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Caring Adults: A Brief Report Assessing Adults' Needs in Feeling More Comfortable Having Sexual Health Conversations with Youth in South Texas

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ABSTRACT

Objectives: As part of a larger Substance Abuse and Mental Health Services Administration-funded project in South Texas, this study sought to understand adults' needs with regard to engaging in sexual health conversations with youth and young adults.
Methods: A total of 223 participants were surveyed to assess comfort engaging in sexual health conversations. Data were analyzed using thematic coding. Stigma surrounding sexual health conversations underlined all themes.
Results: Differences by gender and sexual orientation in the data were noted. Stigma around sexual health topics reduced participants' comfort.
Conclusions: To this end, interventions must go beyond psychosocial and educational programs and address societal factors that contribute to the stigma.

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Introduction

Across the Southern United States, poor sexual health outcomes among youth and young adults (YYA) continue to be worse than in other geographic regions of the United States (Hall et al., 2015; Kann et al., 2014). Like other southern states, rates of HIV and STI are higher in Texas among YYA (Reif et al., 2015). In addition, rates of unintended and unwanted pregnancy among YYA are higher in the Southern United States than the national average (Martin, Hamilton, Osterman & Driscoll, 2017). Contributing to these negative sexual health outcomes is the lack of comprehensive sexuality education in schools (Santelli et al., 2017). The lack of formal, comprehensive sexual health education that YYA receive in school increases the need for parents, family, and other trusted adults to assume a more active role in children's sexuality education (Flores & Barroso, 2017; Thompson, Yannessa, Michael & McGough, 2015).

The positive impact of sexual health communication between adults and YYA is well-documented (Flores & Barroso, 2017; Thompson et al., 2015). Research shows that discussions about sex between YYA and their families result in increased risk-reduction behaviors such as condom use (Thompson et al., 2015; Widman, Choukas-Bradley, Noar, Nesi, & Garrett, 2016). In addition, YYA who engaged in sexual health conversations (SHC) with their parents reported greater ease engaging in SHC with sexual partners, were less likely to be sexually active, and had a later sexual debut (Sutton, Lasswell, Lanier & Miller, 2014; Thompson et al., 2015; Widman et al., 2016). One study established that trusted adults who engage in SHC have the same benefit as parents (Guzman et al., 2003), suggesting that SHC with a trusted adult may be beneficial and

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provide an alternative when parents are unwilling or uncomfortable having this conversations.

Although SHC between parents or other trusted adults and children are beneficial, these conversations often happen only once, and both adults and YYA report that initiating such conversations is uncomfortable (Aronowitz & Agbeshie, 2012; Cornelius, Cornelius, & White, 2013). Although a recent study found that 62% of parents reported being very comfortable discussing sex or sexual intercourse and 59% were very comfortable talking about condoms and birth control (Braun-Harvey & Vigorito, 2015), a substantial number were still not comfortable. Further, the existing research on comfort related to SHC is primarily focused on discussions of sexual behavior and prevention of disease and pregnancy as opposed to a more holistic vision that includes all six principles of sexual health: consent, nonexploitation, honesty, protection, shared values, and sexual pleasure (Braun-Harvey & Vigorito, 2015). This limits our understanding of comfort engaging in more holistic SHC among both parents and other trusted adults.

Methods

All study protocols were approved by the institutional review board at the lead author's institution. As part of a larger community-based project focused on increasing community capacity, this project applied the principles of community-based participatory research (CBPR) from study conceptualization to dissemination of findings. CBPR is a framework that includes community members as equitable partners in the research process and based on nine principles (Israel, Schulz, Parker & Becker, 1998). Table 1 provides

Table 1. Community-Based Participatory Research (CBPR) Principles Used in Caring Adults Study and Examples of Their Application.

