2018). For example, Agbemenu et al. shared how "mothers exposed to myths and taboos while growing up in Africa reported that they did not believe in them" (p. 707). However, the same participants who shared that they did not believe in the myths

also reported that cultural myths and taboos influenced their hesitations to have conversations about sexual health. Many of the participants in Agbemenu et al.'s study shared a desire to have conversations not based on myths or taboos. The findings from the study may present more evidence to support the idea that first-generation Sub-Saharan immigrant parents and their views on sexual health are shifting to a willingness to have conversations based on facts.

Chapter Summary

The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. This literature review was created to provide supporting research that provides justification for the need of the study and to present academic support for the focus of the study.

This chapter presented a review of relevant research providing foundational support. This literature review included an overview of the study and information on the theory that supports the conceptual foundation. Information that highlights the gap in literature was also provided. Search strategies and criteria for researched articles and supporting academic literature were also included. Sections on related literature included information on sexual health and adolescents, sexual health risks for youth, sexual health and parenting, culture and sexual health, cultural barriers, African immigrant culture and sexuality, sexual shame, counseling clients of different cultures, counseling and sexual health, and culturally sensitive interventions. The following chapter presents the methodology. Information is provided on the research design, approach, study sample, and data collection and analysis plan.

CHAPTER THREE: METHODS

The purpose of this phenomenological study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. This chapter presents the research methodology. Information presented includes the research design, research questions, research hypotheses, participants, setting, instrumentation, procedures for data collection, and data analysis.

Research Study Design

A phenomenological qualitative approach was used to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. The study explored how perceived barriers affect Sub-Saharan immigrant parent sexual conversations. Perceived barriers may include (a) sexual shame, (b) knowledge about sexuality, (c) attitudes and beliefs, (d) parental style, (e) acculturation, and (f) Gender (father and mother). This qualitative methodology was selected after considering the nature of the problem, the population, and the interview questions. This qualitative approach was selected as the site, and participants of the study were pre-selected. A qualitative methodology using individual interviews supported the researcher's site and population availability (Salkind, 2006).

As this study aimed to explore the perceptions of Sub-Saharan African immigrant parents, a phenomenological qualitative design in which participants are purposively sampled was appropriate (Creswell & Creswell, 2017). As Sub-Saharan African immigrant families were the focus of this study, a purposeful sample of participants to interview was appropriate (Creswell & Creswell, 2017).

Research Questions

The following research questions were used in this study.

RQ1: What are the perceptions of Sub Saharan immigrant parents concerning the influences of a decision to discuss issues relating to sex and sexuality with their children?

RQ2: What are the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality?

RQ3: What are the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief systems?

Participants and Setting

The sampling design for this study was a purposive sampling method. In qualitative research, smaller sample size is appropriate for interview-based studies (Marshall et al., 2013). Dworkin (2012) reported that an adequate sample size could include anywhere from five to 50 participants for qualitative studies. A smaller sample size is suitable for this qualitative study, as useful information can be obtained from participants, and saturation can be reached (Marshall et al., 2013).

In qualitative studies, purposeful sampling is often used to recruit an identified sample population (Ravitch & Carl, 2016). As the sample population focused on the parents who are interested in participating in the study would be screened using the following criteria: (a) identify as a Sub-Saharan African immigrant parent, (b) attend church once or twice weekly, and (c) biological or adoptive parent of a child and or adolescent 10–16 years old who attends the same church, or (d) joint or primary custody of child 10–16 years old.

Instrumentation

The primary instrument for this qualitative phenomenological research was individual participant interviews. Interviews are often used in qualitative research to collect detailed information from participants that have similar experiences (Creswell & Creswell, 2017). However, before any interviews took place, each participant received an informed consent document that included a summary of the study, information on the design and purpose of the research, and steps taken to ensure confidentiality. The informed consent was signed by each participant before the interviews occurred. Prior to conducting interviews, all participants answered a few demographic questions (see Appendix A). In qualitative research, background information is often gathered to gain an understanding of the participants (Smith & Smith, 2018); therefore, for this study, a few questions were used to gather background information.

Interviews may help identify perceptions of barriers to parental conversations concerning sexual health and sexuality. Perceived barriers may include (a) sexual shame, (b) knowledge about sexuality, (c) attitudes and beliefs, (d) parental style, (e) acculturation, and (f) gender. The interview questions were developed using the purpose and focus as a base and consisted of open-ended interview questions to help answer the research questions. Interviews were scheduled to last approximately 60 to 90 minutes.

Role of the Researcher

As a novice researcher, my role was to examine participants' personal experiences as presented during interviews. Furthermore, as an African immigrant, I understand the participant population and sensitivity of the topic concerning sexual health. Being aware of potential biases is important to ensure the findings are accurate and represent the participants. Tufford and Newman (2012) recommended using a bracketing approach to decrease the chances of

researcher bias. Through bracketing, I placed brackets around phrases or ideas within my notes to separate presumptions from the actual data collected. I also included another step to ensure the study was free from researcher bias. My wife was present throughout the interviews as a proctor and observer. Having my wife as a proctor/observer supported by the ideas of Kalaycı and Serra-Garcia (2016), who highlighted the need to ensure participants do not provide coerced answers to the questions. Having her present helped me be aware of my conversations throughout the interview, and this process ensured I stayed focused on my interview guide and collecting data.

In a qualitative study, researcher bias could potentially affect every aspect of the methodology, from the data collection process to the data analysis to presenting results (Creswell & Creswell, 2017). Although all researcher bias is unavoidable because everyone has an opinion, awareness of potential researcher bias can help limit occurrences. Having an awareness of my role and responsibility as the researcher helped reduce instances of research bias and helped me focus on presenting findings as supported by the participants' interviews.

My role as the researcher was to ensure the study was conducted ethically. I observed the Liberty University and IRB guidelines to ensure all rules and regulations were followed. No data was collected until IRB approval was granted. Maxwell (2013) noted that researchers are instrumental in conducting data collection and analysis. All information from the interviews flowed through me as the facilitator of the study. As the researcher, I asked thought-provoking questions using semi-structured, open-ended questions from my interview guide. I was responsible for listening carefully and asking follow-up questions if I was unsure about a participant's answer or wanted them to share more about an idea or experience. Due to the nature of the discussion, I was sensitive to the participants that were providing information. My role

involved interviewing, taking notes, interpreting the data collected, and presenting the findings as an accurate representation of the participants.

Procedures

The data collection process began once IRB approval was received, and then the recruitment of participants began using a recruitment letter (see Appendix B). The data collection process included the following steps.

1. Recruitment of participants
2. Scheduling individual interviews with participants that meet criteria
3. Sending and collecting signed consent forms (see Appendix C)
4. Interview software will include using Zoom and audio-recording participant responses for future transcription
5. Interviews will begin with using semi-structured interview questions from the interview protocol
6. Transcripts will be sent to participants for member checking
7. Participants will be thanked and informed that the study is concluded

The first step to data collection is recruitment. The recruitment letter included a summary of the study and included the purpose, criteria to participate, and benefits to participation, concluding with my contact information. Participants that meet the criteria used the contact information to share their interest in participation.

For the next part of data collection, I began scheduling interview times with participants that met the criteria. Once I conversed with potential participants and verified they met the criteria to participate, I scheduled a time to conduct the interview via Zoom or in-person. The next step in data collection involved ensuring each potential participant received the consent

form, signed it, and returned the document. Interviews did not occur without having a signed consent form from each participant, demonstrating they understood the purpose and design of the study.

Before participants participated in the interviews, I collected demographic information on the participants, such as gender, age, education, and religious affiliation (see Appendix A). I also informed each participant that my wife would be present through the interview in a proctor or observer role. Although she did not have any speaking roles throughout the interview, the purpose of having her present was to reduce bias and build trustworthiness. My wife signed a confidentiality agreement, agreeing not to share any information presented throughout the interviews. Further steps to ensure participant confidentiality and data protection are presented in the data analysis section. Participants were notified that the interviews would be audio-recorded before the interviews began. Data were collected through audio-recording the interview sessions with each participant for later transcription.

