"SILENCING AS AN ACT OF PROTECTION": A MIXED-METHODS INTERSECTIONAL-ECOLOGICAL EXPLORATION OF BLACK PARENTS' BELIEFS, PERCEPTIONS, AND BEHAVIORS ABOUT SEXUAL HEALTH AND TRAUMA

by

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“Silencing as an act of protection”: A Mixed-Methods Intersectional-Ecological Exploration of Black Parents’ Beliefs, Perceptions, and Behaviors about Sexual Health and Trauma

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Dedication

For Dercy Belle and Gloria Maud, my grandmothers and ancestors.

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List of Abbreviations

AMA .....American Medical Association
CDC .....Center for Disease Control
CTA..... Critical Thematic Analysis
WHO .....World Health Organization

Abstract

"SILENCING AS AN ACT OF PROTECTION": A MIXED-METHODS INTERSECTIONAL-ECOLOGICAL EXPLORATION OF BLACK PARENTS' BELIEFS, PERCEPTIONS, AND BEHAVIORS ABOUT SEXUAL HEALTH AND TRAUMA

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Black people are disproportionately at risk to sexual harm, and for every Black woman who reports being raped, at least 15 do not report the traumatic incident to the police (Hart & Rennison, 2003). The barriers to disclosure to family, close sources, and authorities for Black survivors include a historical "culture of silence" (Gay, 1999). Utilizing Intersectionality and the social-ecological model, silence as a communicative behavior is contextualized by the macro layers of rape culture, the histories of systemic racism and heteropatriarchy, among other forms of structural oppression. This exploratory study utilizes a mixed methodological approach grounded in a transformative framework (Sweetman, Badiee, & Creswell; 2010) with a mandate for social justice and systemic-level interventions (Alinia, 2015; Cho et al., 2013; Collins, 2009; Esposito & Evans-Winters, 2022) in three Phases: Qualitative—Quantitative—Qualitative. Phase 1 employs aspects of community-based participatory research (CBPR) with social workers

and community leaders (i.e., advisory panelists) in focus groups (*N*=5) to discuss cultural beliefs and communicative behaviors about sexual health and trauma that are considered norms within Black communities using Critical Thematic Analysis (Lawless & Chen, 2019). Phase 2 builds upon the recommendations from the advisory panelists in Phase 1 to adapt quantitative measures to explore Black parents' beliefs, perceptions, and behaviors. Phase 2, a survey of Black parents (*N*=457), includes scales that measure rape myths, sexual communication, self-efficacy, religiosity, perceived discrimination, and demographic variables. In Phase 3, focus groups were used to further explore parents' perceptions, beliefs, and behaviors (*N*=21) through their narratives about discussing sexual health and trauma with their children. This study explores silence(ing) as a cultural marker of Black communities regarding stigmatized sexual health topics, particularly sexual trauma.

Keywords: Intersectionality, mixed-methods, perceived discrimination, racism, rape myths, self-efficacy, sexism, sexual health, sexual trauma, social-ecological model

Chapter One

"There is an uncanny silence surrounding the trauma of black rape."
~Charlotte Pierce-Baker, *(2004, p. 18)*

Nearly 60% of Black[1] women report being subjected to coercive sexual contact by age 18. One in four Black girls will be sexually abused before turning 18 years old (The National Center on Violence Against Women in the Black Community, 2018). According to the Center for Disease Control National Center for Injury and Prevention (2019), Black women experience attempted or completed nonfatal sexual assault at a rate more than twice (67.9 per 100 000) that of white women (33.7 per 100 000). In the United States, according to the Institute for Women's Policy Research[2], more than 20 percent of Black women are raped during their lifetimes, thus making Black women disproportionately at risk for sexual violence. Based on national statistics, 1 in 6 men reports being sexually abused as children. Recent studies have highlighted the vulnerability of Black men and boys, asserting that experiences of sexual trauma are pervasive but have not been reported (Curry, 2019; Curry & Utley, 2018). The 2015 U.S. Transgender Survey says

[1] In this study "Black' represents persons who both self-identify and are ascribed an identity connected to African descent, including African American, Afro Caribbean, those born in African nations who migrated to America, and bi-racial or multiracial persons of African descent. Throughout the text B is capitalized as a proper noun, with the intention of recognizing the naming of a group of people with community norms and shared histories. However, there are moments when the b is written as lower case based on the direct quotes from the scholarship. "African American" is used if it corresponds with the scholarship that is being cited in the text.

[2] Report can be found at https://iwpr.org/research/

that more than half of all Black respondents were sexually assaulted in their lifetime, indicating higher susceptibility to sexual violence for Black sexual and gender minorities.