Research phase	CBPR principle	Application of principles
Research question development	CBPR facilitates collaborative, equitable partnerships in phases of the research	1. UNIFY Staff/Leadership participated in literature review 2. UNIFY Staff/Leadership assisted with question development 3. UNIFY community advisory board (CAB) assisted with question development
	CBPR facilitates and achieves a balance between research and action for the mutual benefit of all partners	1. Questions developed that both advance science and are relevant to support community and programmatic needs 2. UNIFY owns the data collected for use in intervention development
Study design	CBPR recognizes community as a unit of identity	1. Measures created in full collaboration with UNIFY Staff/Leadership 2. All measures reviewed and approved by UNIFY CAB 3. Recruitment venues identified by UNIFY staff/leadership 4. Recruitment venues identified by UNIFY CAB
	CBPR builds on strengths and resources in the community	1. Additional community members and organizations identified to facilitate the research 2. Data collection instrument is sensitive to the social and cultural factors of San Antonio
Participant recruitment and data collection	CBPR facilitates collaborative, equitable, partnerships in all phases of the research	1. UNIFY staff, working with university research assistants, led study recruitment
	CBPR builds on the strength and resources with the community	1. Community partners involved in the data collection process
Data analysis	CBPR promotes co-learning and capacity building among all partners	1. UNIFY staff/leadership participated in data analysis and interpretation
	CBPR emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease	1. Analysis guided by an ecological perspective to address downstream, interpersonal, and individual needs.
Dissemination	CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners	1. Data used for developing a UNIFY sexual health intervention 2. Findings intended for use in developing grants to support future projects with UNIFY
	CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process	1. Engaging UNIFY staff leadership in writing and review of manuscripts.

information on how each of the CPBR principles informed this study.

Using a mixed-methods study design (Johnson & Onwuegbuzie, 2004), we collected both qualitative and quantitative data through the use of an online and paper-based survey. The survey contained items assessing participant demographics, comfort discussing specific sex-related topics, as well as an open-ended question, "What can we do to make you more comfortable when discussing these topics?"

This study was conducted in collaboration with UNIFY—a sexual health education and HIV testing for youth and young adults funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Participants were recruited online as well as during UNIFY outreach events. Online recruitment messages were disseminated through social media outlets and relevant websites. Participants completing the online version of the site were taken to a study information sheet providing details of the study and their rights as participants. After reviewing the study information sheet, respondents were asked to indicate whether they wanted to participate in the study by clicking on "yes" or "no." Those completing the paper version of the study were given a print copy of the study information sheet and asked verbally if they wanted to participate in the study. To participate, respondents had to be at least 18 years old, a current resident of Bexar County, Texas, and indicate they had YYA in their lives who have, or could, ask them questions about sex.

Responses were recorded and stored using Qualtrics—an online survey platform (Qualtrics, 2017). Paper-and-pencil surveys were entered into Qualtrics prior to downloading the data for analysis. Quantitative data were analyzed using SPSS version 24.0 (IBM, 2017). Qualitative data were downloaded into an excel file, analyzed, and then binary variables (0 = did not indicate theme; 1 = indicated theme) related to each theme were created in a SPSS file for analysis.

Qualitative data were analyzed first using a semantic thematic analysis approach (Boyatzis, 1998). After multiple reviews of the data, Phillip W. Schnarrs conducted the initial coding and developed a code guide. Two other members of the study team then independently coded the data. The three coders then met to discuss and refine the codes and organize these codes into broader themes. When there were disagreements on how data points should be coded, these differences were discussed until agreement was met about how data should be coded. These qualitative themes were transformed into quantitative variables and entered into the dataset. Following guidelines described in previous research (Baldwin et al., 2017; Creswell, Plano-Clark, Gutmann, & Hanson, 2003; Creswell & Clark, 2007), descriptive statistics were used to measure the frequency of each theme and chi-square tests were performed to identify the relationship between themes, gender, and sexual orientation of participants.

Results

A total of 223 individuals completed the survey. Two respondents were removed from analysis because they did not report their gender, a critical variable in our analyses. The majority of participants (89%) completed the online survey. Table 2 presents data on sample characteristics segmented by gender and sexual orientation.

Topics of sexual health conversations

Table 3 contains data on topics of SHC that participants felt comfortable discussing. A significant relationship was found between gender and the topics of sexting/online sexual behavior, $\chi^2(2, N = 221) = 4.41$, $p = .036$, with women, more frequently than men, wanting to be more comfortable discussing these topics. Women also reported wanting to be more comfortable discussing what sex feels like compared to men and heterosexual participants, respectively, χ^2 $(2, N = 221) = 5.307$, $p = .021$, and lesbian, gay, bisexual, queer + (LGBQ+), χ^2 $(2, N = 221) = 6.510$, $p = .011$.