The next step in data collection involved conducting interviews using semi-structured interview questions from the interview protocol. Each interview lasted approximately 60 to 90 minutes. I used an interview protocol script to present several open-ended questions to the participants based on the focus research questions and relevant to the purpose of the study. Moustakas (1994) explained how a phenomenological interview involves an informal, interactive process using open-ended questions. Castillo-Montoya (2016) shared how researchers that use an interview protocol often experience successful interviews. Therefore, for this qualitative study, I used some of the recommended steps of Castillo-Montoya's (2016) interview protocol framework, including

Step 1: Alignment among interview questions and guiding research questions

Step 2: Open-ended questions using an inquiry-base

Step 3: Interview protocol form to document feedback and take notes (see Appendix A)

This method of data collection provided me with information that could be analyzed.

For the final steps of the data collection, once all interviews were completed, I thanked each participant for their participation. I then sent the audio recordings of the interviews to a professional organization for transcription, such as Rev.com. Other novice researchers have used the professional transcription services of Rev.com. Using a professional service helped provide transcripts in a Microsoft Word document form to make verification easier. I verified the accuracy of the transcripts by comparing the professional transcript with the audio-recording of each participant to ensure the conversation matched the transcription. I sent each participant a summary of the transcript for member checking, ensuring the information captured represented the information participants shared during the interview. Participants were given 1 week to respond to the transcript to offer additional feedback or request clarifications. No changes or additions were requested; therefore, the data collected was assumed as a true representation of the participants, and data analysis began.

Data Analysis

Data from the transcripts were analyzed. For each participant, names or any information that could identify the participant were removed and replaced with a code. For example, the first participant was coded P1. Using a code in place of a name protected the identity of the participant and supported presenting the findings in a confidential format. Only I have access to the identities of each participant. Also, all data is stored on a password-protected computer. Because interviews were audio-recorded and transcribed, all interview recordings and data from

the transcriptions will be stored on a password-protected computer for 3 years and then destroyed.

Data collected from participants during interviews helped with answering the research questions. Once all transcripts were reviewed and returned, I began the data analysis process using a thematic analysis approach. Braun and Clarke (2019) noted how a thematic analysis allows researchers both accessibility and flexibility for analyzing qualitative data. I used the recommended steps of Braun and Clarke's (2019) thematic analysis, including

Step 1: Familiarizing the data

Step 2: Coding

Step 3: Forming themes

Step 4: Examining themes

Step 5: Labeling themes

Step 6: Reporting themes

To become familiar with the data, I organized the transcripts that provided the feedback from the participant interviews. For coding, I read and identified common words and phrases and assigned them a code that was relevant to the research (i.e., taboo). Next, I began forming themes using the codes that were supported by the participant data. I then examined the themes by organizing the codes as they answered each research question; for example, a taboo code was organized with the third research question. Once I labeled the themes, I reported each theme by the research questions and included supporting evidence and feedback.

Trustworthiness

Trustworthiness considerations support the accuracy of findings from the qualitative analysis. Lincoln and Guba (1985) identified that trustworthiness and its four components were

essential to supporting the merit of the data. Using the basis of Lincoln and Guba's (1985) research, Stenfors et al. (2020) shared trustworthiness strengthens the value of the findings. Lincoln and Guba (1985) proposed four elements of trustworthiness, including credibility, transferability, dependability, and confirmability. Each of these components were considered to support the trustworthiness of the findings.

Credibility

Credibility in a qualitative study is dependent on the details presented and how the details accurately represent the data collected. Lincoln and Guba (1985) recommended two ways to support the credibility of research, including triangulation and member checking. Triangulation is a common strategy for establishing credibility involving using and comparing results from various instruments. For this study, triangulation involved comparing researcher notes and interview transcripts. Transcripts were shared with each participant for verification and member checking to ensure the transcripts were a true representation of the interview conversations. Thus, triangulation and member checking supported the credibility of this research.

Transferability

Another method of ensuring trustworthiness is transferability or providing ample details to support the findings (Stenfors et al., 2020). Lincoln and Guba (1985) explained that transferability could be achieved by detailing every phase of the research process. Transferability is supported by presenting organized steps and details on the methodology and approach to recruitment, data collection, and analysis. To support the transferability of this study, detailed information was provided. Transferability allows other researchers access to detailed information to replicate the study can locate and obtain similar results.

Dependability

According to Lincoln and Guba (1985), dependability is supported through reporting data with consistency and conciseness. For this qualitative study, dependability was established through analysis bracketing, which helped focus the findings on actual data presented by the participants. Dependability was supported through reporting data consistently.

Confirmability

To establish confirmability, researchers may use triangulation (Lincoln & Guba, 1985). Confirmability represents the level of confidence in the reported findings. For this study, findings were compared against the original interview transcripts and researcher notes. Confirmability was also established through the use of direct quotes and detailed information.

Ethical Considerations

To ensure confidentiality, identifying information was coded with numbers to protect participant identities. Data is stored on a secured computer that only the researcher has access to. Data will be stored on a password-protected computer for the specified amount of time that the Liberty University IRB recommends. Once the specified time has ended, all data will be erased and digitally destroyed from the password-protected computer.

Participants were recruited through the Ghanaian Minister's Association (GMAC). A recruitment letter (see Appendix B) was submitted to the Ghanaian Minister's Association for approval and distribution to potential participants. The Ghanaian Minister's Association helped me purposively identify potential candidates that met the recruitment criteria. The recruitment letter included information on the study, the purpose of the study, and the aim of the study. Information on participant privacy and rights was also included. Participants could contact me, the primary researcher, with any questions or concerns. Recruitment information included study

details, the purpose of the study, benefits of participation, the benefits of findings from the study, participant confidentiality information, researcher contact information. Before participating in the study, participants needed to sign a document of informed consent (see Appendix C). All documents collected throughout the study are kept safe in a secure and locked file that only I have access to. Also, I am the only one with access to any digital data that is stored on a password-protected computer.

Chapter Summary

The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. A basic qualitative methodology was used to explore the perceptions of Sub-Saharan African immigrant parents. The data collection instrument used was individual participant interviews. The findings could benefit counselors that work with parents of adolescents and parents that experience sexual shame and face communication difficulties.

CHAPTER 4: RESEARCH FINDINGS AND DATA ANALYSIS RESULTS

Researchers have found that United States immigrant parents often experience uncertainty when considering how to engage in a conversation about sexuality (Christensen et al., 2017). Despite past studies that have been conducted on sexuality and youth health, there remains a gap in research that explores how Sub-Saharan African immigrant culture and sexual shame may affect teen sexuality (Gabbidon et al., 2017). Therefore, exploring perceptions of Sub-Saharan African immigrant parents were needed to identify a lack of effective resources and parent training to help overcome cultural barriers to discussing sexuality-related topics with their children. The problem was parental communication barriers (e.g., sexual shame, taboos) of Sub-Saharan African immigrant families may generate interference in meaningful sexual conversations with adolescents ages 10-16 years old. The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Chapter 4 presents the findings and data analysis results. Information includes data collection, data analysis, finding results, reliability and validity, and a summary.

Restatement of Purpose and Methodology

A phenomenological qualitative approach was used to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. The study was conducted to explore how perceived barriers affect Sub-Saharan immigrant parent sexual conversations. Participant recruitment was conducted using the following criteria: (a) born in a Sub-Saharan country, (b) fluent in English, (c) have one or more

children who are now aged 10-16 years of age, (d) have lived in the U.S. with their child for at least 10 years. Upon approval from the IRB and with organization site permission, recruitment flyers were sent on my behalf by the faith-based organizations to potential candidates. Before I began the data collection process, consent forms (see Appendix C) were collected from each participant. Each participant received the informed consent form with instructions on signing and returning the form electronically. Table 1 presents the demographics of the participant LPC associates by gender, age, education, and religious affiliation.

To explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices, a phenomenological qualitative approach was appropriate for identifying findings relevant to the research questions. The sample population included 12 Sub-Saharan African immigrant parents. The inclusion criteria for the sample population was participants had to be (a) born in a Sub-Saharan country, (b) fluent in English, (c) have one or more children who are now aged 10-16 years of age, (d) have lived in the U.S. with their child for at least 10 years. Most participants classified their church denomination as charismatic; however, one participant identified as non-denominational (see Table 1).

Table 1

Demographic Information

Participants	Age	Gender	Country of Origin	No. of years lived in U.S.	Education	Church Denomination
P1	40	Female	Ghana	10+	Associates	Charismatic
P2	44	Male	Ghana	10+	Associates	Charismatic
P3	50	Male	Ghana	10+	Associates	Charismatic
P4	45	Male	Ghana	10+	Bachelors	Non-Denominational
P5	43	Male	Ghana	10+	Masters	Charismatic
P6	37	Female	Ghana	10+	Bachelors	Charismatic
P7	41	Male	Cameron	10+	Ph.D.	Charismatic
P8	50	Female	Ghana	10+	Bachelors in social work	Charismatic
P9	52	Female	Ghana	10+	HS Diploma	Charismatic
P10	53	Male	Ghana	10+	Masters	Charismatic
P11	51	Male	Liberia	10+	MDIV	Charismatic
P12	48	Female	Ghana	10+	Some college	Charismatic

Gathering demographics is common in all types of research. Gathering demographic data from participants helps provide an overview of who the participants are and how their perspectives may be relevant to the focus of the study. For this qualitative study, the following

demographics were gathered, age, gender, country of origin, years in the United States, the highest level of completed education, and church denominations. Twelve Sub-Saharan African immigrant parents participated in this study, with seven males and five females. The countries represented included Ghana, Cameron, and Liberia. All levels of education were represented, ranging from a high school diploma to a Ph.D.

Zoom was used to gather feedback from the study participants. To verify and clarify responses, member checking occurred. For member checking, each participant received their transcript from the interview, and participants were asked to review the transcripts for accuracy and respond within two weeks if any changes or additions were required. After two weeks, no participants contacted me with a request for changes or additions, and the data collection was considered complete. There were no deviations to the data collection process to report, and no significant events occurred that would have affected the data collection.

Findings and Results

To identify themes relevant to Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices, an analysis of the transcript data was performed.

The analysis involved following the recommended steps of Braun and Clarke's (2019) thematic analysis. The following six steps were followed, including (a) becoming familiar with the data, (b) coding, (c) forming themes, (d) examining themes, (e) labeling themes, and (f) reporting themes. Categorizing the codes supported the identification of themes, and Table 2 presents examples of phrases identified throughout the participant transcripts and also includes coding examples.

To become familiar with the data, I organized all the transcripts from the participant interviews. For coding, I read each transcript three to four times to help identify common words and phrases; then, I assigned the common phrases a code relevant to one of the three research questions. Next, I formed the themes using the codes as supported by the participant data. I examined the themes by organizing the codes as they answered each research question; for example, a taboo code was organized with the third research question. Table 3 presents the themes which were developed from the analysis and shows the number of occurrences in the data.

Table 2

Organizations of Codes and Themes

Common Phrases or Terms	Codes	Themes
• Western culture • Social media • Internet, online, or cell phones	Western influences and technology	Acculturation and Technology
• School campus • Peers or friends	School and social interactions	School and Friends
• Role model • Help with making decisions • Teaching children	Parents talk to and teach their children	Parental Authority and Responsibility
• Bible • God/ Sins • Premarital sex • Culture	Culture and religion steer conversations	Religion and Cultural Beliefs

Common Phrases or Terms	Codes	Themes
• Not comfortable/ timid • Do not talk much • Gender differences and discomfort	Variety of situations cause discomfort among parents	Discomfort in Initiating Conversations
• Clueless • Have no knowledge • Not sure what to say • Not sure where to start	Parents uncertainty on how to start a conversation and what to say	Uncertainty
• Approach • Shaving or menstruation • Mothers and fathers	Opposite gender-based topics may cause discomfort to parents	Parent-Child Gender Barriers
• Don't talk • Conversations not part of culture practice	Family values, religion, and taboo	Cultural Taboo
• Grew up in culture with no discussion • Parents want to learn	Parents lack knowledge but are willing to learn how to talk about sexuality	Lack of Knowledge or Parental Uncertainty

Table 3

Themes and Number of Occurrences in Data

Theme	Number of Occurrences in Data
Acculturation and Technology	19
School and Friends	19
Parental Authority and Responsibility	9
Religion and Cultural Beliefs	24
Discomfort in Initiating Conversations	10
Uncertainty	17
Parent-Child Gender Barriers	10
Cultural Taboo	18
Lack of Knowledge or Parental Uncertainty	8

The findings are organized by research questions and themes.

Research Question One

Research Question One was: What are the perceptions of Sub Saharan immigrant parents concerning the influences of a decision to discuss issues relating to sex and sexuality with their children? Four themes were identified as relevant to answering the first research question. The four themes include (a) acculturation and technology, (b) school and friends, (c) parental authority and responsibility, and (d) religion and cultural beliefs.

Acculturation and Technology

The first theme of acculturation and technology emerged as parents discussed influences to discussions relating to their children and sexuality. The theme developed as many parents shared influences of the Western culture that affected how their children are learning about sexuality. Many parents shared Western influences such as cell phones, television, social media, and the internet (P11, P6, P3, P10). When sharing about influences on children, P11 shared,

> The sources of their knowledge about sex, especially the online thing, you know, these children, they spend a lot of time on the internet. Initially, I didn't really want to give a cell phone, [because they] were going to middle school, and I told their mom, you know because there's so much of that sexual information is online.

Oher parents shared how technology influences exposure to sexuality among their children. P3, a parent of three children, shared how the influences of sexuality are more prominent in the United States, explaining, "Currently, I mean, when they were in Ghana, you know, it was through TV, but for the past five years that they've been with me down here [United States], It's been the internet and the TV." Similarly, P6 noted that social media apps on cell phones were also a negative influence, sharing "the one that I hate the most is TikTok." Most parents shared that their children can access information on sex and sexuality via technology, whether through television, cell phones, social media apps, or access to the internet. P10 reported, "They [children] have access to information technology. So, they may know things that you already know." Even if students lacked access to television at home, they could still connect to information through other means. For example, P6 also noted that "I don't even have cable anymore, because they don't watch it. Okay. So, it's probably mostly the web."

Compared to many Sub-Saharan countries, Western culture provides easy access to information via technology. Based on the feedback from the parent participants, Sub-Saharan immigrant parents perceive acculturation and technology as influences to their decision on discussing issues relating to sex and sexuality with their children. Parents have to be prepared to discuss topics that their children may have already been exposed to through technology outlets or, as seen in the next theme, through friends and school.

School and Friends

The second theme of *school and friends* emerged as parents discussed influences relating to their children's sexuality. The theme developed as many parents shared social media and technology influences were a part of their children's school environment (P2, P3, P11) and were shared among peers and friends (P2, P7, P10). Based on the feedback of participants, many parental conversations on sexuality often occur after children have already been exposed to information at school, through friends, or through technology. P11 shared, "I think they know a lot about sexuality and sex. You know, it's everywhere around school, especially, you know, the era is to put a cell phone in their hands" Other parents shared similar feedback. P2 shared that children know about sex "because they talk with their friends and the things they see on social media." Many public schools teach some form of sex education. P6 noted, "I haven't really spoken to them too much about that. But, I know they know because of school." P7 also shared, "it's [sex] everywhere around their school, phone, and online because there's so much of that sexual information is online. In this country, the U.S., you're talking about 15 years, 17 years, he already knew a lot." Parent participants shared concern over how early children are learning about sexuality. For example, P10 shared concern noting what children are "doing in middle school frightens me because they're irresponsible, but think that they're responsible." Based on

the feedback from the study participants, Sub-Saharan immigrant parents perceive school experiences and peers as influences to their children's early exposure and knowledge to sexuality, and this, in turn, affects parental decisions on discussing issues relating to sex and sexuality with their children.