According to the World Health Organization (WHO), sexual violence is defined "as any sexual act or any attempt for the purpose of obtaining a sexual act through violence or coercion"(Borumandnia et al., 2020). Sexual trauma includes psychological symptoms and responses beyond the act of violation or attempt (Lang et al., 2003). While studies are being conducted to understand the rate of sexual violence and trauma among Black people, data is scarce because many survivors do not report or disclose their experiences (CDC, 2020). Even with these startling statistics, sexual assault is grossly underreported, and for every Black woman who reports being raped, at least 15 do not report the traumatic incident to the police (Hart & Rennison, 2003). This fear of experiencing re-traumatization has led to a silencing of survivors, which comes at the expense of survivors' health and wellbeing. In addition, the silencing or lack of disclosure often leads to maladaptive coping and revictimization of sexual trauma (King, 1988). For more than 25 years, the American Medical Association, the Center for Disease Control (CDC), and the World Health Organization have identified it as a "silent-violent epidemic" (AMA, 1995). Furthermore, according to the CDC, prevention of sexual violence includes early childhood healthy communicative behavior about sexual health in general and discussing the social norms that contribute to rape culture and the stigmatization of survivors (*Preventing Sexual Violence |Violence Prevention|Injury Center|CDC*, 2020).

Purpose

Sexual health and trauma are undoubtedly health communication issues that benefit from transdisciplinary and translational research within the discipline. Multidisciplinary research on sexual trauma has identified short-term and long-term health effects of sexual violence, including physical injuries, sexually transmitted diseases, unwanted pregnancies, depression, posttraumatic stress disorder, subsequent substance abuse, and suicidal ideation. Nevertheless, there are gaps in interpersonal and family communication and health communication literature, particularly with marginalized and under-researched communities. By exploring the perceptions, beliefs, and behaviors of Black parents, this study centers on a cultural exploration emphasizing the need to understand the family context of sexual health and trauma to promote healthy communicative behaviors as a critical measure of parental support. Therefore, the purpose of this critical intercultural health communication study is to address one of those gaps by exploring the perceptions, beliefs, and behaviors of Black parents in communicating about sexual health and trauma with their children.

The family is a discursive site for health communication, particularly about health risks and sexual trauma. This study identifies the phenomenon of parents' communication about sexual health and trauma as an essential precursor to destigmatizing sexual violence, providing openness and safe spaces for promoting healthy sexual behavior, and disclosing sexual trauma. Furthermore, this study contextualizes sexual health and trauma communication within the family system, specifically in Black families. This study examines the influences of perception and communicative behavior towards sexual health

among Black parents. This exploratory study gathers empirical insights to develop health promotion and interventions that provide culturally responsive tools for parents and caregivers as they navigate the risks of sexual trauma and enhance the supportive communicative behavior that will foster disclosure.

The next section outlines the theoretical framework of this study utilizing Intersectionality and the Social-Ecological Model. In addition, this study uses concepts from intercultural, health, and family communication scholarship to provide the context of the literature in Chapter 2. Following is a brief synopsis of the methodological plan (outlined in Chapter 3), and the aim of the study to provide empirical and critical findings (Chapter 4) on the experiences of Black parents and caregivers in their navigation of communicating about sexual health and trauma with their children. Finally, in conclusion (Chapter 5), will discuss the utility of this study, both an exploratory contribution to theory development and translatable research for social justice.

Theoretical Framework

Intersectionality is a theoretical paradigm that proposes the examination of the processes of structural and institutional systems of inequality and the overlapping of socially determined categories of identity and locations (e.g., race, ethnicity, gender, class, sexual orientation, religion, abilities) (Alexander-Floyd, 2012; Bowleg, 2017; Breuner et al., 2016; Cho et al., 2013; Crenshaw et al, 1995; Few-Demo, 2014a). Intersectionality is rooted in Black Feminist Thought and other critical theories including Critical Race Theory (Bell, 1980; Few Demo, 2014; Else-Quest & Hyde, 2016; Collins, 2000; Collins, 2019; Crenshaw et al, 1995). The philosophical positions of

Intersectionality are underpinned by critical historical perspectives of power, which Collins (2000) conceptualizes as "an intangible entity that circulates within a particular matrix of domination and to which individuals have varying relationships" (p. 274). Intersectionality guides the exploration of the cultural manifestations and communicative behaviors among Black parents, which include both positive and harmful responses to sexual trauma, including the silencing of Black survivors' pain.

In the late twentieth century, critical race scholar Kimberlee Crenshaw identified a metaphor in two influential pieces of legal scholarship as "Intersectionality," a term that described the overlapping systems of subordination and oppression (Crenshaw, 1991). In using Intersectionality as a theoretical framework and critical epistemology, Moradi and Gzanka (2017) encourage the responsible use of the concept identifying with roots in U.S. Black feminism and women of color activism discussed in more depth in Chapter 2. In her first groundbreaking piece (1989), Crenshaw argued that both feminist theory and antiracist policy discourse neglect the interaction of race and gender discrimination. The resulting blind spot facilitates the marginalization of Black women, ignoring the differences within and among social groups in the context of the legal experiences of Black women. Intersectionality was cemented as a heuristic term in the social science scholarship through the work of Crenshaw and Collins (1991).

Within the communication discipline, the use of Intersectionality as a theoretical framework is part of a discursive turn applied through the work of feminists and critical family communication scholars who theorize power as a systemic construct within families and the larger society and the possibilities for transformation (Few-Demo, 2014).