Increasing comfort engaging in sexual health conversations

Five themes are described below. Responses indicating "nothing" and "unsure" are not reported

Table 2. Sample Characteristics, Stratified by Gender and Sexual Orientation.

		Gender			Sexual orientation		
Item	Total sample ($n = 221$) %	Men ($n = 41$) %	Women ($n = 180$) %	$\chi^2(\phi)$	LGBQ+ ($n = 59$) %	Heterosexual/ straight ($n = 162$) %	χ^2 (ϕ)
Age, *M* (*SD*)**	38.15 (10.67)	39.26 (10.92)	37.95 (10.63)	0.713	36.31 (11.61)	38.88 (10.26)	−1.594
Gender				–			1.428 (0.080)
Man	19	–	–		24	17	
Woman	81	–	–		76	83	
Sexual orientation				1.428 (0.080)			–
Heterosexual/straight	73	66	75		–	–	
LGBQ+	27	34	25		–	–	
Hispanic/Latino ethnicity				0.001 (0.002)			2.943 (0.115)
Yes	42	42	58		32	45	
No	58	42	58		67	55	
Race				4.441 (0.142)			9.836 (0.211)
White	80	78	80		71	83	
Black/African American	6	10	5		9	5	
American Indian/Alaskan Native	1	2	1		2	1	
Asian/Pacific Islander/Native Hawaiian	2	0	3		2	3	
Multiple races	5	7	4		12	3	
Other	6	2	7		5	6	
Educational attainment				11.291* (0.226)			0.192 (0.029)
High school diploma/GED	9	15	8		9	9	
Community college or technical school	24	37	21		25	24	
Four year college	25	29	24		24	26	
Graduate/professional school	42	20	47		42	41	
Are you currently attending college?				0.254 (0.034)			4.002* (0.135)
Yes	20	17	21		29	17	
No, I do not currently attend college	80	83	79		71	83	
Employment status				4.689 (0.146)			0.813 (0.061)
Employed full-time (35+ hours/week)	66	78	63		63	67	
Employed part-time (<35 hours/week)	14	5	16		15	13	
Unemployed (full-time student)	5	2	6		7	4	
Unemployed (other reason)	16	15	16		15	16	

*Chi-square test ($p \leq .05$). **t-test.

Table 3. What Topics About Sex and Sexuality Participants Wish They Were More Comfortable Discussing With Youth and Young Adults, Stratified by Gender and Sexual Orientation.

		Gender			Sexual orientation		
Item	Total sample ($n = 221$) %	Men ($n = 41$) %	Women ($n = 180$) %	χ^2 (ϕ)	LGBQ+ ($n = 61$) %	Heterosexual/ Straight ($n = 162$) %	χ^2 (ϕ)
How to have honest conversations about sex	43	51	42	1.240 (0.075)	53	49	2.715 (0.111)
How to avoid being pressured to have sex	43	37	45	0.962 (0.066)	46	43	0.177 (0.028)
That sex is not like porn	41	46	40	0.457 (0.554)	42	41	0.048 (0.015)
Peer pressure and sex	39	44	37	0.630 (0.053)	41	38	0.167 (0.027)
How to say no to sex	39	32	41	1.237 (0.075)	39	40	0.005 (0.005)
How to respect the sexual decisions of others	37	37	37	0.006 (0.005)	39	36	0.122 (0.023)
Masturbation	36	24	39	3.039 (0.117)	42	34	1.328 (0.078)
How to avoid STI/Hepatitis C/HIV	35	34	37	0.795 (0.017)	34	35	0.032 (0.012)
Sexting/online sexual behavior	34	20	37	4.412* (0.141)	36	33	0.161 (0.027)
Where to go if they were sexually assaulted	34	34	34	0.001 (0.002)	37	33	0.300 (0.037)
Sex is not like in the movies	32	37	31	0.459 (0.046)	42	41	0.116 (0.023)
Drug use and sex	32	32	32	0.004 (0.004)	29	33	0.405 (0.043)
That sex is okay	31	44	28	3.769 (0.131)	41	28	3.352 (0.123)
Telling their sexual partners what they like	30	22	32	1.505 (0.083)	39	27	3.195 (0.120)
How to prevent pregnancy	30	34	29	0.349 (0.40)	31	30	0.001 (0.003)
Not everyone is heterosexual	25	29	24	0.411 (0.043)	25	25	0 (0.001)
What sex feels like	24	10	27	5.307* (0.155)	36	19	6.510* (0.172)
What being in love feels like	24	32	22	1.871 (0.092)	32	20	3.366 (0.123)
Body parts related to sex	24	30	25	0.552 (0.050)	22	25	0.168 (0.028)
How sex is pleasurable	22	20	23	0.206 (0.031)	23	20	0.157 (0.027)
Sexual secrets about our family	17	7	19	3.449 (0.125)	24	15	2.414 (0.105)
Other	8	5	8	0.561 (0.50)	7	8	0.094 (0.021)

