

[African-American Fathers' Perspectives on Facilitators and Barriers to Father–Son Sexual Health Communication](#)

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Abstract:

African-American males ages 13 through 24 are disproportionately affected by sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), accounting for over half of all HIV infections in this age group in the United States. Clear communication between African-American parents and their youth about sexual health is associated with higher rates of sexual abstinence, condom use, and intent to delay initiation of sexual intercourse. However, little is known about African-American fathers' perceptions of what facilitates and inhibits sexual health communication with their preadolescent and adolescent sons. We conducted focus groups with 29 African-American fathers of sons ages 10–15 to explore perceived facilitators and barriers for father–son communication about sexual health. Participants were recruited from barbershops in metropolitan and rural North Carolina communities highly affected by STIs and HIV, and data were analyzed using content analysis. Three factors facilitated father–son communication: (a) fathers' acceptance of their roles and responsibilities; (b) a positive father–son relationship; and (c) fathers' ability to speak directly to their sons about sex. We also identified three barriers: (a) fathers' difficulty in initiating sexual health discussions with their sons; (b) sons' developmental readiness for sexual health information; and (c) fathers' lack of experience in talking with their own fathers about sex. These findings have implications for father-focused prevention interventions aimed at reducing risky sexual behaviors in adolescent African-American males.

Keywords: adolescence | fathering | infectious diseases | HIV | sexual health communication

Article:

When compared to other races, African-American males ages 13 through 24 are disproportionately affected by sexually transmitted infections. They account for over half of human immunodeficiency virus (HIV) infections among all youth in the United States (Centers for Disease Control and Prevention [CDC], 2014; Satterwhite et al., 2013). Sexual risk behavior

is higher among Black young men than their counterparts: African-Americans public high school students engaged in more at-risk sexual behaviors than White students over time (Fergus, Zimmerman, & Caldwell, 2007), and young African-American males had a much higher likelihood than young White males of having sexual intercourse for the first time before they were 13 years old (13.9% vs. 3.9%) and of having had intercourse with four or more persons during their lifetimes (24.8% vs. 13.1%; CDC YRBS, 2012). Due to this disparity, attention on African-American male preadolescents and adolescents is essential.

Parent–youth sexual health communication has been found effective in addressing this disparity. Sons who talk to their fathers about sexual health have higher rates of sexual abstinence, condom use, and the intent to delay initiation of sexual intercourse (Akers, Schwarz, Borrero, & Corbie-Smith, 2010; Coley, Votruba-Drzal, & Schindler, 2009; Dilorio, McCarty, Resnicow, Lehr, & Denzmore, 2007; Guilamo-Ramos et al., 2012; Harris, Sutherland, & Hutchinson, 2013). Nonetheless, most research to date on sexual health communication has focused on parent–daughter communication and on mothers as sexual health educators, and studies that included African-American fathers have had a broader focus. For example, Wilson, Dalberth, and Koo (2010) conducted 16 focus group discussions with parents of children 10–12 to explore fathers' views of their roles in protecting their preteen age youth from sexual risk and their role in promoting youth's healthy sexual development, but only two groups were of only African-American fathers. Although fathers have an effect on sexual debut and condom use of their adolescents, further exploration of African-American fathers' influence on sexual health communication and behavior is needed (Burns & Caldwell, 2016; Glenn, Demi, & Kimble, 2008; Julion, Gross, Barclay-McLaughlin, & Fogg, 2007; Wilson et al., 2010). Having an understanding of why fathers may or may not discuss sexual health issues with their sons could lead to future socially and culturally congruent interventions aimed at supporting African-American fathers to be effective sexual health educators.

Facilitators and Barriers of Parent–Youth Sexual Health Communication

Parent–adolescent closeness or connectedness is a facilitator of sexual health communication (Caldwell, Rafferty, Reischl, DeLoney, & Brooks, 2010; Doyle et al., 2015). Harris et al. (2013) found that parent–child closeness, defined as the bond a father has with his son, was positively correlated with amount of parent–child sexual communication with both mothers and fathers and with higher condom use self-efficacy, less permissive sexual attitudes, fewer sexual partners, and fewer incidents of unprotected sex (Harris et al., 2013). Burns and Caldwell (2016) also reported a positive correlation between father involvement and closeness of nonresidential fathers (fathers who do not live in the home with their sons, but remain active in their lives) and sexual health communication with their adolescent sons.