Family and communication scholars who have applied a feminist lens in communication scholarship since the mid-2000s, like critical feminist theories and Intersectionality, examine structural and historical experiences/expressions of power. The analysis of power is essential to the relationship between private interpersonal/familial relations and the public sphere, particularly in researching gender as a system of social stratification (Alexander-Floyd, 2012; Few-Demo et al., 2014; Few-Demo, 2014a; J. Moore & Manning, 2019; Suter, 2016; Wood, 2005). Furthermore, they utilize a social justice approach and seek to use research to critique, resist and transform the status quo within family systems.

Critical family communication scholars assert that communication is embedded within the framework of intersecting power dynamics that impact identities and social relationships. Few-Demo, Moore, & Abdi (2018) emphasize that "communication is central to the intersectional framework because communication creates, sustains, and transforms both identity categories and their relations to power and privilege" (p. 179). Thus, communication scholars are in a prime position to expand the utility of Intersectionality as a critical theory through a comprehensive analysis of how power is communicated and constituted through intrapersonal, interpersonal, and societal relations and sense-making.

Intersectionality, as the overarching framework of this study speaks to the interplay the ways in which power is communicated through multi-level analysis and evokes a socio-ecological examination of sexual trauma across societal levels. In the 1970s-80s, Urie Bronfenbrenner developed the social-ecological model (SEM) as a

theoretical frame. SEM postulates that individual behaviors, intrapersonal attitudes, interpersonal relationships (family and community networks), are influenced by larger structural and institutional systems, including the political and socioeconomic environments (Bronfenbrenner, 1977; Bronfenbrenner & Morris, 1998; Eriksson, Ghazinour, & Hammarström, 2018; Kilanowski, 2017). For the last several decades, SEM has been used in public health, epidemiology, and health communication scholars have encouraged empirical examination of how individual-level behavioral change are influenced by the complex intersections of a multi-level analysis to advance theory and interventions (Moran et al., 2016). The World Health Organization (WHO) has encouraged the use an ecological framework for practitioners and academics interested in developing interventions that reduce gender-based violence. Furthermore, scholars have applied SEM in sexual assault research in various contexts (Campbell et al., 2009; Casey & Lindhorst, 2009; Gomez, 2019; Grauerholz, 2000); and Opara (2018) has recently combined the work of Black feminist theory and SEM to propose an intervention with African American parents and communication HIV-risk with their daughters. The combination of critical theories with SEM allows for an examination of the processes of power and oppression within and among the ecology layers.

Intersectionality is the organizing paradigm for the theoretical framework of this study, which asks how power is constituted through communication about sexual health and trauma at various levels of society, community, and individual relationships. Figure 1 is an image of concentric circles, which provide the visualization of how Intersectionality, within ecological levels, will be used to interpret and apply

communication concepts as analytical tools for the study. This study utilizes this ecosystem approach to analyze Black parents' communicative behaviors and belief systems surrounding sexual health and trauma. Therefore, developing and applying an Intersectional-ecological model as the research paradigm, the foundational question for this study is:

> *How do intersections of social categories, such as, race, class, and gender, influence Black parents' a) beliefs, b) attitudes, and c) communicative behavior regarding sexual health and trauma?*