Parental Authority and Responsibility

Another theme of parental authority and responsibility emerged as parents discussed influences to discussions relating to their children and sexuality. Not every parent expressed the same concerns about sexuality conversations with their children. Some parents were concerned with choosing the topics to discuss (P2, P6, P8, P11, P12), some participants were concerned with how their approach to addressing sexuality is lessened by Western culture or early exposure to topics outside of the home (P1, P4, P9, P11), and others were concerned with emphasizing the dangers of sexual irresponsibility, such as pregnancy or sexually transmitted diseases or STDs (P3, P5, P7).

For parents that felt responsible for choosing the topics of discussion, P8 shared using life experience as a tool to teach their children. P8 noted, "I teach them using my own self." When discussing the roles and responsibilities of being a parent, P11 shared

> We are role models before our children, and they follow. And so, we told you this culture [U.S. culture] is too sexually explicit. You know, even the words we use, the language that we use, you know, is very sexually oriented.

The roles and responsibilities include having difficult discussions with children. P2 shared that parental discussions are important to have early on before children have an opportunity to learn from their friends or outside influences. P9 explained how many children are learning about sexuality from outside sources. P9 shared, "They [children] have access to information

technology. So, they may know things that you already know." Experiences also provide parents with the responsibility to teach their children parental views on topics of sexual health. P6 shared how she also used experiences to determine the topics of discussion. P6 explained how personal hygiene was an important topic, sharing

> Oh, I want them to know, especially with my girl, how to keep herself. Yeah. Because I've been around people, I've heard conversations where men will say something like, 'Oh, I was dating this girl, and she was so beautiful. But maybe her hygiene down there, it wasn't good smelling. So, I couldn't agree with her; I had to leave her.' You know, all of that. I feel like all of that needs to be, it needs to be discussed.

The dangers and complications of sexuality and the focus of some parents. For example, P3 shared they are mostly concerned with preventing pregnancy at an early age. P3 shared, "I try to tell them, you know, you can be 10 years or you can be 11 years, when you go to mess up, you can easily get pregnant. My number one topic has always been pregnancy." Similarly, P7 shared, "So, I'd be bold and tell them that these are the consequences of sex. We are role models before our children, and they follow." P5 was concerned with STDs and explained, "I mean, the most important is disease prevention. There are diseases around, okay, STDs and stuff like that." Overall, despite the difference in chosen topics of discussion on sexuality, many participants noted their responsibility as a parent to share their stance and beliefs concerning sex and sexuality with their children.

Based on the feedback from the participants, Sub-Saharan immigrant parents perceive their parental role and authority as an influence to their decision on discussing issues relating to sex and sexuality with their children. Overall, parents noted that the topics of discussion were determined by the parent's decision on what they deemed appropriate for their child. Many of the

participants shared that, as parents, it is their responsibility to ensure their children learn the values and family beliefs concerning sexuality. Parents also emphasized that children need to know what sexual activities and experiences are acceptable based on religious beliefs and culture. However, despite every parent having views on what should be a topic of discussion, not every parent participant was comfortable initiating these conversations.

Religion and Cultural Beliefs

The final theme relevant to influences to parental discussions relating to their children and sexuality was religion and cultural beliefs. Early on, participants shared their church affiliation as part of gathering participant demographics. One participant identified as non-denominational, and the rest of the participants identified as charismatic. Religion and culture were reflective in the statements of the Sub-Saharan immigrant parent participants. Some parents shared how biblical beliefs influenced their conversations (P1, P2, P4, P6, P8), and some participants shared how cultural beliefs hindered their comfort level in having parental conversations on sex and sexual health (P7, P11, P12).

Many of the parent participants shared how their faith and biblical teaching guide the topics of sexuality with their children. For example, P8 shared

> So far as we are Christians, we are supposed to do all the proper engagements before we enter into sexuality, so far as male and female sexual life is concerned. I know the Bible says that premarital sex is sinful. So far as we are Christians, we have to identify ourselves different from others and go with what the Bible says, that we should stay be chaste.

P1 also shared similar biblically-based ideas, reporting, “I think the Bible says our bodies are the Temple of God. Well, we shouldn’t play with our bodies like having multiple partners. No sex

outside of our marriage." P2 shared that the "Bible says that sex should be between married couples, right? And nothing else." Culture was also reported as an influence on parental conversations. P7 noted that in the African culture, sexuality is not discussed. P7 shared how life in "Africa, in growing up, we didn't talk about it." Although culture presented more of a barrier to conversations (see Research Question Three), culture was mentioned as an influence on topics that were discussed. However, biblically-based views were most prominent in discussions of how religious beliefs influence parental conversations.

For Question One, four themes developed relevant to influences on decisions to discuss issues relating to sex and sexuality with their children. Sub-Saharan immigrant parents face influences that affect how and when they have conversations with their children on sexuality. Influences included (a) acculturation and technology, (b) school and friends, (c) parental authority and responsibility, and (d) religion and cultural beliefs.

Research Question Two

Research Question Two was: What are the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality? Two themes were identified as relevant to answering the second research question. The two themes include (a) discomfort in initiating conversations and (b) uncertainties.

Discomfort in Initiating Conversations

The first theme relevant to attitudes about their self-efficacy in parent-child communications was Sub-Saharan immigrant parents experience discomfort in initiating conversations with their children. Based on the feedback provided by the participants, culture and acculturation play a role in the comfort level of parents having discussions on sexuality with their children. The discomfort was described in two forms: discomfort in having discussions on

sex and sexual health (P6, P7, P8, P10) or discomfort in discussing sexual matters such as menstruation (P3, P5, P10, P12).

Although many parents shared topics concerning sexuality they felt were important or necessary, initiating the conversations was more challenging for many participants. Many parents shared being uncomfortable in their self-efficacy concerning having parental conversations on sexuality. For example, P10 said, “I don’t talk much about it to my kids.” Some participants noted that their children could tell if they were knowledgeable or not. P8 explained how “some parents, when we are talking, the children listen to us, and they see that we have no knowledge. Yeah. Sometimes parents are clueless. The child doesn’t even care about whatever you say.” P6 shared a need for guidance to know what is appropriate for conversations and at what time. P6 explained a guide should share something like, “at this age, this is what we [child] should know.” P7 gave great examples to illustrate discomfort related to knowing what to talk about. P7 shared uncertainties in

> Knowing what is the right thing to say. When do you say it, and whether they have been at a certain appropriate level to understand certain things. Am I comfortable addressing these? Because for example, sometimes I may, like with my son, I may out a word to gauge or to see his reaction; how many girlfriends do you have? Do you have any girlfriends in your class? I am clueless about what to say, so it’s been a challenge for me.

Other participants shared their concerns and discomfort in initiating conversations with their children. Some parents described being uncomfortable talking to children of opposite genders concerning sexuality and the changes a body goes through during puberty. For example, P12 explained that her husband is uncomfortable talking to their daughter. Similarly, P10 shared, “So if I have to address menstruation, how will you do that? I will not even go there. I don’t know

what it is to talk to somebody about it." P7 shared that sometimes, even talking to his sons would involve emotions he was not expecting. P7 explained, "Even though [my] sons now are turning to be also emotional. But I think there is a lot more care and tact needed when talking to daughters. It's like it's the personalities that are different. And with the different personalities, there are different ways that you have to talk." Menstruation was mentioned by several participants as a topic that mothers could handle better. P3 noted, "About the menstrual stuff that they go through, their mom also takes care of that." P5 shared being more comfortable talking to his sons than his daughter. P5 said,

> So, I think I will dwell on talking to my son more of the things I know a guy should go through. I think with my daughter, I wouldn't know too much to say, but I would just lay the basis of the things I know about.