Another facilitator of sexual health communication is having the necessary resources to talk about sex (O'Donnell et al., 2005; Pluhar, Jennings, & DiIorio, 2006; Weekes, Haas, & Gosselin, 2014). For example, in an intervention with African-American parents (21 fathers and 37 mothers), those who received resources (CD, printed material) and structured role playing had higher self-efficacy in a conversation with their sons about sex (Weekes et al., 2014).

Barriers to parent–child sexual health communication for fathers include being uncomfortable talking with their children about sex (Jerman & Constantine, 2010; Odum, Smith, & McKeyer, 2014; Ohalete, Georges, & Doswell, 2010). Wilson et al. (2010) found that both mothers and fathers reported feeling uncomfortable or embarrassed to talk with their youth about sex. Fathers expressed wanting to talk with their youth but found it difficult to do so. Some fathers reported that they were more permissive with their sons than their daughters and less likely to encourage their sons to delay having sex. They were also less likely to discuss issues of values and emotions related to sexuality with their sons.

Another barrier is communication of information that is not age-appropriate. For example, when Ohalete et al. (2010) interviewed 19 African-American fathers on the content and timing of sexual health communication, the values fathers intended to impart on youth and their comfort level in communicating about sex, they found as did others (Dilorio et al., 2007; DiIorio et al., 2006; Odum et al., 2014), that fathers had conversations that were inappropriate for the youth's developmental age.

Although the roles of fathers are increasingly being explored in sexual health communication research, there is a need to further investigate facilitators and barriers for African-American fathers. Thus, the purpose of this study was to explore the facilitators and barriers that African-American fathers perceive in communication about sexual health with their pre-adolescent and adolescent sons.

Methods

Design

In this qualitative study, five focus groups were conducted to elicit fathers' perspectives on what promotes and inhibits them from talking to their sons about risky sexual behaviors, and fathers' experiences of conversations with their sons about risky sexual behaviors. Data were collected in May and June 2015 after institutional review board approval.

Sample and Setting

A purposive sampling strategy and word of mouth were used. Inclusion criteria were fathers who (a) self-identified as African American or Black; (b) were biological, step, or adoptive father; and (c) had a son between 10 and 15 years old. This age group was chosen because preadolescence is the best time to communicate about sex, before children become sexually active (Guilamo-Ramos et al., 2007; Jaccard & Levitz, 2013; Wyckoff et al., 2008).

Fathers were recruited from barbershops in metropolitan and rural NC communities. Barbershops are considered to be a trusted place where in addition to receiving haircuts and grooming, African-American men gather to engage in conversation about entertainment, and various health, political, and social issues (Linnan, D'Angelo, & Harrington, 2014). Of 10 barbershops willing to participate, five were selected as possible focus group sites on the basis of adequate space and scheduling availability. A reserved, closed space was important to ensure privacy. Three groups met in a barbershop, one group met at a library, and another met in the conference room of a

local university. Although the settings for sessions varied, the trust built at the barbershops enhanced the men's candor in the groups.

Barbers assisted with recruitment by distributing the study flyers to their African-American clients. The prospective participants either called the project team using the contact information from the flyers or contacted their barbershops to communicate interest in participation. Forty-nine eligible fathers verbally agreed to participate, and each was given a focus group date, time, and location. However, 20 fathers did not keep the appointments. The sample consisted of 29 African-American men who were biological fathers of boys ages 10–15. A majority of the fathers (62%) resided in homes with their sons (Table 1).