*Chi-square test ($p \leq .05$).

below given the lack of context available to interpret meaning behind these responses. Tables 4 and 5 provide information on themes.

Providing education and access to resources

Over one-third (33%) of participants described needing education and/or resources. Participants described needing not only better general information, but information on specific sexual health topics, including age-appropriate content and language, to feel comfortable engaging in SHC. For example, one heterosexual woman described needing, "resources to read about how to approach these topics and what to say [and] when to say it to get through to kids at various age levels."

Help reducing feelings of awkwardness and embarrassment

Overall, 26% of respondents provided descriptions focused on reducing, in their words, the "awkwardness" of discussing sex-related topics with YYA. Respondents identified feeling embarrassed when discussing certain subjects as one sexual minority woman reported, "the areas around 'sex feels good and this is what it can feel like' feel more embarrassing to me than the others." Respondents not only referred to their own embarrassment regarding talking about sex but indicated those they were speaking with might feel the same as well. For example, one heterosexual man expressed concern about, "having my daughter not be embarrassed by talking with me."

How and when to have sexual health conversations

Overall, 17% of participants' responses were associated with this theme, which concerned needs associated with how to begin having SHC, how to have SHC, and when to have SHC. This theme was comprised of three subthemes: initiating SHC, identifying and maintaining boundaries, and engaging in open/honest dialog.

Table 4. Frequency of Themes, Stratified by Gender and Sexual Orientation.

Theme	Total	Gender			Sexual orientation		
What can we do to make you more comfortable discussing sex-related topics with youth and young adults?	sample ($n = 125$) %	Men ($n = 28$) %	Women ($n = 97$) %	χ^2 (ϕ)	LGBQ+ ($n = 36$) %	Heterosexual/ Straight ($n = 89$) %	χ^2 (ϕ)
Already comfortable	16	21	14	0.832 (0.081)	13	17	0.300 (0.049)
How and when to have sexual health conversations	17	21	15	0.588 (0.068)	11	19	1.477 (0.108)
Help reducing feelings of awkwardness and embarrassment	23	7	28	5.119* (0.202)	29	21	1.080 (0.093)
Providing education and access resources	33	25	35	0.932 (0.334)	32	33	0.023 (0.013)
Addressing social stigma	18	14	19	0 (0.000)	18	18	0.057 (0.021)
Unsure	13	11	13	0.128 (0.032)	16	11	0.469 (0.061)
Nothing	4	7	3	0.952 (0.087)	5	3	0.239 (0.044)

*Chi-square test ($p \leq .05$).

Table 5. Analytic Themes Stratified by Gender-Identity and Sexual Orientation.

	Heterosexual		LGBQ+	
Themes	Man	Woman	Man	Woman
Already comfortable	"I am completely comfortable talking about all aspects of sex."	"I feel very comfortable talking about these topics freely with my children."	"I am comfortable."	"Nothing, I'm very comfortable."
How and when to have shc	–	"Something to open up/begin the conversation."	"Ways to be able to communicate the ideas and conversations intelligibly."	"A conversation starter or how to know when a good time comes to talk about it."
Reduce embarrassment/ awkwardness	"More openess"	"Having my daughter not be embarrassed by talking with me."	"Having open dialog."	"The areas around "sex feels good and this is what it can feel like" feel more embarrassing to me than the others."
Provide education/resources	"Group"	"Diagrams, a book, a guide with discussion questions, a peer group with an educator as a moderator to ensure my peers (or I) don't unintentionally share misinformation."	"Just more information in general. Where to get said info."	"more knowledge, books on talking to young people."
Address social stigma	"Less judgement/hypocrisy"	"Getting more up to date information. I used to have access to informational workshops etc. … in NYC. Sex seems to be a bit taboo to really talk about here."	"knowing that stigma doesn't rest in their heads."	"Not feeling like these topics were so taboo. Social expectations to not discuss them openly,"

