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Family Discussions About Contraception and Family Planning: A Qualitative Exploration of Black Parent and Adolescent Perspectives

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Abstract

CONTEXT—Parent-adolescent communication is associated with increased adolescent contraceptive use. However, studies of this association are limited by their lack of examination of the communication process, reliance on cross-sectional designs and infrequent comparison of parent and adolescent perspectives. Examining communication in black families is particularly important, given the high pregnancy rate among black adolescents.

METHODS—Between December 2007 and March 2008, a total of 21 focus groups were conducted with 53 black families (68 parents and 57 adolescents) in Pennsylvania. Separate groups were held for males and females, and for parents and adolescents. The discussion guide explored family communication about sexual health topics, including contraception, family planning and abortion. Sessions were audio-recorded; data were transcribed and analyzed using a grounded theory approach to content analysis and the constant comparison method.

RESULTS—Five key themes emerged among both parents and adolescents. First, discussions about contraception were indirect and framed in terms of the need to avoid negative consequences of sex. Second, contraceptive knowledge was low. Third, parents more often reported helping male adolescents get condoms than helping females get contraceptives. Fourth, discussions emphasized planning for the future over contraception. Finally, negative attitudes toward abortion were prevalent.

CONCLUSIONS—Parent-adolescent communication interventions should improve contraceptive knowledge, help parents understand the harmful effects of gender biases in information dissemination, and provide mothers and fathers with communication skills tailored to enhance the role they play in their adolescents' sexual development.

Approximately 750,000 adolescents become pregnant in the United States each year,[1] and most of these pregnancies are unintended.[2] Consistent contraceptive use is the critical factor mediating adolescent pregnancy risk,[3] but multiple barriers prevent adolescents from using contraceptives; chief among these are lack of access to services and adolescents' concerns about parental attitudes toward contraceptive use.[4] However, parents do not only impede adolescents' contraceptive use; they also may exert a positive influence.[5,6] Thus, improving parent-adolescent communication about contraception and family planning is one way to encourage young people's consistent, effective use of contraceptives.

Several studies have documented a positive relationship between parent-adolescent communication and adolescent contraceptive use. Jaccard et al.[7] and Tucker[8] found that maternal communication about contraception was associated with increased use among adolescent males. Newcomer et al.[9] found that adolescent females whose mothers discussed contraception were twice as likely to use contraceptives as those whose mothers did not.

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Other work has shown that parent-adolescent communication is linked to adolescents' sexual behavior and capacity to negotiate sexual situations with partners. For example, DiClemente et al.[10] noted that family communication was positively associated with adolescent females' condom use and communication with partners about protection.

Previous studies assessing the association between parental communication and adolescent contraceptive use had several major limitations. First, most focused on mother-adolescent, particularly mother-daughter, communication. Few examined how communication with sons is related to male contraceptive use[7] or how parents of each gender discuss these issues with their children.[8] Second, most studies used cross-sectional questionnaire designs and therefore could not assess the causal nature of these associations. Third, questionnaire designs limit exploration of the broad processes by which parents teach their children about contraceptive use and adolescent pregnancy. Fourth, most existing studies used either parents or adolescents as informants, rather than collecting and comparing data from both to obtain a more robust picture of communication within families.

To develop effective parent education and communication skills-building programs, health care providers and sexual health educators need to understand how parents cultivate their children's contraceptive knowledge, attitudes and behaviors; the role fathers and mothers play in this process; and the challenges parents face. Despite the sizable literature on parent-adolescent communication, important questions have been inadequately explored, including when discussions begin; what factors spark conversations; the content of discussions; how discussions evolve over time; what affects children's receptivity to these discussions; how discussions affect adolescents' contraceptive behaviors; and how discussions with mothers differ, in content and effect, from those with fathers.