Table 1. Characteristics of African-American Fathers Who Participated in Focus Groups (N = 29)

Characteristic	%
Biological father	100.0
Live with son(s)	
Yes	61.1
No	37.9
Age	
20–29	3.5
30–39	34.6
40–49	61.9
Education	
<High school	3.5
High school diploma	41.4
2-year college degree	17.2
4-year college degree	27.6
Graduate degree	10.3
Marital status	
Single	24.1
Married	69.0
Divorced	6.9

Group Facilitators

Two African-American male graduate research assistants facilitated the focus groups. They were selected based on Coard, Foy-Watson, Zimmer, and Wallace's (2007) guidelines for selecting a group facilitator. The African-American female principal investigator (PI) had intended to facilitate the focus group session, along with the two RAs, but it was evident that the participants did not feel comfortable having a female present, based on their body language and silence. These gender effects were congruent with previous studies (Agula, Barrett & Tobi, 2015; Wilson, Brown, Mejia, & Lavoria, 2002).

Data Collection

In each group, five or six fathers participated. Sessions averaged 2 hours in length and were audio-recorded. The focus groups were designed to elicit fathers' perspectives on the facilitators and barriers of sexual health communication with their sons. Focus groups can reduce participants' anxiety by providing a comfortable setting for discussion. Participants become familiar with the environment and feel a connection to the other focus group members (Krueger, 2000). Fathers might be more likely to participate in a group setting where they would have the support of other men instead of a one-on-one interview, where support and interaction with other fathers would not exist.

Interview items were developed based on important factors concerning father–son communication about sex as gleaned from the literature. Items were refined using input from a trial-run focus group of African-American fathers of middle-school boys. Incorporating the fathers' input prior to using the items in the focus groups allowed investigators to design a relevant interview guide for African-American fathers. A semi-structured focus group interview guide (Table 2) was designed by the first three authors to obtain information regarding facilitators and barriers to father–son sexual health communication and included questions such as: “When do you talk to your son about sex?” “How do your own personal experiences impact your communication with your son(s) about sex?” and “Tell us of a time when you talked to your son about sex, and what led to this conversation.”

Table 2. Focus Group Interview Guide

<ol style="list-style-type: none">1. When do you talk to your son about sex?2. What topics do you discuss?3. What are some things that promote or inhibit you from talking to your son about sex?4. Tell us of a time when you talked to your son about sex and what led to this conversation. What was the response of your son when talking to him; how did your son receive the communication?5. How do your past interactions with your father impact your role now as a father and your ability to communicate with your son(s) about sex?6. How do your own personal experiences impact your communication with your son(s) about sex?7. How do your morals, values, and beliefs impact your communication with your son(s)?8. How does culture (pop/mainstream or African American culture) inhibit or promote constructive conversations about sex?9. Do you use any specific resources (websites, literature, handouts) to assist you in communicating with your son(s) about sex? What resources do you think will be useful in talking with your son(s) about risky sexual behaviors (e.g., multiple sex partners, sex without a condom)?10. What goals do you have for your son(s); what do you want their sexual behaviors and views about sex to look like?
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To encourage truthfulness, participants were assured that their identities would not be revealed, conversations would be confidential, and they could speak without risk of judgment. Throughout the focus group sessions, the first facilitator probed for examples and experiences, summarized

initial interpretations and confirmed with participants to allow for clarification of the findings. The second facilitator took notes during the session. Following the focus group session, participants received a \$50 gift card as an incentive.

Immediately following the focus groups, the PI and moderator met to debrief and discuss group characteristics, group interactions, what went well or not, and potential improvements for future focus groups. A professional company transcribed the recordings verbatim, and two members of the study team reviewed them for accuracy.

Data Analysis

A qualitative content analysis of the interview transcripts and field notes was conducted by the first and second authors. Each transcript was initially read multiple times in order to become familiar with each group's distinctive features. Then, chunks of data were aggregated into first-level codes that shared a central meaning. During this stage, inductive coding was used, in which in vivo codes were derived from participants' own words. From this breaking up and breaking down of the data, codes were organized into categories. These emergent categories referred to obvious or visible descriptions (manifest content) while the themes generated next were linked to the underlying meanings of the categories (latent content) (Graneheim & Lundman, 2004).