Overall, parents noted that comfort levels among parents did influence how conversations were initiated, if they did occur at all. For example, many participants shared that they did not feel comfortable having conversations based on a lack of knowledge or being uncomfortable talking with a child of the opposite gender about sexuality and puberty. Although every parent participant shared views on a topic of sexual-based conversation, many parents were not comfortable initiating these conversations.

Uncertainties

The second theme relevant to parental attitudes about self-efficacy in parent-child communications was Sub-Saharan immigrant parents experience uncertainties on what to discuss with their children. Based on the feedback provided by the participants, uncertainties may either be related to timing and knowing what is age-appropriate (P2, P4, P6, P7) or may be related to parents' concerns over the receptiveness of their children (P1, P8).

Knowing what to say and when to talk about sexuality was a concern for some participants. P2 explained how parents need "to know what kind of words to use for your girls, and also to use for your boys." Adding to what to say, other participants noted the importance of how to address them. For example, P4 noted the need to "talk to them [children] on their level." In addition, some parents shared reaching out to other parents for suggestions on starting conversations. For example, P7 shared reaching out to church members and getting suggestions on books that members used in combination with conversations. Other parents shared feelings of inadequacy. For example, P1 reported, "I will say I know enough to answer some questions that might come up. But I'm still learning. I'm not there yet."

One parent stressed uncertainties of receptiveness to parental conversations based on understanding their child. P8 shared, "When you don't know what is going on in their life, you cannot even talk to them." Another parent noted that her son was not as receptive to discussing sex as her daughter. P1 noted,

> With my son, even though he opened up for me, he was like, Oh, Mommy, I know it already. So, you are weird. Why are you even talking to me about this? Because I already know. He wasn't comfortable.

In summary, participants shared influences on their self-efficacy and the level of comfort in having sexuality-based conversations. Many participants shared a lack of knowledge on age appropriateness for initiating sexual health conversations and what to include. Another factor that participants shared was the receptiveness of their children. Many parents were hesitant to start conversations in fear of their children viewing them as clueless.

Research Question Three

Research Question Three was: What are the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief systems? Three themes were identified as relevant to answering the third research question. The three themes include (a) parent-child gender barriers, (b) cultural taboos, and (c) lack of knowledge or parental uncertainty.

Parent-Child Gender Barriers

Parent-child gender differences were the first theme relevant to the perceptions of Sub-Saharan immigrant parents concerning communication barriers. Based on the feedback provided by the participants, gender differences between parent and child may present a barrier to conversations on sexuality and sexual health.

Many father participants shared being uncomfortable talking to their daughters about menstruation. The gender difference between the parent and child was noted as the cause of the discomfort. For example, P2 shared, “for menstrual stuff. That’s one thing that I’m not sure what to do. Yeah, I’m not really sure what to do. I can tell you [daughter] to go clean it up and stuff. But there’s something I would say Mama will have to talk to you about.” Menstruation was the most noted topic that fathers had difficulty with. Also, many mothers noted talking to their daughters was easier. P7 shared being cautious when talking with his daughter. P7 shared, “I really have to pay attention for my words. For my words that I share because I don’t want to hurt their [daughters] confidence and self-esteem issues at some point.” P8 shared how she “feels free talking about it. I think with the daughters because they are women. So, [I can] talk about it with them. And then with the men, I don’t know.” Another father discussed his comfort level in conversations was different between his sons and daughter. P11 stated

> I think it is much more easier for me to talk to my sons about sex as you know, as opposed to talking to my daughter, you know. I think I would be a little bit reserved, in a way I present a sexual issues to my daughter, as opposed to, you know, the other way around. I'm more both in telling my sons what this thing is all about. When it comes to my daughter, um, there'll be a reserve only, we normally will go along the lines of, 'you are beautiful,' and, 'you know, you've got a very good future, you are reserved yourself for a man.'

Although some parents noted they would talk to their children regardless of gender, several parents noted one gender was easier to talk with than another. This ease in conversation was represented by similarities in gender, such as father to son and mother to daughter conversations.

Cultural Taboo

Cultural taboo was the second theme relevant to the perceptions of Sub-Saharan immigrant parents concerning communication barriers. Based on the feedback provided by the participants, many cultural beliefs presented barriers in past experiences and current experiences in conversations with children. For example, many African cultures do not approve of conversations about sexuality and sexual health.

One participant offered a great explanation of how African culture presents a barrier to conversations about sexual health. P11 stated

> Africans see sexually related conversation as a taboo. Okay. You will barely see an African parent talking about sexual matters. Even when I lived with my parents, my father never talked to me about sexual matters. So, Africans have the tendency to shy away from saying we are discussing it.

Other participants shared similar perceptions and experiences. For example, one participant noted that a cultural barrier was not discussing sexual matters with children. P7 explained that the biggest barrier to parental conversations is

> Not talking about it begins with Africa, in growing up when we didn't talk about it. The only time my mom mentioned it was when we grew up to the age where we could go out. And she would describe it as this is what is happening out. And then that was, I think I grew up in the era when HIV became rampant.

Similarly, P12 shared, "When I was growing up, and nobody talked to me about sexuality, and I tried to figure it myself. Okay, I make wrong choices. Okay. And I have come to understand that I cannot pretend like it doesn't exist." P8 shared that, in Ghana, there was cultural taboo on conversations about sex. P8 noted, "we don't even communicate about [sex]." Cultural taboo is a barrier for parents to communicate to their children on sexual matters. P1 noted that, "back home, we don't generally talk about sexuality." Many participants shared experiences from their childhoods to demonstrate how sexual matters are not commonly discussed in open conversations within the African culture.

Lack of Knowledge or Parental Uncertainty

Participant feedback on lack of knowledge and uncertainty on what information they share with children is supportive of both Research Question Two and Research Question Three. For Research Question Three, the theme of lack of knowledge and parental uncertainty is relevant to the perceptions of Sub-Saharan immigrant parents concerning communication barriers. Based on the feedback provided by the participants, many parents feel inadequately prepared to initiate and hold a conversation with their children concerning sexuality and sexual health.

One parent shared how the Western culture approaches conversations of sex more openly than in their African culture. A difference in culture can present some immigrant parents with feelings of uncertainty. P1 explained, “It’s a big difference here [U.S.]. It’s like, a lot of people are comfortable talking about it, but back home, people are not comfortable.” P4 expressed a need for immigrant parents to know more about the Western culture and practices, so they are prepared to address the needs of their children. P4 shared,

> Africans, sometimes we are kept in the dark. When we think that we don’t want to talk about sex, eventually, something that is on your body, and it’s in your hormones. Yes. You would like to know about it. It’s your body. Yes. So, I think that we just need to be able to learn from both sides and draw a decent balance. So, there’s something to learn from the Western world.

Other parents noted that African immigrant parents needed to learn how to be more open with their children and be more knowledgeable about their children’s lives to hold meaningful conversations. For example, P2 stated, “Parents must be open to allow kids to discuss their struggles.” Similarly, P1 offered advice to African immigrant parents that struggle to have meaningful conversations with their children. P1 shared

> We must not be too judgmental of our kids. Like when our kids tell us whatever they are going through, we don’t have to judge them. We have to open our arms and listen to them and advise them with any advice that we may have. And also, we have to be transparent to them. We don’t have to hide things from them.

While many participants shared not having enough knowledge to talk to their children, many parents shared sentiments and advice that demonstrate a willingness to learn and adapt to the Western culture and the needs of their children. All of the twelve participants expressed interest

in attending training to help parents initiate and maintain effective conversations with children concerning sexual matters.