In this analysis, we explored some of these questions from the perspectives of black parents and adolescents of both genders. Understanding family communication about contraception and family planning among black adolescents is particularly important because this population initiates sex at an early age,[11] has one of the lowest rates of adolescent contraceptive use in the United States[11] and is disproportionately affected by adolescent pregnancy.[12]

METHODS

We used focus groups as our primary method of data collection. In contrast to individual interviews, focus groups allow one to gather data from a number of participants at the same time while encouraging information exchange and a continual assessment of group norms, values and attitudes. They rely on interactions among participants, who ask questions of each other, reflect on one another's comments, and consider and reconsider their understandings of specific situations and experiences. The interactive nature of the process is a critical feature of this approach, because it leads to greater insights regarding the origins of certain beliefs and opinions, and highlights commonalities and variations in participants' values and beliefs.

Eligibility and Recruitment

The study was conducted between December 2007 and March 2008 in Allegheny County, in western Pennsylvania. Participants were invited to attend one study session, during which they completed a self-administered questionnaire and then took part in a focus group. Families were eligible if they identified themselves as black and if at least one 15–17-year-old and one biological parent (or legal guardian) agreed to participate. We chose the 15–17-year age range because, according to national estimates, most adolescents have received sex education from their parents by this age.[13] We limited parental participants to biological

parents or legal guardians in accordance with a requirement of our institutional review board.

To recruit a diverse sample of black families, we used several strategies. We posted flyers in public libraries, community centers, social service organizations, and community- and university-based clinics. We advertised in city newspapers, in church newsletters and on Craigslist. We also recruited through a research registry operated by a local women's hospital and used snowball sampling.

Eligible families were mailed a consent packet. Parents provided written informed consent for themselves and their participating children. Adolescents provided written informed assent. Parents and adolescents received $50 and $25, respectively, for participating. The higher payment to parents was intended to compensate them for travel and additional child care costs. Families received an additional $25 if both parents participated; this added incentive was designed to encourage participation by fathers, a group traditionally hard to recruit for family health research,[14] The study was approved by the University of Pittsburgh's institutional review board.

Data

Study sessions were held at a local women's hospital. Before engaging in the focus groups, participants completed a questionnaire that assessed social and demographic characteristics, family communication (in general and with regard to sexuality-related issues) and, for adolescents, self-reported sexual history. The paper-and-pencil questionnaires took about 20 minutes to complete.

Focus groups had an average of six participants each (range, 3–12), lasted 1.5–2 hours and were audio-recorded. We pilot-tested our questionnaire and discussion guide in two mixed-gender focus groups, one for parents and one for adolescents, and then conducted 19 additional focus groups, which were specific to participant type (parents or adolescents) and gender. In all, members of 53 families participated—51 mothers, 17 fathers, 37 daughters and 20 sons. Four focus groups—one each for mothers, fathers, adolescent males and adolescent females—were scheduled to be held simultaneously on each of five dates; this approach allowed all members of a family to attend and participate at the same time. At the final study session, a mixed-gender adolescent group was held, because only one adolescent male showed up, and the adolescent females invited him to join their discussion.

Each discussion was facilitated by a moderator who was black and had had training in conducting qualitative interviews. A research assistant took detailed notes and operated the digital audio recorder. Research assistants received a one-hour training in qualitative note-taking tailored to the project.

Our discussion guide was informed by an integrative conceptual framework developed by a National Institutes of Health consensus panel comprising leading proponents of behavior change theories.[15] The framework identifies 10 factors as primary behavioral influences: skills, intentions, environmental barriers or facilitators, self-efficacy, perceived social norms, perceived benefits, consistency with personal standards, outcome expectations, knowledge and beliefs. The semistructured question guide explored these factors as they related to the process and content of family communication about sex. For example, a question about the process of communication was "When do you think parents should begin discussing sex with their children and why?" Questions about the content of communication included "Tell me some of the things you have talked with your children about" and "What have you talked only to your son or only to your daughter about?" Discussions about family communication about contraception and family planning arose naturally in all groups.