Themes were formulated based on frequency, similarity of core concepts and marked differences between categories. The criteria used to help substantiate the trustworthiness of qualitative findings included credibility, or accurately describing and interpreting participants' accounts, variability of participants' accounts, neutrality/unbiased methods, and generalizability of findings (Krefting, 1991; Krueger, 2000; Sandelowski, 1986). The resulting collection of themes was conceptualized as complete, but we caution against generalizing these results beyond a specific segment of African-American fathers who possess socio-demographic characteristics similar to our sample.

Results

Three themes of facilitators and three themes of barriers to father–son communication were identified. Facilitators included father's acceptance of his role and responsibility in their sons' sexual health education, a positive father–son relationship, and the fathers' perceived ability to speak honestly and openly with their sons about sex. Barriers to communication included difficulty initiating sexual health discussions with sons, sons' developmental readiness for sexual health information, and fathers' lack of experience in talking with their own fathers about sex.

Facilitators

Acceptance of fatherhood roles and responsibilities

The majority of fathers saw their role in sexual health communication as being a provider, supporter, and involved and responsible for their son's sexual health. Although fathers agreed that mothers played a significant role in their sons' health, they believed there was a positive effect on the son if the father was present and engaged in his life. Fathers said that they were responsible for providing structure and guidance to their sons. Additionally, fathers said they

needed to be good listeners and trustworthy when it came to talking with their sons about sexual health. One father stated, “I feel a father should be in the child's life to provide some structure, some guidance.”

The role of the father was also described as “someone to show him [the son] how to be a man, put that man in him. I'm not saying women can't raise a man, but it ain't nothing like their father being there.” Although majority of fathers perceived their roles as important in sexual health, a few fathers acknowledged difficulties and challenges in carrying out this responsibility; this was mainly because of problems in their relationship with their son's mother and not being in the home full-time.

Building a positive father–son relationship

All fathers reported that fathers and sons who had a closer relationship had more effective communication. Relationship meant understanding the son's attitude and temperament. Fathers engaged with their sons in sports and other extracurricular activities that offered opportunities to understand their children's personalities and to discuss life lessons and daily living:

Well, if you don't know your child's personality type, their temperament, then you're going to have a one size fits all mentality. If you don't know what yours is, then you're not going to even know how you affect your children.

This relationship-building was essential to being able to discuss sensitive topics such as sex. Without a father–son relationship, talking about heavy issues would be difficult. Fathers said they wanted their sons to be comfortable with them but still understand their authority and position in the relationship, as a father described:

But it's basically having that relationship, because you don't want them to think you're there with a ball and chain. But just being able to talk to them, but make sure you distinguish between a friend and your father. I'm your friend, but I'm your daddy.

Being straightforward in sexual health communication

Fathers perceived good communication with their sons as “keeping it real” and being “straightforward.” Fathers had a strong desire to be honest and open with their sons about sex and the consequences that come along with sexual intercourse. Fathers did not hesitate to inform sons of the chances of getting a girl pregnant and becoming a father before they were ready. The vast majority of fathers consistently, without hesitation, asked sons about condom use and informed them to “strap up” or “put a rubber on” if they might be sexually active. All fathers wanted their sons to be informed to make good decisions, and they wanted to play an essential role in providing sexual health education. One father stated:

I try to keep it real with him, talk to him like I would talk to anybody else. I try to keep him smart. I don't want him going into life blind, have people sugar coat stuff.

Barriers

Fathers' lack of sexual health communication experiences with their fathers

When they were growing up, fathers in our sample had varying degrees of involvement from their own fathers. Some had fathers in the home, some had fathers who were not present, and some had not known their fathers at all. Nevertheless, all had a desire to be better fathers and to have difficult conversations with their sons that they reportedly did not have with their own fathers. For example, one father said,

And my biggest hindrance is [when he says], “Did you do this with your dad?” And I keep trying to explain to him, “Dude, my father was gone before I was a latchkey kid in kindergarten. You need to understand that this is new to me. I don't have a handbook for this. So when I'm talking to you, I'm frustrated a lot. You think I'm mad, I'm upset. I'm not. I have the weight of the world on my shoulders out here.”