Chapter Summary

The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Overall, throughout the interviews, participants discussed feeling inadequate to talk to kids about sexuality in relation to children's gender, cultural impact, and topic. Themes that were identified include participant perceptions on influences to parental conversations, including (a) acculturation and technology, (b) school and friends, (c) parental authority and responsibility, (d) religion and cultural beliefs, (e) discomfort in initiating conversations, (f) uncertainty, (g) parent-child gender barriers, (h) cultural taboo, and (i) lack of knowledge or parental uncertainty. Participants shared many views on essential topics of sexuality-based conversations; however, many parents were not comfortable initiating these conversations. The following chapter presents a discussion of the findings, recommendations for future research, and a conclusion of the study.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Understanding the perceptions of immigrant parents concerning having meaningful conversations with their adolescent children on sexual health and sexuality is essential to counselors and mentors working with this population. This study addressed the gaps in literature concerning the exploration of parental perceptions concerning potential barriers to initiating sexual conversations among immigrant families. The findings from this study identify parental struggles and provide information that can help improve conversations concerning sexuality and sexual health within Sub-Saharan African immigrant families.

Summary of Chapters

This research study included an introduction to the study defining the need for the research and the purpose. In Chapter One, the introduction, the study problem identified was parental communication barriers (e.g., sexual shame, taboos) of Sub-Saharan African immigrant families may generate interference in meaningful sexual conversations with adolescents ages 10-16 years old. The purpose of this study was to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices.

Chapter Two presented a literature review of empirical research of current and historical value to the focus of the study. Chapter Three presented the methodology of the research and included details on research design and methods to collect and analyze the data. This research explored the perceptions of Sub-Saharan African immigrant parents to identify a lack of effective resources and parent training to help overcome cultural barriers to discussing sexuality-related topics with their children. Finally, Chapter Four presented the findings and data analysis results.

Chapter Five presents a summary of the participants, findings with previous supportive literature, conclusions, implications for practice, implications for research, recommendations, limitations to the study, and a final summary.

Conclusions

Twelve Sub-Saharan African immigrant parents participated in this study. The countries represented by the parents included Ghana, Cameron, and Liberia. These countries (and the corresponding number of participants) were Ghana (n = 9), Liberia (n = 2), Cameron (n = 1); participants were married couples and ranged in age from 37 to 53 years. Participants have lived in the United States for more than 10 years. Eighty percent were married, and all the participants had some college education or higher. All participants were Christians, and all the participants had a child between 10-16 years of age. A phenomenological qualitative approach was used to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. The study was conducted to explore how perceived barriers affect Sub-Saharan immigrant parent sexual conversations. Four themes were relevant to answering the first research question, What are the perceptions of Sub Saharan immigrant parents concerning the influences of a decision to discuss issues relating to sex and sexuality with their children? Two themes were relevant to answering the second research question, What are the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality? Three themes were relevant to answering the third research question, What are the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief

systems? The following sub-sections present a summary of the findings by research question and include supporting relevant empirical research.

Research Question One

Research Question One was: What are the perceptions of Sub Saharan immigrant parents concerning the influences of a decision to discuss issues relating to sex and sexuality with their children? Four themes were identified as relevant to influences of parental decisions to discuss issues relating to sex and sexuality with their children. The four themes were (a) acculturation and technology, (b) school and friends, (c) parental authority and responsibility, and (d) religion and cultural beliefs. Extending the research of Gonzalez and Méndez-Pounds (2017), many participants shared how the influences of Western culture affected how their children were learning about sexuality. Gonzalez and Méndez-Pounds (2017) reported first-generation immigrant parents do not agree with many liberal ideas of Western culture. Similarly, participants from the current study highlighted how Western influences such as cell phones, television, social media, and the internet present their children with sexually explicit materials and content. Western culture, compared to the culture of Sub-Saharan countries, presents easy access to information via technology. Adolescents also gain access to learning about sexuality through school and friends. These findings support the research of Dune and Mapedzahama (2017), who noted that without a good understanding of the role of culture and sexuality, it might be confusing for first and second generations of immigrants to receive one message from their parents and another from school.

Participants noted that parental conversations on sexuality are often too late as their children have already been exposed at school or through friends. These findings are in line with the research of Agbemenu et al. (2016), who shared many immigrant parents are not prepared to

initiate sexual health conversations. Many public schools in the United States teach some form of sex education (Szlachta, 2015). Participants shared concerns over how early their children were learning about sexuality. These reported concerns confirm the research of Szlachta, 2015), who shared conflict among immigrant families with U.S. teachers concerning sex education. For the current study, Sub-Saharan immigrant parents perceived early and outside exposure to sexuality as an influence that affects parental decisions on discussing sexuality with their children. Most parents shared how they struggled with conforming to the U.S. culture and noted they struggled with acculturation. These findings extend the findings of Meschke and Dettmer (2012), who shared acculturation poses challenges for immigrant parents, presenting parents with difficulties in having meaningful sexually-related communication with their children. Participant concerns also support the findings of Nundwe (2012), who noted, in some cultures, a lack of direct communication presents barriers in communicating sexual health to children.

Despite Western culture and the early exposure to sexuality-based topics outside of the home, participants shared that they are responsible for choosing the topics of discussion as parents. Sub-Saharan immigrant parents perceived their role and authority as an influence to their decision on discussing issues relating to sex and sexuality with their children. Participants emphasized how, as parents, they are responsible for ensuring their children learn family values and beliefs concerning sexuality and sexual behaviors. Similar to the findings of Christensen et al. (2017), immigrant parents of young children struggle to provide sexual health education before puberty and adolescence. Ogunnowo (2016) reported generational gaps between immigrant parents and their children might exacerbate barriers of acculturation. This may be accurate, as participants shared uncertainties in when to begin conversations and frustrations

over their children becoming exposed to information before parents were ready to hold discussions.

Religion and culture were reflective in the statements of the Sub-Saharan immigrant parent participants. Gabbidon and Shaw-Ridley (2018) noted that strong Christian views among immigrant parents often clash with acculturation. This clash may be evident in reports by participants' parents, emphasizing that children need to know what sexual activities and experiences are acceptable based on religious beliefs and culture. Several participants shared biblical teachings to help guide their topics of discussion concerning sexuality with their children. This practice was supported by Nundwe's (2012) research, noting cultural barriers in communicating sexual health to children resulted from parents using religious instruction as a tool with their children in place of direct communication. Although biblically-based views were most prominent in discussions, culture was reported to influence sexuality-based discussions.

Research Question Two

Research Question Two was: What are the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality? Two themes were relevant to identifying the perceptions of Sub Saharan immigrant parents concerning attitudes about their self-efficacy in parent-child communications about sex and sexuality. The two themes include (a) discomfort in initiating conversations and (b) uncertainties. Participants shared experiencing discomfort in initiating conversations with their children. Based on the data, culture and acculturation play a role in parents' comfort level having sensitive discussions.

Discomfort was described in two forms: discomfort in having discussions on sex and sexual health and discomfort in discussing gender-based sexual health such as menstruation. For

example, some parents described being uncomfortable talking to children of opposite genders concerning puberty and how the body changes. These reported discomforts support the claims of Amayo (2009), who reported that the merging of two cultures (African and U.S. culture) causes immigrant families to face stressful parenting. Similarly, Ogunnowo (2016) noted that immigrant parental stress influences parent-child communication on sexuality. Rempel and Baumgartner (2003) reported that immigrant parents with a higher awareness of sexuality were more likely to be comfortable in initiating conversations. This was apparent among the current study participants, as parents from cultures that did not discuss sexuality or sexual health struggled with initiating conversations.

Participants shared that comfort levels did influence how they initiated conversations (if they occurred at all). Other self-efficacy attitudes involved uncertainties related to timing, knowing what is age-appropriate, or concerns over their children's potential receptiveness. Participants also noted levels of comfort in having sexuality-based conversations or a lack of knowledge on age appropriateness as challenges to their self-efficacy. These findings support the research of Campero et al. (2010), who stressed parental embarrassment or a lack of education to discuss sexuality present barriers to meaningful conversations. Christensen et al. (2017) indicated educating immigrant parents could help them feel more comfortable. Parental education was a topic of discussion among participants, and many parents shared openness to attending counselor-led parent education sessions to improve their comfort level with parent-child discussions on sexual health.