After each study session, moderators and the principal investigator met to discuss whether discussion guide revisions were needed and compared emergent themes to determine whether thematic saturation had been achieved. Thematic saturation appeared to have been achieved after the third day of focus groups. However, we conducted sessions on two additional days, for two reasons: to confirm that thematic saturation had been reached, and to obtain additional adolescent female focus group data, because as a result of technical errors, one of the groups had not been recorded. For the unrecorded session, we interviewed the moderator and note taker regarding the discussion content, and used the written notes from the focus group session as the primary sources of information. Interviews occurred three days after the focus group and were conducted separately to minimize recall bias.

Analysis

We calculated descriptive demographic statistics from the questionnaires. Focus group recordings were transcribed, and the data were entered into Atlas.Ti, version 5.2, a qualitative data management program. Because our goal was not to develop theory, we used a modification of the grounded theory approach,[16] along with the constant comparison method to identify emergent themes within and across focus groups. Coding involved three steps. First, two coders reviewed the text line by line to identify relevant themes. This open coding resulted in a list of words and phrases representing a broad array of family communication process and content characteristics. The two coders then met to perform axial coding, in which the broad list of initial themes is condensed into a code book that organizes themes into hierarchical categories. In the last step, the coders independently recoded each transcript using the code book, then met to review the coded transcripts and decide how to resolve discrepancies.

Although our analytic focus was on family discussions about contraception and family planning, we recognized that condoms were an important facet of these discussions, given that they are the only method that protects against pregnancy and STDs. Hence, we coded transcripts for all quotes related to condom use, to examine how they were discussed. Condoms were discussed extensively; however, most of these discussions focused on STD prevention, not birth control or protection against both STDs and pregnancy. We restricted our analysis to discussions about condom use for contraception, whether alone or along with STD prevention.

We compared emergent themes across genders, between parents and adolescents, and among all four participant types. The content of discussions regarding contraception in the mixed- and single-gender focus groups was similar, and thus data from all 21 focus groups are reported here. Reported themes arose consistently across all groups and participant types, unless otherwise noted.

RESULTS

Most participating adolescents (65%) and parents (75%) were female. The mean age was 41 among parents and 16 among adolescents. Fifty-one percent of parents were married; 7% had less than a high school education, 22% had completed high school or had a GED, and 71% had postsecondary education. Sixty percent of parents worked full- or part-time, 16% were unemployed, and 9% had a disability that prevented them from working or were retired; 15% wrote in another answer or did not respond. By comparison, an average of 25% of black county residents aged 15 and older were married, 31% of those who were older than 25 had a postsecondary education and 8% of those older than 16 were unemployed.[17] Half (46%) of adolescents reported having had sex; 2% of adolescent females reported a prior pregnancy. Male adolescents were more likely than females to have had sex (70% vs. 25%).

Qualitative Findings

Five major themes emerged. First, discussions about contraception often are indirect and are framed in terms of the need to avoid negative consequences of sexual activity, such as adolescent pregnancy or STDs. Second, knowledge of available contraceptive options is low. Third, the degree to which parents help their adolescents get contraceptive services varies for sons and daughters. Fourth, family discussions about the importance of adolescents' planning for the future, including planning when and with whom to raise a family, occur more frequently than discussions about contraception. Finally, highly negative attitudes toward abortion were common; parents expressed a perceived obligation to help their adolescents raise a child, should an unintended pregnancy occur.

Communication styles—Parents and adolescents both considered birth control one of the most important sexual health topics for families to discuss. Contraception was usually the first topic parents—particularly mothers—cited when asked to list the sexual health topics they had discussed with their children. When asked to describe the content of these conversations, many parents reported discussing the importance of "avoiding the consequences" of sexual activity without explicitly talking about contraception. One father explained:

"I [told my child,] 'You want to set a goal and go down by the right road so you can eventually get to your goal. And if your goal is some sort of career, you want to get to that goal. The things that will take you off of that path [include] unplanned pregnancy, because all of a sudden you have a life you are responsible to take care of. But there are ways to avoid that.' I didn't get into birth control or anything."