A father whose dad was present in the home when he was growing up shared his experience in talking with his dad about sex:

My dad was there. He was always busy working two jobs, going to college. But he always found time for us to talk. He kind of danced around it a little bit, and I felt like I needed to be more aggressive with the talk because of the time, the social media, and the generation.

Difficulty initiating sexual health discussions

Fathers reported they had difficulty initiating conversations with their sons. The majority wanted their sons to approach them about sex and initiate a conversation, but they did not believe that most sons would do this. One father expressed,

I wish it was easier. They're not going to bring it to us, I wish they would. It's like you're in the major leagues, and you hope somebody is going to throw you an underhand pitch. It's not going to happen.

Another stated,

It's hard, man. In most cases, to be honest, the boy is not going to come to you. They're not going to go to you for that. We have to be attentive. My son, he's more comfortable now talking about girls he's interested in ... But in terms of sex ... trying to approach it, I have to get it out of him.

Most fathers wished their sons would initiate sexual health conversations because the fathers lacked the skills and strategies for approaching their sons about these issues. Even so, fathers remained steadfast in their belief that it was their responsibility to have these conversations with their sons. One father said he feared not doing it right. “But I think sometimes, I guess for me, what would keep me from talking to my son about it is that I may not know the right approach for him.” However, a few fathers believed no father should fear talking to his son. Whether the son approached him or not, it was important to protect him from sexual risks. One father stated:

I don't think there should never be a road block between you and your kids when it comes to talking, because they're yours ... You sitting down and talking to them shouldn't be a

problem at all. You shouldn't be scared, afraid or nothing. You should hold nothing back, because guess what? If you don't teach them, somebody else is.

Sons' developmental readiness for sexual health information

Fathers agreed that their sons' developmental status was a good indicator of when to talk about sexual health issues. Still, there was some uncertainty about developmental stages and appropriate content. Fathers reported that age alone was not a good determinant of when their sons were ready to talk about sex, but they believed the earlier the conversation took place, the better. Fathers said a better indicator of the time to talk about sex was when sons would talk about girls or showed certain nonverbal behaviors when they were interested in a girl they saw in person or on television.

Fathers reported that there were two different sexual health conversations to have with sons. The first conversation was to discuss body parts and protecting your private parts, which occurred at toddler age. The second conversation, which began around age 9 or 10, was about having sex.

The majority of fathers saw consistency as important in their communication about sex, but some fathers questioned whether or not they had shared enough details about sexual health. None of the fathers reported using resources or information related to developmental needs of sons to guide sexual health conversations. One father stated: "Whether I go in enough, maybe not. Maybe not." If they said too little or too much, their sons might not return to them for further discussions. One father summed it up:

It's hard though, it's really hard to talk to your kids about the sex part. Not that I don't know about sex, not that I can't have a conversation, but sometimes your first time having that conversation with him determines whether there's a next time or if that was your last time. It's like playing double dutch [jump-rope]. You want to jump in at the right time with the right conversation and touch them the right way. So if you're not certain and sometimes you kind of fall back and say, "Okay, maybe neither one of us is ready to have that conversation with each other."

Discussion

As STIs and HIV continue to disproportionately affect young African-American males, there is a critical need to facilitate father-son communication as a protective factor against sexual health risks. Understanding why fathers may or may not discuss sexual health issues with their sons can inform future interventions aimed at supporting African-American fathers to be effective sexual health educators. Studies like this one of African-American fathers' perceptions of sexual health communication with their sons are vital in expanding the knowledge in this study area.

All fathers in this sample accepted their role to educate their sons about sex. As did those studied by Burns and Caldwell (2016), fathers in our study also pointed to the significance of a positive father-son relationship as essential to be able to discuss sensitive topics such as sex (Doyle et al., 2015; Harris et al., 2013) and promote effective sexual health communication. These fathers reported limited experience in talking about sexual health with their own fathers because their fathers were absent or did not take on the role to educate them about sexual health. Parents in

other studies (Odum et al., 2014; Wilson et al., 2010) also reported a lack of role models and that their parents did not talk to them about sex. African-American fathers' relationships with their sons are influential regardless of fathers' residential status. Although nonresidential fathers may have limitations in their involvement with their sons, they must be included in efforts to support African-American fathers as sexual health educators. The societal and cultural barriers that affect African-American men are similar whether the father resides in or outside the son's home.