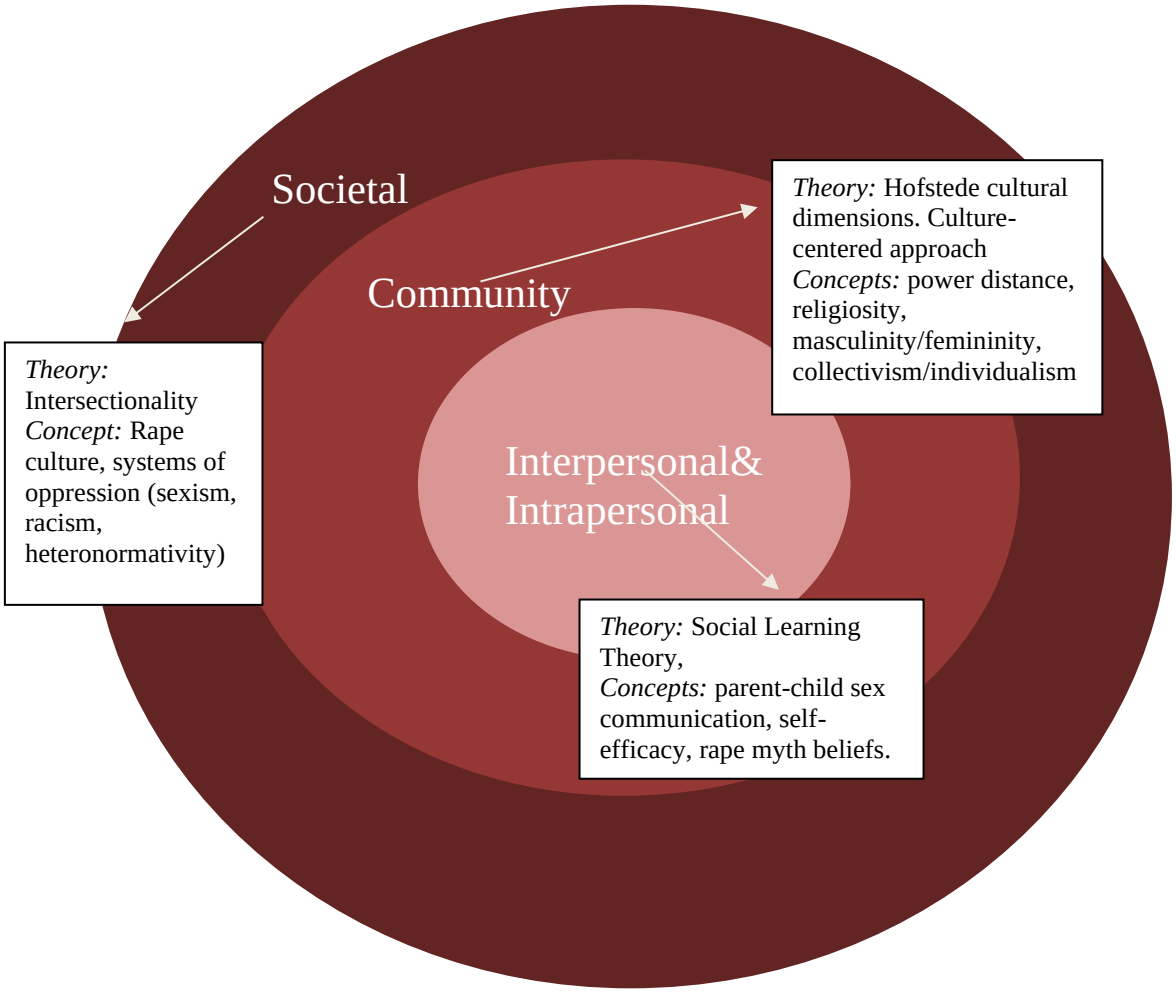

Figure 1: Intersectional-Ecological Framework of Sexual Health Communication in Black families

Macro– Rape culture

This study explores Black parents' communicative behavior as influenced by the intersections of structural inequality and macro-level rape culture by applying an Intersectional-Ecological framework. Culture is constituted through dynamic communication processes—human interactions and meaning-making. Rape culture, "a pervasive ideology that effectively supports or excuses sexual assault" (Burt, 1980, p. 218), is the hegemonic force that influences all other layers within the model for this study. Thus, rape culture provides context to the broader culture of patriarchy and misogyny. Moreover, sexual violence is a fundamentally gendered phenomenon that requires critical analytical frameworks of the structural problems that Intersectionality outlines. Rape culture normalizes sexual violence against women, people of color, and trans and nonbinary gendered persons through objectification and heteronormative scripts that emphasize cis-gendered men's sexual desires over others (Rosetto & Tollison, 2017). Survivors do not experience the harm of sexual assault based on their gendered identity only, or the racial or sexual identity primarily, but as a human being with a multifaceted identity that embodies dimensions of sexism, racism, ableism, homophobia, classism, among many other demographic factors that are used to silence and denigrate the experiences of survivors. Thus, this study will emphasize the ways in which systemic oppression and societal dimensions, including rape culture, influence the community and micro-level communication of Black parents.

Rape culture is established and maintained through communicative behaviors (i.e., rape myths) that reinforce heteronormative and sexist values throughout all levels of

the ecological model above. Rape myths are false beliefs based on the intersections of heteropatriarchy, sexism, and other systems of inequality and oppression resulting from the larger context of rape culture. Following the critical paradigm of Intersectionality, exploring the ecological influences of the discursive struggles among Black parents surrounding their beliefs in rape myths is essential.

Community level .

It is important to understand the heterogeneity of cultures, particularly ones that have been under-researched and are considered marginalized. In this study, Black culture is explored as diverse beliefs, values, attitudes, and communicative behaviors among those who self-identify as belonging to the African diaspora in the United States (Jackson, 2004; King, 1988). An Intersectionality perspective will provide insight to the hegemonic discourse of Black communities and people in the context of sexual violence.

Geert Hofstede's theory of cultural dimensions is a framework that has led to intercultural comparative analyses across, nations, businesses, and other institutions (Hofstede, 2001, 2011; Hofstede & McCrae, 2004). According to Hofstede there are six main dimensions that are statistically distinct from one another that lead to categorization and assessments of cultural norms and values in countries and organizations (Hofstede, 2011). The three dimensions discussed in this study are: (1) Power distance, (2) Individualism versus Collectivism, and (3) Masculinity versus Femininity. Moreover, these three dimensions that will be discussed in this study have been explored in other studies on sexual harassment behaviors in international contexts (Luthar & Luthar, 2007; Luthar & Luthar, 2002).