Help initiating sexual health conversations

Respondents described uncertainty around how to begin SHC, and they indicated a need for strategies that would assist them in beginning these conversations. For example, one lesbian woman said "I don't know where to start." Similarly, a heterosexual woman indicated needing, "something to open up [or] begin conversations," to feel comfortable having SCH with YYA.

Help identifying and maintaining boundaries

Participants reported that guidance on maintaining boundaries was also an area that could improve their comfort engaging in SHC as some were concerned about being too open. For example, as one heterosexual woman explained, "I have fears of being misinterpreted, concerns about professional or personal boundaries, and discomfort with sharing some aspects of positive sexuality, so negotiating those things would make me feel more comfortable."

Help with engaging in open and honest communication

Participants also indicated they needed openness from youth and young people in order to feel comfortable having these conversations, as a heterosexual woman indicated, "willingness to have an honest dialogue," or as sexual minority woman stated, "better open communication." This need for honest dialog was not only focused at the interpersonal level, but also broadly at institutions and society, as participants wanted "more open dialogue in mainstream reality [and] in schools" (heterosexual woman).

Already comfortable

Finally, 16% of participants reported they were already comfortable talking about sex with YYA. For example, a heterosexual man reported, "I am completely comfortable talking about all aspects of sex" and another heterosexual man indicated, "I'm comfortable conversing about any and all topics related to sex with young people." This shows some adults are comfortable talking about all topics related to sex. Others specified that while comfortable with a range of sexual-related

topics, their comfort was related to discussing with family, "I feel very comfortable talking about these topics freely with my children" (LGBTQ + man).

Addressing social stigma (in Texas)

Participants (14%) also identified the need to address social stigma surrounding sex and SHC, specifically related to South Texas culture. Social stigma was described by participants using words like "taboo" and "judgement." For one heterosexual woman, this stigma was related to the norms of South Texas, "Getting more up to date information. I used to have access to informational workshops etc. … in NYC. Sex seems to be a bit taboo to really talk about here." Social stigma was also discussed in terms of the reactions of other adults as indicated by a sexual minority woman:

> If it were less taboo to talk about it amongst adults. I feel I want to teach my kids about their sexuality and safety but I'm afraid if they share that information with their friends, other adults may shun them or restrict their kids from playing with mine. This happened to me as a child.

Discussion

These data were collected as part of a needs assessment in collaboration with UNIFY, a community-based, youth-focused sexual health program tasked with reducing HIV and HCV and improving all areas of sexual health among youth in San Antonio. To improve sexual health in San Antonio, one of UNIFY's goals is to improve SHC between adults and young people by increasing adults' knowledge about the principles of sexual health and normalizing SHC throughout the broader community. To improve SHC, we first needed to identify what factors were contributing to comfort and discomfort with engaging in SHC with YAA and potential strategies to improve comfort from the perspective of adults.

This study adds to the existing literature by documenting comfort levels specific to SHC content related to all six principles of sexual health (Braun-Harvey & Vigorito, 2015). Wanting to be more comfortable discussing HIV/STI and pregnancy did not rank highest among the list provided, though this is largely the focus of existing research. Items related to the principles of sexual health of nonexploitation, consent, and honesty were most frequently described. This suggests that sexual health interventions aimed at increasing comfort with SHC need to expand their focus beyond HIV/STI and pregnancy prevention. A holistic understanding of sexual health holds that all of these principles are important including sexual pleasure. Less than a quarter (22%) of respondents indicated needing to be more comfortable discussing the pleasurable aspects of sex. This could be attributed to a simplistic concept of "sex feels good" and being comfortable with that messaging, rather than the holistic understanding that includes pleasure and ways to increase pleasure as important components of sexual health. This finding suggests a need for more research about adults' conceptualization of pleasure and how it could and should be incorporated into SHC with YYA.