Research Question Three

Research Question Three was: What are the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief systems? Three

themes were relevant to the perceptions of Sub Saharan immigrant parents concerning communication barriers based on cultural taboos and belief systems. The three themes include (a) parent-child gender barriers, (b) cultural taboos, and (c) lack of knowledge or parental uncertainty.

For some participants, gender differences between parent and child presented a barrier to sexuality and sexual health conversations. Past research with a focus on immigrants and diverse cultures has used the SCT as a theoretical basis. Garcia et al. (2019) used SCT to examine how immigrant parents communicate, and Dutta (2018) used SCT to examine how acculturation and immigration influenced immigrant parenting with a focus on cultural differences in gender equality. Comfort in communication and gender was also present among some participants of the current study. For example, some participants shared how when having discussions with their children, one gender was easier to talk with than another. This ease in conversation was represented by similarities in gender, such as father to son and mother to daughter conversations.

Kingori et al. (2018) noted immigrant parents from Africa come from diverse cultures with different culturally-based beliefs and taboos. In the current study, participants linked their parents' failure to engage in sexual conversations to taboo cultural beliefs. Many cultural beliefs also presented barriers to conversations with children. For example, many African cultures do not approve of conversations about sexuality and sexual health. Dune and Mapedzahama (2017) noted first- and second-generation immigrants that did not experience sexual health conversations growing up are confused by the Western culture and direct approach used in school and among American families. In the current study, participants shared childhood experiences in Africa, demonstrating examples of how sexual matters are not discussed openly within African culture. These findings reflect the findings of Romo et al. (2010), who postulated

that cultural factors impact parental communication on sexuality, including the belief that sex is shameful.

A lack of knowledge and parental uncertainty was relevant to the perceptions of Sub-Saharan immigrant parents concerning communication barriers. Clark (2017) indicated that any form of sexual health communication is considered off-limits in many African cultures. Without restrictions on discussions, any immigrant parents do not feel comfortable with holding parent-child conversations based on sexual health. This was evident in the participants of the current study. Many participants reported feeling inadequately prepared to initiate conversations with their children concerning sexuality and sexual health. These findings are supported by the work of Salami et al. (2017), who identified challenges to parenting among African immigrants involve acceptable discipline practice), embedding cultural and religious practices in their U.S.-born children, and accessing support services for assistance.

Overall, this shared lack of knowledge presents a need for immigrant parents to know more about the Western culture and practices to help them prepare for sensitive conversations. Supporting this need, Agbemenu et al. (2018) shared immigrant mothers were interested in getting assistance with parent-child communications. The need identified by the participants of the current study is supported by the reports of the immigrant parents who shared sentiments demonstrating a willingness to learn and adapt to the Western culture and the needs of their children.

Implications for Counselor Educators and Supervisors

Counselors should have a diverse background knowledge when working with immigrant clients experiencing sexual shame (religious or cultural) or discomfort in having parent-child conversations. Practical implications for counselor educators and supervisors include diverse

training opportunities. Counselor educators should offer counseling students educational opportunities to learn how the views of Western culture may differ from clients of other cultural backgrounds. Findings from the study support a need for cultural sensitivity training and providing counselor-led training for parents. War and Albert (2013) indicated culturally-based silence on issues related to sexuality contributes to sexual silence among immigrant parents. Clinical supervisors could provide counseling associates with learning opportunities such as learning how to initiate and lead parent workshops and training focused on improving the comfort levels among immigrant parents to hold sensitive conversations. Counselor-led workshops on sexuality and sexual health that are specific to a culture and cultural values will be beneficial to immigrant families.

Counseling educators and supervisors must devise highly creative interventions that engage fathers in sex education as sub-Saharan immigrant fathers offer minimal sex education to their children (Feldman & Rosenthal, 2000; Wilson et al., 2010; Wyckoff et al., 2008). This postulation has been confirmed by my study. Research that explicitly targets fathers of the sub-Saharan population could help shape professional understanding of the struggles of sub-Saharan immigrant fathers (Coatsworth et al., 2006; Woody et al., 2005). Targeting communities with trusting and valuing programs or intervention, can have a positive impact on fathers in recognizing the importance of their participation in their children's sexual education (Martino et al., 2008)

Supervision plays a crucial role in professional development and provides critical support (Mori et al., 2009). In addition, research underscored the impacts of cultural discussion, including the self-efficacy, stress levels of the supervisee, and perceptions of the supervisor (Nilsson, 2007). However, there are barriers in clinical supervision, and the lack of cultural

discussion can sabotage their professional growth. Culturally trained supervisors are needed for adequate preparation of supervisees from diverse cultural communities as studies indicate that western expectation and approach to sexual health is limited (Dune & Mapedzahama, 2017).

Supervisors must take leadership roles in promoting diversity in the profession and advocate for them in their workplace (Lee, 2018). As such, examining clinical supervision training is crucial to ensure that international supervisees receive adequate culturally sensitive training. One key area that supervisors must be aware of is ensuring that they do not impose western values on their international supervisee (Marsella & Pedersen, 2004). Not setting western values is vital to developing international students' competencies and helps them become more effective in their communities; cultural discussion must be at the center of supervision. Previous studies confirm the need for culturally sensitive programs and resources (Botfield et al., 2017). Programs focused on teaching about sexuality and sexual health can benefit from understanding the needs of immigrant parents.

Counselor educators must also devise research and practice initiatives to demonstrate that fathers, children, and parents are not the only responsible beneficiaries of home-based sex education. Schools, churches, and the community also have a stake in promoting culturally sensitive sex education (Alcalde & Quelopana, 2013; Shangase & Egbe,2015). Supervisors can incorporate diversity in training by asking supervisees to discuss how their background informs their clinical work. Finally, the needs of a Supervisee can be met by simply providing the means for cultural exploration (Lee, 2018).

Implications for Practice

The findings from this study have practical implications. The qualitative study findings could help counselors, pastors, and social work professionals identify and address cultural

barriers to initiating parental conversations on sexuality and sexual health. Findings from the study indicate that Western society influences immigrant children on sexuality through school, friends, social media, and the internet. Findings indicate that Sub-Saharan parents expressed a desire to educate their children but were not easily able to talk about sex with their children. The findings of this study provide Sub-Saharan immigrant parents with insight into their adolescent children and parenting style. These findings support culturally-based communication barriers such as sexual silence and sexual taboo present challenges to Sub-Saharan parents. Gibson (2016) indicated a need for professional counseling services among more diverse cultures, such as immigrant parents. Training and educational opportunities on understanding Western culture were highlighted by participants as a potential solution to conversations with adolescent children concerning sexuality and sexual practices.

Advocacy is needed for immigrant families and counseling services can help support indigenous cultures and conflicts. The study can benefit any institution and counselors seeking to improve communications between first-generation children and their Sub-Saharan parents. Cashwell and Young (2011) indicated that understanding diverse cultures and religions is essential to developing good counselor-client relationships. Counselors and other individuals that work with the Sub-Saharan community may benefit from the findings and create resources to help immigrant parents initiate discussions on sexuality.

Implications for Research

The findings from this study present implications for research on immigrant culture and parental conversations of sexual health. The findings indicate that many Sub-Saharan parents view Western culture as too explicit concerning sexuality. As many of the participants shared a primary responsibility should be focused on parents as role models, not society, the findings add

to research on parenting styles of Sub-Saharan cultures. Finally, as many of the participants shared they are interested in opportunities to learn about Western culture and new approaches to parenting styles, the findings also contribute to current literature focused on immigrant parents and adapting to Western culture.