In health communication scholarship, Dutta and colleagues (Dutta, 2018) have developed Culture-Centered approach (CCA), which asserts that health promotion and interventions should be undergirded with a nuanced understanding of the cultural context of the population for there to be sustainable change, particularly in marginalized communities (Dutta et al., 2017). In chapter 2, these cultural dimensions and framework provide the community-level framing of the discussion around cultural markers in Black families pertaining to the beliefs, perceptions and communicative behaviors among Black parents.

Interpersonal and Intrapersonal Level

The conceptualizing of power at the family and interpersonal level in this study is through an exploration of parent to child communicative behaviors and beliefs regarding sexual health and trauma. According to Flores and Barrosa (2017) "Parent-child sex communication is the bidirectional communication between parents (or parent figures) and their children about sex-related issues including sex, sexuality, and sexual health outcomes" (p. 532). The scholarship that examines parent-child communication about health topics, particularly sexual health, is central to the purpose of this study.

In health communication scholarship, self-efficacy is integral in understanding the potential for behavioral change (Bandura, 1977; Strecher et al., 1986). Scholars who explore the correlates of parent-to-child sex communication have analyzed how parental self-efficacy influences the frequency of sex-communication (DiIorio et al., 2001; Ferguson et al., 2022). Previous studies of parents' sex communication provide a rich understanding of how perceptions and awareness of a health issue influences

communicative behaviors about sexual health. In addition, the information regarding self-efficacy is often a necessary precursor to developing health promotion messages (C. J. Jones et al., 2014). This study explores the perceptions of parents' self-efficacy in relation to sexual trauma specifically.

Exploring the family communication dynamics of sexual health and trauma requires a critical analytical framework, and Intersectionality is a critical paradigm that provides the complex conceptualization of how structural oppression influences an overarching context creating dialectical tensions on interpersonal levels. Black feminist scholarship, the social-ecological model, and Intersectionality has been utilized in sexual assault literature, particularly when examining survivors of color and sexual minorities, and this study seeks to contribute to the growing literature that is expanding the utility of this critical theory. In summary, the conceptual model discussed provides the framework to explore the various factors that influence communication about sexual health and trauma among Black parents.

Study Design

While social science scholarship has increased in awareness and use of Intersectionality, there is still a need to grasp the undeniable call for social justice and empowerment of subordinated communities through translatable research. This study's overall objective to explore the family environment, beliefs and perceptions of parents is to provide preventive messages and supportive environments in the event of sexual trauma. Intersectionality is a fitting framework for this study because the analytical root of this theory is connected to the context of violence against women of color (Crenshaw,

1991), the canon of Black feminist ideology (Collins, 2000; Collins, 2019). Moreover, the ecological framing of this study seeks to understand the relational and structural dynamics of race, gender, and class, among other demographic identifiers, as influential of Black parents' communicative behaviors and beliefs about sexual trauma.

Bowleg and Bauer (2016) assert that researchers who use Intersectionality as a theoretical framework often utilize qualitative methods with a critical interpretivist epistemological paradigm. However, the essence of Intersectionality calls for mixed methods investigation of the power dynamics within the social-structural context and individual-level experiences (Bowleg, 2012, 2017; Few-Demo & Allen, 2020, McCall, 2005). To center marginalized populations, there needs to be an in-depth analysis and breadth in the understanding of the experiences of Black parents as a culturally diverse group. McCall (2005) refers to this approach to Intersectionality as "intracategorical complexity," which intends to examine the lived experiences within a social group, culture, or social category. Moreover, much of the work on sexual assault uses the experiences of college students as the main population for empirical analyses on social support and other buffers that influence long-term negative health outcomes for survivors, but there is a gap in the scholarship about Black families and children who are particularly vulnerable to sexual assault and are less likely to disclose and seek formal support (Hakimi et al., 2018; Sualp et al., 2020). There are also implicit assumptions about the socioeconomic status of Black participants as being from low-income backgrounds, and we risk missing nuanced connections about Black parents who may have socioeconomic privileges, yet face intersecting forms of oppression. Thus, it is

imperative to investigate the lives of Black people as a heterogeneous group of human beings whose experiences are worth empirical investigation, not just in comparison to the dominant group, or other nondominant groups. Intersectionality also requires self-reflexivity, a critique and knowledge of oneself, throughout the research process. In Chapter 3, I speak more to the journey of self-reflexivity and praxis as a Black mother and scholar.

A considerable amount of the scholarship on parents and caregivers applies qualitative methodologies of interviews with grounded theory and phenomenological analytical approaches that have led to in-depth analysis of communication between parent and child about sexual health and risks. However, there is a need to further explore and identify salient variables of culture and social categories that influence Black parents' perceptions, beliefs, and behaviors around sexual trauma. Therefore, this study is an exploratory sequential mixed methods study (Creamer, 2018), which includes three phases: Qualitative—Quantitative—Qualitative. This study also employed aspects of community-based participatory research (CBPR) through building partnerships with non-profit organizations in Washington D.C. and Philadelphia that specifically work with underprivileged families of color, specifically Black families. Phase I is a focus group with these social workers and community leaders (i.e., advisory panelists) to discuss rape myths that are culturally specific and communicative behaviors about sexual health and trauma that are considered norms within Black communities. Phase II includes a survey of Black parents utilizing purposive sampling based on the network of the researcher and data sourcing through Qualtrics data management system. This survey includes scales

that measure rape myths, sexual communication, self-efficacy, religiosity, perceived discrimination, and demographic variables. Phase III uses focus groups with parents recruited from the survey, as well as a purposive sampling among the social networks of the researcher to examine the experiences and narratives of parents in relation to perceptions, beliefs and communicative behaviors of sexual health and trauma.