Fathers in the present study wanted to talk more in-depth with their sons in order to protect them from sexual health risk, but lacked the knowledge and skills to talk about sex, although they were not uncomfortable talking with their sons about sex if the sons started the conversation or the opportunity was presented based on the son's behavior. Others also have found that fathers experienced discomfort when talking with their children about sex (Jerman & Constantine, 2010; Ohalete et al., 2010; Wilson et al., 2010). When the topic of sex did arise, they were able to be open, honest, and straightforward. They directly addressed condom use, valuing and respecting women, and how sex can cause emotional and long-term consequences for which sons might not be prepared. However, as reported by Wilson et al. (2010), fathers did find it difficult to initiate sexual health conversations and preferred that their sons approach them about sex.

Knowing at what age to talk about sex and age-appropriate content was another barrier to sexual health communication. Boys vary in their timeline for development, which can influence the degree of their risk-taking behaviors that lead to STIs and HIV (Glenn et al., 2008).

Conversations might differ, depending on the son's developmental stage socially, emotionally, and cognitively. Practitioners who work with African-American fathers must provide relevant knowledge to enhance fathers' confidence (self-efficacy) in sexual health communication with their sons. They can provide fathers with information about how to approach their sons in order to initiate and conduct sexual health talks based on developmental readiness.

Several fathers in our study did not provide developmentally appropriate content to their sons, based on the explicit language and terminology they reported using during conversations with their son about sex. Some also relied on the cues their sons offered, such as verbal and nonverbal responses to girls, as indicators of whether or not to talk to them about sex. If fathers miss those cues, they may miss opportunities to talk to sons. Previous researchers reported similar findings (Burns & Caldwell, 2016; Caldwell et al., 2010; Odum et al., 2014). Father-son interventions must extend beyond providing fathers with sexual health content to integrate developmentally appropriate content and strategies for communicating with sons about sex.

Future researchers should aim to build and sustain father-son relationships for both residential and non-residential fathers. An investigation focusing on closeness of father-son relationships, as well as how positive that relationship is, might give us greater understanding about the extent to which fathers can influence sons' sexual health outcomes. Practitioners could also benefit from education to better assist parents to know the best time to talk about sex, how the conversation should be initiated and approached, and what should be discussed at various ages and developmental stages, so that sons will be able to understand the content and be willing to listen and apply what is learned.

Researchers could also complement the current study by exploring sons' perspectives about the effectiveness of sexual health communication with their fathers (Guilamo-Ramos et al., 2012; Widman, Choukas-Bradley, Noar, Nesis, & Garrett, 2016). A dyadic approach to communication might illuminate factors and processes that guide the development of African-American boys (Caldwell et al., 2010; Leavell, Tamis-LeMonda, Ruble, Zosuls, & Cabrera, 2012). Additionally, future research should focus on teaching fathers strategies to approach their sons about sexual health issues. Empowering fathers to initiate sexual health conversations could lead to more consistent and sustainable sexual health communication between fathers and sons, thus having a greater impact on positive sexual health outcomes.

Limitations

This study has several limitations. Our sample reflected fathers who were predominantly married, resided in the home, educated, and from the southeast region of the United States. Therefore, findings may differ for fathers who do not share these sociodemographic characteristics. Additionally, the specific age of the fathers' sons could not be matched to the fathers' responses, therefore we were not able to report whether fathers' responses differed according to their sons' age.

Conclusion

African-American fathers had a desire to take the lead in educating their preadolescent and adolescent sons about sexual health risks. However, they needed strategies for approaching their sons and engaging in these conversations. Practitioners and researchers must understand the perspectives of African-American fathers in order to have a clearer picture of the nuances of communication between African-American fathers and their sons. The present findings can be applied in father-focused prevention interventions to support African American fathers and their pre-adolescent and adolescent sons.

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