Adolescents corroborated that most parents did not address the issue of contraception directly. They reported that parents discussed the importance of adolescents' avoiding the "consequences" of sexual activity, by which they implicitly meant adolescent pregnancy and STDs. However, adolescents, particularly females, cited contraception as a topic they wished their parents provided more information about. Adolescent females were far less conflicted about these issues than parents were, and felt they had a right to information about contraception and that parents should be willing to provide it. As one adolescent female stated, "If a child went to a parent, they shouldn't be fighting like, 'Mom, I want to be on birth control.'"

Although adolescent pregnancy was universally depicted as unwelcome and dishonorable for both the adolescent and her family, some parents struggled to reconcile what they perceived as their duty to promote abstinence with their fear of their child's becoming pregnant. One mother admitted:

"I am a little torn. . . . I do teach her abstinence, but then on the other side of it, I don't want her to get pregnant. So … if she comes to me and says that she's having sex, even [though] I'm preaching 'Don't do it,' I would still kind of feel torn as to putting her on something, because I don't want her to be on [birth control]."

Other parents struggled with how open to be in discussing contraception, fearing that providing an adolescent with information might increase sexual curiosity and promote sexual activity. A mother said:

"When my daughter gets to that particular teenage age, if she was having sex, I would want her to be protected. But I'm not okay with as much information as [my friends give] their daughters. In my eyes, it makes their daughters a little more wild."

Not all parents approached discussions about contraception circuitously. Several reported being candid about their expectation that their sexually active children use contraceptives. This was corroborated by children. One daughter recounted, "My dad was more like 'Every time you have sex, use a condom.'" These parents attributed their motivation for candor to their own adolescent experience of having received little or no education about contraception from their families. One mother described how her family had dealt with the subject:

"It took teenage pregnancy to hit my family for someone to really speak about it. And they wouldn't speak about the sex part of it. They just taught … you know, the financial, and the burden, but never, like, educating us on, 'Well, if you use something, you won't get pregnant.'"

The content of discussions about contraception differed markedly for adolescent males and females. Most mothers and fathers made it clear that they expected their sexually active sons to use condoms. Parents were very explicit that this was to prevent both unintended pregnancy and STDs. One son explained:

"My father is comfortable with [me having sex]. My mom, as long as she knows I am using a condom, there ain't nothing to be worried about. She just don't want me catching STDs or get no babies."

A number of parents reported periodically asking their sons if they had initiated sexual activity and regularly reinforcing the need for condom use once their sons had done so. Few parents (all mothers) mentioned similar conversations with their daughters about either condom or contraceptive use before discovering that their daughter was already sexually active. Similarly, few daughters mentioned that a parent had engaged them in a frank discussion about contraceptive use. More commonly, parents expressed distress upon discovering that a daughter was sexually active or pregnant, and responded by imploring their child to either abstain or use condoms and contraceptives. One mother shared her story of discovery:

"I didn't say 'You can have sex.' They chose that on their own. Okay, fine. . . . I just asked, 'Please don't do it any more until you are on some form of birth control.' That is all I ask."

Contraceptive knowledge—Although some parents reported talking about contraception, knowledge about the range of available methods, their risks and their side effects generally was lacking. Among parents who cited awareness of specific methods, most named only condoms and oral contraceptives. When probed, some parents said that they had heard of other methods, but did not know what these methods looked like or how to use them. A comment from one mother illustrates this point: "I would like to see … how to use condoms, what do birth controls look like: the IUDs, the Depo shots."

Contraceptive knowledge varied by gender. Mothers and daughters were generally aware of a wider range of birth control options than were fathers and sons. One father admitted, "It's just basically condoms with me because I don't really know of many devices for women." Another father said that the rapid pace at which female contraceptive options have grown has limited his ability to remain informed:

"They say something to you, you thinking to yourself, 'Oh, I ain't never heard that one. Let me in on that a little bit more, you know?'"