Chapter 4 includes analyses of all three phrases separately that then leads into Chapter 5 which provides a discussion on the exploration of the intersections of Black parents' experiences and their beliefs, perceptions, and communicative behaviors regarding sexual health and trauma.

Summary and significance

Sexual trauma is a health risk that should be examined within the context of health disparities and social inequity, and Black people are disproportionately at risk to sexual harm. Several studies provide an examination of Black parents communicative behavior in comparison to White parents, but few locate their experiences as the foci of a mixed methods study, and how marginalized identities and experiences of structural oppression intersect with communicative behavior regarding stigmatized health topics, specifically sexual trauma. This study will provide exploratory analysis of the communicative behavior of Black parents by centering their attitudes and experiences in the context of high rate of sexual violence among Black people and low disclosure.

The barriers to disclosure to family and close-knit sources for Black survivors include a historical "culture of silence", which Gay (1999) emphasizes the historical roots where "[Enslaved Black women who were assaulted and raped] could either go silently to

the grave or go to the grave for breaking the silence." This historical legacy of silence has become self and community-imposed communicative behavior used to avoid reinforcing negative stereotypes about Black people as hypersexual and deviant (Berger, 2018; Tillman et al., 2010; Ullman & Lorenz, 2020b). Silencing and victim-blaming are harmful communicative practices that survivors of sexual assault often experience within the families across all genders, race, and socioeconomic statuses(Ullman & Peter-Hagene, 2016). Nevertheless, for African American survivors, this silencing is compounded by the racist and sexist scripts that are part of everyday discourse (Tillman et al., 2010).

Collins asserts that, "Solving social problems within a given local, regional, national, or the global context requires intersectional analyses" (2019, p. 48). Intersectionality, as a critical theory, calls for a social justice approach that seeks transformation regarding the phenomenon, which is in line with what health communication scholars regard as "health activism" (Zoller, 2005). The challenge that the phenomenon of beliefs and perceptions that influence a safe space and open communication for survivors of sexual assault to disclose their experiences within their families and communities. Utilizing Intersectionality and SEM as the overarching conceptual lens provides an environmental scan of parent-child communicative behavior among Black parents, and how this contextualizes the culture of silence that Black survivors have been experiencing.

This mixed-methods study comprehensively explores the cultural manifestations and analyzes the factors that influence Black parents' communicative behaviors about

sexual health and trauma. The study seeks to understand the silencing of sexual trauma and survivors' pain within a family context after experiencing sexual trauma. This study aims to expand the utility of Intersectionality as a critical theoretical framework and provides analysis that contributes to intercultural and health communication. Finally, this study has implications for further research that will lead to developing message interventions to reduce sexual trauma stigma and enhance supportive communication among Black parents.

Chapter Two: Literature Review

This study explores the communicative behavior, perceptions, and beliefs about sexual health and trauma among Black parents to understand the family communication context in dealing with the risks of sexual violence. The family system is the cornerstone of this study as a critical relational context for sexual health education, prevention of sexual harm, disclosure of sexual trauma, and support for survivors. Based on the Intersectional-ecological framework described in the introduction, this chapter outlines the literature that will fit into the critical socio-ecological discussion from rape culture as a macro-level construct to the community-level context of Black families, to the interpersonal behaviors of parent-child communication about sexual health and trauma.

The scholarship in this chapter comes from interdisciplinary research conducted to analyze rape culture, the family context of Black people, and the cultural and interpersonal norms that may influence communicative behaviors around sexual health and trauma among Black parents. Firstly, the historical and present conceptualizations of Intersectionality will provide the theoretical background of the literature and study. Secondly, a discussion of rape culture as the status quo of interlocking systems of patriarchy, racism, and heterosexism contextualizes sexual violence as a manifestation of the abuse of power that is gender-based and racialized. The following section highlights some of Hofstede's cultural dimensions related to Black family life and the

communicative patterns and behaviors considered cultural norms, particularly in discussing sexual health topics. The last section includes a review of the family and health communication literature that analyzes the correlates of parent-child communication around sexual health. The research questions and hypotheses are outlined at the end of this chapter.