Findings from this study may encourage future indigenous studies on sexuality, sexual health, and parental conversations. Understanding indigenous perspectives will benefit counselors and the communities they serve. Sexual health and sexuality are taboo for many immigrant cultures, so researching ways to address parental needs with cultural sensitivity is needed.

Recommendations

A phenomenological qualitative approach was used to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Future researchers could expand the findings by conducting similar research with other African immigrant parents outside of the Sub-Saharan regions. Researchers could also expand the research of perspectives of Sub-Saharan immigrant parents by reaching out to other English-speaking nations. Although this study was qualitative, future researchers using other nations could conduct comparison studies to see if Sub-Saharan immigrant parents face similar barriers to communication as in the United States. Another recommendation is to examine the difference of perspectives between new immigrant parents who have been in the United States less than 3 years and immigrant parents who have lived 10 or more years.

Individual interviews were used to conduct this study. Future researchers may consider conducting interviews with parents as a couple. Conjoint interviews with a husband and wife

may help identify synergistic ideas for expanding information on immigrant families and parental conversations. Future research could focus on how couples are addressing conversations about sexuality and sexual health.

One of the findings from this study is that all 12 participants expressed interest in attending training for help to initiate and maintain effective conversations with children concerning sexual matters. Future researchers may consider conducting a qualitative study to gather topical ideas from immigrant parents concerning training and educational needs. Counselors could also be a focus sample for a qualitative study to explore perceptions on the needs of immigrant parents served by counselors and social workers.

Future researchers may consider conducting a study of African immigrant fathers and their sexual communication with their children. Findings from the current study suggest that some immigrant parents have difficulty having conversations with a child of the opposite gender. Some participants shared that a mother was viewed as more approachable in some instances. Future researchers could examine how an immigrant father's perception of sexual communication may differ from a mother's perception.

Religion and culture were also highlighted as potential barriers to sexual conversations between Sub-Saharan immigrant parents and adolescents. Future researchers could investigate the relationship between various religious groups and educate their members on sex education. In addition, researchers could examine how churches support teaching parents regarding sex education.

One of the findings indicates that Sub-Saharan immigrant parents feel conversations on sexuality are often too late as their children have already been exposed at school, through friends, on via technology. Future researchers may consider adding to these findings using a non-

experimental quantitative survey. Researchers could survey Sub-Saharan immigrants to generate data on parental concerns by issue and topic. All of these recommendations could provide further support to Sub-Saharan immigrant families and the professionals who work and support these families as they adjust to a new culture.

Strengths and Limitations of the Study

During the qualitative research process, the data collection and analysis process presented some strengths and limitations to the study. Throughout the qualitative study, the data collection and analysis highlighted the strengths and weaknesses of the study. One strength of the study is that the participant selection and topic of focus are unique to existing research and contribute to counseling regarding how counselors can work with a diverse population. The sample included Sub-Saharan African immigrant parents. A limitation could be that other African immigrant parents outside of the Sub-Saharan were not included. The sample participants were all living in the United States, so Sub-Saharan immigrant parents of other nations (i.e., Canada) were not included.

Another strength of the data collection process was interviewing, presenting a means to gather detailed experiences from immigrant parents regarding concerns stemming from acculturation. Interviews were the instrumentation used to collect data from the participants. Having the perspectives of Sub-Saharan immigrant parents of other English-speaking nations could provide valuable insight on barriers to parental conversations. As a doctoral candidate, time was a limitation to the data collection process. Due to limitations in time to conduct the study and perform an analysis, the limitation of sample selection was appropriate. Despite the limitations, overall, the strengths of the research design supported gathering parental

perspectives that are valuable to counselors, counselor supervisors, and key stakeholders that work with diverse populations of immigrant families.

Chapter Summary

This chapter presented an overview of the chapters, the research process, a summary of the participants, and findings. Information also included the study findings with previous supportive literature and conclusions. Implications for counselor educators and supervisors were presented along with implications for practice, implications for research, recommendations, and limitations to the study.

This study explored the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. Participants shared many views on essential topics of sexuality-based conversations; however, many parents were not comfortable initiating these conversations. Despite every participant sharing views on potential topics of discussion, not every parent participant was comfortable initiating these conversations. Cultural differences present challenges to parents, and many participants emphasized how Western culture influences such as cell phones, television, social media, and the internet present sexually explicit materials and content to their children. Sub-Saharan immigrant parents need to understand the Western culture and practices to prepare for sensitive conversations with their adolescents.

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APPENDICES

Appendix A
Interview Protocol

Demographic Questions

- Gender
- Age
- Education
- Religious Affiliation

Interview Questions

1. What words would you use to describe your relationship with your children? (Don't prompt them unless they don't understand. Would you describe the relationship, for instance, as being particularly warm and close, friendly, formal, aloof, or distant and reserved, etc.?)
2. Describe your weekly communication with your child(ren). If this differs depending on each child, describe them one by one. How often would you say you talk, and what do you speak about?
3. If I were to ask your child to describe your relationship, what would they tell me?
4. Let's focus mainly on discussing sex with your children. Where do you think that your children have found out or will find out about sexual matters? (You are looking for responses like their friends, television or movies, books, school, their parents, etc.)
5. What do you think the Bible has to say about sexual matters?
6. Discuss your comfort level with sexual language and conversation.
7. Discuss how knowledgeable you are about sexual matters.
8. Does it matter whether you are discussing sexual matters with girls or boys? [looking to see whether there is a double standard, and whether they mention menstruation, etc. Prompt if necessary.]
9. What do you think your children have learned about sex from you? [consider from watching you and spouse interact, affection, etc.]
10. What do you believe is important to communicate when talking to your children about sex?
11. With your children, how did or do you think sexual issues ought to be communicated w/your children? [attempt to get age-related information here, prompt if necessary]
12. Let's speak about our African culture. What cultural differences have you found between attitudes in your home country and the United States about sex and sex education?
13. Would you attend a training session to help you in approaching and discussing sexual matters with your children? If so, what would you like to see addressed in that session?
14. How does speaking of culture helps you in discussing sexual matters with your children.

Appendix B
Recruitment Letter

Exploring parental perceptions concerning sexual communication between Sub-Saharan African immigrant parents and their children

- Are you an African parent with at least one child aged 10-16 years living at home with you?
- Were you born in a sub-Saharan African country?
- Are you fluent in English?
- Have you lived both in the US with your child for at least 10 years?

Then you may be eligible to participate in research on parent-child communication on sexual health

The purpose of this study is to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices. This study will use audio-recorded interviews to gather information from participants.

Individuals that meet the criteria may contact the researcher to schedule a time for an interview. All interviews will be conducted using Zoom.

Kwame Frimpong, a doctoral candidate in the Counselor Education and Supervision program at Liberty University, is conducting this study.

Please contact Kwame Frimpong at [redacted] for more information.

Appendix C
Informed Consent

Title of the Project: Exploring parental perceptions concerning sexual communication between Sub-Saharan African immigrant parents and their children
Principal Investigator: Frimpong Nyanor, MA, APC, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must:

1. Have been born in a Sub-Saharan country,
2. Be fluent in English,
3. Have one or more children who are now aged 10-16 years of age,
4. And have lived in the U.S. with their child for at least ten years.

Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of this study will be to explore the perceptions of Sub-Saharan African immigrant parents concerning sexual shame and parents' attitudes, knowledge, and comfort level in having a conversation with their adolescent children concerning sexuality and sexual practices.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

- A 60-90 minute interview that will be recorded for accuracy.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include counselors will have new information needed to address the cultural barriers of Sub-Saharan African immigrant families concerning sexual shame, enabling parents to instigate a discussion on sexuality. Also, the findings from this study could provide recommendations that counselors could use to help promote healthy conversations about sexuality between immigrant parents and their adolescent children.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of codes. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Interviews will be recorded and transcribed. Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

What are the costs to you to be part of the study?

There will be no cost to the participants.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Kwame Frimpong. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted] You may also contact the researcher's faculty sponsor, Dr. John Thomas, at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date