Like fathers, most male adolescents knew only about condoms, which they viewed as an important tool for avoiding unwanted pregnancy and STDs. Many felt they did not need to

know about other contraceptives because birth control was not their responsibility. As one said, “That’s a girl thing.” One mother remarked that this skewed view of responsibility for pregnancy prevention reflects, in part, that “there’s a thousand birth controls on the market for women,” but only one—the condom—for men.

Access to contraceptive services—Parents identified several avenues through which adolescents could access contraceptive services, including schools and community clinics, such as Planned Parenthood facilities. One father noted:

“They have things in the school called wellness centers, and they give the guys condoms, and legally they can give the girls, if she is of age, birth control pills.”

Many parents expressed concern that their children could access condoms or other contraceptive services without their consent. Some also expressed anger that they were legally responsible for ensuring their child’s health, yet were barred from being consulted or even informed if their daughter was given a contraceptive method. Others were disquieted by the possibility that their child might be harmed by using contraceptives. One father recounted that he and his wife learned of his daughter’s contraceptive use only after she experienced side effects:

“She went and had the thing you stick in you for birth control [implant]. And the way we found out is because she was on [had her period] for almost three weeks or more. I was noticing things in the garbage can too long. And, no, we didn’t know she had that thing in her.”

One mother recounted her dismay over her daughter’s ability to access confidential health services and described how she circumvented this policy:

“[A health care worker told me] they are not allowed to disclose what goes on between [the health service provider] and my 12-year-old. At that point, they start to tell you they can give your child birth control, even at Planned Parenthood, without your knowledge. And there is nothing we can do about it. I had to force the doctors to make her sign a paper in front of them saying that they were allowed to discuss with me what goes on.”

Some parents reported helping their adolescent access contraceptive services. Here again, distinct gender biases were evident. Both mothers and father reported providing sons with condoms—either directly or indirectly, by making them available in a known location in the house. One mother explained:

“I’ve got boys and girls. . . . My boys is already having sex. . . . So, the only thing I can do for them at this point is keep them with condoms. Because they had the taste of it [sex], and they don’t want to hear nothing I have to say pertaining to ‘don’t.’”

Few parents (only mothers) reported helping their daughters to access contraceptive services by taking them to a health center. One mother related what she told her daughter about contraceptive access:

“I will take you to the clinic because I’m not one of those parents who [think], ‘Not my daughter.’ … I don’t have a problem with you having sex. I would rather you wait, but I want to protect you from babies.’”

Parents of adolescent parents particularly supported helping their children access contraceptive services. One mother, whose daughter had recently had a baby, said that she “constantly” talks to her daughter about contraception—“Every day, I’m like, ‘What’s going

on?’”—because her own mother had told her that “some girls, when they go back for their six-week checkup, they’re already pregnant again.” At the six-week checkup, the mother said, she will ensure that her daughter gets a contraceptive method “that’ll keep [her] safe for five years.”

Several mothers reported that their daughters were more likely to learn about contraceptives and access to services from a female sibling or other relative than from them. One mother related that her daughter’s sisters accompany her on visits to her gynecologist and to “anything that has to do with [her] becoming more aware of her sexuality.” Furthermore, they “pass their information on to [her] in hopes that she won’t go through the same trials and tribulations that they did.”

Adolescent females also indicated that they learned a lot from their older siblings. One said:

“My sister was always there telling me stuff. . . . My sister got pregnant at a young age, and she said she don’t want me to follow the same footsteps as she did. . . . I can talk to her more. I can be more open with my sister. With my mom, I can’t be open.”

Planning for the future—A central theme parents communicated to their children was the importance of planning for the future—achieving educational goals, becoming self-sufficient through gainful employment and taking time to enjoy life before taking on the responsibilities of a committed relationship or supporting a family. One father captured this theme in the following remarks:

“My son wants to play football, go to college. I said, ‘I’m not raising any grandkids. All your future dreams are linked to your ability to stay away from sex, because if you have a baby, it’s gone.’ So, that’s the biggest thing for me right now, the selling point—the risk and consequences.”