Intersectionality – A Critical Approach in Communication Scholarship

There is a rich history of family and health communication scholars theorizing about power and inequity as a structural construct within families and larger society; and these scholarly conversations are part of the critical and discursive turn within communication and behavioral sciences (Dutta, 2010; Few-Demo, 2014a; Moore & Manning, 2019; Pitre & Kushner, 2015; Suter, 2016; Zoller & Kline, 2008). The development of Intersectionality as a theory and critical epistemology should be connected to roots in U.S. Black feminism and Black women's civic engagement in antidiscrimination, antiracist, and social movement organizing (Collins, 2019; Crenshaw, 1991; Hancock, 2007b, 2007a; King, 1988; Moradi & Grzanka, 2017). Sociologist and Black Feminist Thought theorist Patricia Hill Collins, traces the formation of Intersectionality through "Resistant knowledge traditions" (Collins, 2019, p. 13) that were necessary to combat westernized notions of knowledge development and construction in scientific inquiry. This section discusses the foundation and development of Intersectionality, the tenets and assumptions, and the relevance to this study as the overarching paradigm.

Sojourner Truth's poignant "Ain't I a Woman" speech, from 1851, is one of the earliest rhetorical articulations of Intersectionality. As Sojourner Truth addressed the Ohio Women's Rights Convention, speaking about the inadequacies of women's rights as a Black woman who cried a desperate motherly cry reflecting on most of her thirteen children being sold into slavery only to be disregarded. Black women, including Maria Miller Stewart, Ida B. Wells, Anna Julia Cooper, continued to highlight the limitations of both civil and women's rights since the mid-19th century. Over a hundred years later, the Combahee River Collective's "Black Feminist Statement," first published in 1975, states,

> The most general statement of our politics at the present time would be that we are actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking (1995, p. 232).

Intersections are identified in this statement and pave the way for further resisting the status quo while developing a paradigm that explores the complex structures of inequality.

Contemporary Black feminist scholars including bell hooks (1981, 1990), Angela Davis (1983), Audre Lorde (1984), Deborah King (1988), Beverly Guy-Sheftall (1995), Crenshaw (1991), Collins (1991, 2000, 2019) have solidified this critical theory and stabilized the foundation for more recent millennial scholarship from Brittany Cooper (2018) and Mikki Kendall (2020) among many others. Thus, the construction of Intersectionality is hardly a new critical lens for analyzing the social phenomenon of

structural inequity and marginalized people. Based on this history, Intersectionality has a dual mandate in academic knowledge production and social justice praxis by straddling both worlds of academia and social movement building. The theoretical formation of Intersectionality is interdisciplinary and identified under the body of critical theories (including standpoint theory, feminist theory, post-colonial theory, critical race theory, and queer theory), which aim to decolonize westernized knowledge claims through dialectical analysis of power and privilege in relational and societal contexts (Collins, 1998; 2019).

Critical and feminist scholars offer various definitions and typologies of Intersectionality (Crenshaw, 1991; Cho et al., 2013; Collins, 1991, 2019; Few-Demo, 2014b; Greenwood, 2008; Hancock, 2007c, 2007a; McCall, 2005; Moradi et al., 2020). Cho, Crenshaw, and McCall (2013) review the transdisciplinary applications and praxis of "Intersectionality Studies," solidifying the scope and depth of Intersectionality as a theoretical and methodological paradigm. In a recent review of the last decade of literature on families that utilizes gender, feminist, and intersectional perspectives, Few-Demo and Allen (2020) define Intersectionality as "the examination of the complex interplay of social location and systems of oppression imbued in institutions, policies, practices and culture" (p. 335). This definition is inclusive of the conceptualization by Crenshaw, in which three types of Intersectionality are defined (1) representational, (2) structural, and (3) political. Embedded within these definitions and typologies is the interplay of these intersections.

As one of the earliest theorists of Intersectionality, Collins (2000) identifies an intersectional analysis as one that explores the "matrix of domination," which articulates power relations based on social inequalities. Collins (2019) recently reviewed the growing body of Intersectionality and Black feminist scholarship in her book, *Intersectionality,* and has compiled a comprehensive list of the core constructs encapsulating the definitions highlighted earlier. The six dominant constructs include *relationality*, *power*, *social inequality, social context*, *complexity, and social justice*. While these constructs provide a critical guide in conducting Intersectionality research, they are not a fixed checklist of what constitutes Intersectionality since there is varied use and interpretation of the constructs within the scholarship (Alexander-Floyd, 2012; Alinia, 2015; Cho et al., 2013; Collins, 2019; Few-Demo, 2014a, McFall, 2005).

There are many definitions of power that are utilized by Intersectionality scholars that come from critical race theory, queer theory, and post-colonial theories (Collins, 2019; Crenshaw et al, 1995; Foucault, 1990). Within Intersectionality analyses for family communication, Few-Demo and colleagues establish that "power [is] a fluid, multidimensional, and contingent force, operating as an oppressive and/or privileging structure in people's daily lives through social practices, law, cultural symbolism, and communication" (2018, p. 182). This study examines power through the intersecting social positions of Black parents within the ecological contexts of social categories, cultures, and structural institutions.