Overall, LGBTQ + individuals were similar to self-identified heterosexuals in their responses and only with regard to comfort discussing what sex feels like. This discomfort with engaging in SHC about what sex feels like may exist because of the lack of social scripts, role models, or resources sexual minorities had access to themselves (Robertson, 2014). As differences in sexual experiences across sexual orientations is often highlighted, the lack of difference related to SHC conversations and specific topics within those conversations was an interesting finding. It is possible that overall stigma surrounding SHC envelopes all individuals regardless of sexual orientation.

There were significant differences between women and men, with women desiring to be more comfortable discussing what sex feels like and sexting/online sexual behavior. Given that women are often the adults who engage in SHC with YYA, further research should explore underpinnings for these gender differences. Comfort related to what sex feels like could be related to traditional gender norms and stigma surrounding discussions of sexuality for women (Armstrong, Hamilton, Armstrong, & Seeley, 2014). Comfort discussing sexting/online sexual behavior could

be related to gender roles and initiation of sexual contact and communication with partners was deemed not appropriate for women in previous generations (i.e., generation X, baby boomers) and similarly, these generations would not have used sexting/online sexual behavior with their sexual partners as youth. Education should be provided to adults about sexting/online options, its potential consequences, and why YYA engage in this behavior.

Previous research (Thompson et al., 2015) suggests that youth often seek out "adult friends" when they have questions about sex. Coupled with our findings, this suggests a need to begin thinking more broadly about who should be prepared to have SHC with YYA and decrease stigma and fear about having SHC with all YYA—not just one's own children. Participants were interested in reducing embarrassment and awkwardness involved in SHC. Given the centrality of stigma in preventing these conversations, we believe that future interventions would benefit from implementing multilevel strategies. First, individual-level education about sexual health for both adults and YYA should involve practice discussions, so both YYA and adults become more comfortable with these topics. A second macrolevel approach is addressing upstream factors that contribute to the stigma surrounding sexual health. Further, this theme—making it easier to talk about sex—was the only one with significant gender differences. Compared to men, women more often indicated needing assistance reducing embarrassment and awkwardness when engaging in SHC. This finding suggests that individuals have different needs regarding comfort based on their gender. Given the norms surrounding women's sexuality, it is likely that they have received less education and information about sex compared to men, but it is often women who become "de facto" sexual health educators (Flores & Barroso, 2017), which may partly explain the desire to make these conversations less embarrassing and awkward among women.

Participants also identified more concrete needs regarding SHC. Commensurate with previous research (Flores & Barroso, 2017; Santelli et al., 2017), our study found that respondents wanted help with initiating SHC. Participants wanted to know how and when to have these conversations. Specifically, they indicated difficulty with initiating SHC, which was also linked to stigma. Although adults need help identifying moments to engage in SHC and how to initiate, and sustain SHC with YAA, there is also a need to address broader stigma that prevents these conversations from occurring. It is imperative that sexual health interventions also target broader social systems and institutions to normalize SHC. Participants also identified the need for resources and education. There was overlap between the desire to initiate SHC and the need for resources. Participants identified several reasons for their hesitation to initiate conversations including lack of knowledge, needing assistance with setting appropriate boundaries, and how to discuss specific topics.

Although our study provides useful information about the needs of adults to become more comfortable engaging in SHC, it is not without limitations. Because these data come from a community-based project, we used a community sample. As such, data may be biased toward participants who are more comfortable discussing sex-related topics. In addition, the data is qualitative and descriptive in nature, so it may not be generalizable beyond the study area.

In conclusion, reducing stigma underscored all seven of the themes identified. Stigma was often linked to cultural norms and religious institutions specifically associated with South Texas. It is the "social expectation to not discuss [sexual health topics] openly" that continues to fuel poor sexual health outcomes in the region. This is not to say we should limit our focus on providing strategies, tools, and education to individuals to help them in engage in meaningful SHC. Rather, sexual health interventions, particularly in more conservative regions in the country, must include components that address stigma from a systems perspective. These interventions should not be solely focused on how stigma affects individuals but more broadly on how to address systemic stigma related to SHC.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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