And a son reflected the theme of planning in these comments:

“[Pregnancy] is not good at an early age. You should think about it when you get older—how you are going to provide for your family, what job you are going to get, going to college and how many kids you want.”

In addition to talking about general planning for the future, parents specifically discussed how adolescents should prepare themselves for parenthood, focusing on topics such as choosing partners, timing parenthood and providing for a family. Fathers and sons described discussing these topics more often than mothers and daughters did. The most consistent message fathers reportedly delivered to their sons during these discussions was the importance of being able to provide for a family financially. One son recounted his father’s succinct explanation: “Make sure you can take care of a family before making a family.”

Attitudes toward abortion—Many families had not explicitly discussed abortion before participating in the study. However, several parents indicated that the study made them realize that this was a topic that needed to be addressed with their children. A father recounted:

“As we were answering … [the study questionnaire, my wife] turned and looked at me and … said, ‘You know what? We never talked about abortion.’ And I said, ‘You know what? I don’t think we have.’ So, we actually planned just downstairs that we need to talk to them about that.”

Although participants displayed a range of attitudes toward abortion, the vast majority of parents and adolescents of both genders held negative attitudes. One mother reported being "totally against it." A daughter reported, "I do not believe in abortion." And a father, speaking on behalf of his family, said, "We obviously don't agree with it." Adolescent males expressed the least supportive attitudes. For example, one said, "If I got a girl pregnant, I would talk her out of getting an abortion," while another remarked that with abortion, "you're paying money to kill your own seed; it's not right." Despite their negative attitudes, some participants, particularly mothers, felt that abortions were common, though primarily covert.

Participants described a variety of factors that influenced whether families discuss abortion. For some, experience with having an abortion acted as a prompt. As one mother explained, "My daughter said, 'You never talked to me about that.' And I never even thought of that, because I never had one, so I never thought of it." Some discussions occurred when individuals within a family's social network had an abortion. For example, one daughter shared that her family first discussed the topic when her sister had an abortion. A father similarly related that in his family, "It comes up indirectly. My relative's daughter got pregnant, and then all of a sudden she's not pregnant. So indirectly, [my daughter] heard about abortion." Finally, media messages about abortion were reported to spur family discussions.

Despite universal disapproval of adolescent pregnancy, participants expressed a sense that the expected norm is that adolescents who become pregnant will raise the child with support from their family. One son said, "If it happens, it happens. You have a baby. You have to take care of it." Parents and adolescents described a cultural tradition in which families share responsibility for raising children born as a result of unplanned pregnancies. One father recalled that before becoming parents, he and his partner had known that their extended families provided "a network of safety":

"Her parents knew that [we were having sex]. It was not condoned, but we did it behind their backs. But we also knew that they … would be there to provide for us and give us a security blanket if something happened. It is that extended family on many issues that allows you to grow and … to make it in life."

DISCUSSION

Families are the primary social context in which children's sexual socialization begins. In this study of black urban families, parents stressed the importance of their adolescent children's setting broad life goals while avoiding adolescent pregnancy. However, the language parents used to frame contraceptive discussions was often vague and influenced by gender scripts. The gender biases inherent in family discussion about condom and contraceptive use, as well as in parents' provision of access to condoms and contraceptives, may ensure better sexual health outcomes for adolescent males than for females. Whether intentionally or not, parents appear to reinforce larger societal biases that sanction sexual activity among adolescent males while dictating chastity for adolescent females. Helping parents to identify their gender-based biases could help promote more equitable discussions and possibly even improve access to prescription contraceptives for adolescent females.

Parents and other family members play a key role in shaping adolescent females' attitudes towards contraceptive use.[18] This is particularly true for highly effective reversible methods and for minority adolescents.[19] A review of studies examining contraceptive compliance among adolescents found that adolescent females and their families are very concerned about the safety of menstrual irregularities associated with many hormonal methods.[20] We

found low levels of contraceptive knowledge among our study participants, as well as negative attitudes toward some long-acting methods. The social nature of contraceptive acceptance suggests that strategies to educate parents about the mechanisms of action and side effects of various contraceptive options may increase adolescent uptake and compliance while dispelling common myths.

Consistent with earlier work,[21,22] we noted that parents were apprehensive about adolescents' access to confidential contraceptive services. This concern persists despite the obvious public health need for adolescents to access contraceptive services and parents' desires to have their children avoid unintended pregnancy. The medical and public health communities could do more to educate parents about these services. For example, social marketing campaigns offered through schools, clinics or the media could educate parents (and adolescents) about the rationale for offering confidential services. Such approaches could assuage parents' fears that contraceptives might be harmful by raising awareness about clinical guidelines that promote tailored method selection to reduce side effects.

A number of interventions to improve parents' skills for talking with their children about sexual health issues have been developed.[23] While most reportedly try to increase parents' sexual health knowledge, it is unclear how many provide parents with contraceptive information or improve parents' self-efficacy for communicating with their children about contraceptive use. Given our findings, and national data showing that only half of adolescent females and a third of adolescent males report receiving information about contraception from parents,[24] refinement of parent communication skills-building programs is needed to help improve parents' knowledge and communication skills in this area.

Although contraceptive use has traditionally been women's responsibility, men are often involved in decision making, and a number of studies have noted that teaching adolescent males about contraceptive use beyond condoms is important. For example, males' contraceptive knowledge is positively associated with their partners' oral contraceptive use.[25,26] And adolescent males' ignorance about and negative attitudes toward contraceptive methods can be a fundamental barrier to their partners' contraceptive use.[27] We found that adolescent males not only were uninformed about contraceptives, but did not think it was their responsibility to learn about methods other than condoms. We also found that fathers feel a responsibility to educate their sons about sexual responsibility and condom use. One implication of these findings is that fathers should be taught about contraceptive methods and enlisted to help their sons broaden their notions of reproductive responsibility.

Study Strengths and Limitations

Many studies of parent-adolescent communication about sex explore either parents' or adolescents' perspectives. This approach is problematic, given the low correlation between parent and adolescent reports of family communication about sex[28] A major strength of our study is that we explored the perspectives of both parents and adolescents. For several of our findings, comparing parent and adolescent reports provided a more complete understanding of communication dynamics and discussion content. For example, parents frequently reported that they encourage condom and contraceptive use among sexually active adolescents, whereas adolescents recalled rhetoric emphasizing avoiding the consequences of sexual activity but little concrete information regarding how to do so. Another strength was our examination of gender variations in parental communication, which highlighted the different roles mothers and fathers play in educating children about sex. Although mothers may be primarily responsible for educating children about sex, fathers also play an important role, particularly in shaping their sons' contraceptive attitudes.

Our results should be interpreted in the context of several important limitations. First, our sample consisted of black families from a single urban community; our results may therefore not be generalizable to all black families or to families from other racial or cultural backgrounds. Second, although our study population included a range of social backgrounds, two-parent households headed by educated parents represented a greater proportion of our sample than they do of black families in Allegheny County. Thus, our findings may not be generalizable to other family structures, given that family communication may be more positive, supportive and harmonious in two-parent households or those with fairly educated parents than in families with other social structures.[29,30] Third, our institution required that parent participants be biological parents or legal guardians of participating adolescents. However, national and local data show that black children younger than 18 reside primarily in single-parent, female-headed households,[31] and sociological studies demonstrate that childrearing within black families is often intergenerational.[32] Fourth, our methodology did not allow us to link the commentary from parents and their children. Finally, we cannot exclude the possibility that social desirability bias, or the tendency for individuals to endorse group norms in focus group discussions, may have limited participants' expression of dissenting opinions. This may explain the fairly homogenous opinions regarding sensitive topics, such as abortion.

Conclusion

Our findings indicate that programs aimed at improving parent-adolescent communication about sex should teach parents about the range of contraceptive options, help them understand the harmful effects of gender bias in information dissemination and provide mothers and fathers with communication skills that are tailored to enhance the role they play in their adolescents' sexual development.

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