An incorrect assumption of Intersectionality is that this framework is limited to identity politics resulting in an additive model (Bowleg, 2012); and many scholars have

endorsed the expansive and inclusive conceptual trajectory of Intersectionality (Bowleg, 2008; Cho et al., 2013; Moradi et al., 2020). Gender and race are not examined as separate or additive aspects of identity because Intersectionality frames identity markers and experiences as interactive and mutually constitutive (Cho et al., 2013; Crenshaw, 1991; Hancock, 2007b). Moreover, Intersectionality theorists assert that we should not reduce the paradigm to inquiring only about the interplay of static identities but to frame the analysis based on the multiple axes of social life that are mutually constructed and shaped by dynamics of structural/systemic power (Cho et al., 2013; Moradi & Grzanka, 2017).

Several studies about sexual assault and trauma have applied Intersectionality and social-ecological conceptualizations in examining the complex interplay of social categories and lived experiences of survivors (Brown et al., 2017; Casey & Lindhorst, 2009; Harris, 2013; Leung & Williams, 2019; Tillman et al., 2010; Worthen & Wallace, 2017). The scholarly roots of Intersectionality used the experiences of the sexual trauma of Black women as a focal point to discuss the gaps. Crenshaw asserts that,

> In feminist contexts, sexuality represents a central site upon which the repression of women; rape and the rape trial are its dominant narrative trope. In antiracist discourses, sexuality is also a central site upon which the repression of Blacks has been premised; the lynching narrative is embodied as its trope. (Neither narrative tends to acknowledge the legitimacy of the other. (1992, p. 405)

Even with this mandate to analyze the intersections of those who survive sexual harassment and trauma, there remain noticeable gaps in the literature that utilizes

Intersectionality as an analytical framework to examine the dynamics of communication about sexual trauma, particularly in the disclosure of sexual violence within a family setting.

Rape culture: Communicating Rape Myths

Rape culture describes the normalcy in which sexual harassment, child abuse, intimate partner violence, and other forms of sexual trauma are accepted as everyday occurrences within our society. According to feminist scholarship and the campaigns of global movements, rape culture is a hegemonic force that has infiltrated cultures across the world but manifests in nuanced ways that are specific to the context of nation, community, and race (Kemp, 2020; White et al., 1998). Rape culture manifests the communicative behaviors (perception, patterns of cognition, verbal and nonverbal behaviors, and context) about unwanted sexual contact and experience. Moreover, rape culture has an agenda-setting function in how society, communities, and families interact with survivors and perpetrators. South African feminist scholar Gqola provides a meaningful description of rape as a communicative act that fits the overarching discussion of rape culture from an intersectionality perspective:

> Rape is the communication of patriarchal power, reigning in, enforcing submission, and punishing defiance. It is an extreme act of aggression and power, always gendered and enacted against the feminine. Rape has also been central to the spread of White supremacy, and to the way race and racism have organized the world over the last four hundred years. (2015, p. 21)

This framing identifies rape as a physical and emotionally violent manifestation of racism and sexism for centuries. Consequently, examining rape culture requires interrogation of how sexual violence is normalized across cultures and identities. For this study, it is essential to understand the defining characteristics of rape culture and how this culture influences responses to sexual violence within Black communities.

Communicating Rape Culture through Silencing

Silence as an expected response to sexual trauma should be contextualized within the institutionalization of sexual violence against Black bodies, which has deep roots in American history and present-day culture (Collins, 2004). From the transatlantic voyage of enslaved Africans to lynching during Jim Crow to mass incarceration, sexual violence has been a tool of oppression in the United States (Barlow, 2020; Davis, 1989; West & Johnson, 2013). Furthermore, the denial of the sexual assault experiences of Black women has historical roots in slavery when Black women's bodies were not considered their own, and they would be killed for breaking their silence (Gray, 1999;). Thus, from an intersectionality and social-ecological model, silence as a communicative behavior is contextualized by the macro layers of rape culture, the histories of racism, heterosexism, and gender inequality, among other forms of structural oppression.

The dominant communicative behavior that is a consequence of rape culture is to deny, or silence, the experiences of victims and survivors, which ranges on a spectrum based on a contested disclosure (i.e., the lack of belief and doubt) or a stigmatized existence resulting in shame, victim-blaming, and rejection (Heath et al., 2011; Ullman & Lorenz, 2020). This silencing effect is a result of the stigma associated with sexual

violence. Goffman (1963) defines stigma as an attribute that is deeply discrediting" (p. 3). Concerning health challenges, Goffman describes three forms of stigma (a) the illness's biological and physical manifestations (such as abscesses), (b) the blemish of one's character, and (c) the choice to associate with groups already prone to infection or devalued within the community (i.e., collective stigma). Sexual illness and surviving sexual trauma carry various forms of stigma that communication scholars have analyzed (Overstreet et al., 2013; Sualp et al., 2020; Tillman et al., 2010).

Sexual assault, a highly stigmatized health issue, influences how survivors are cared for and supported (Gill, 2018; Paul et al., 2009). Moreover, sexual assault-related stigma is a significant barrier in supporting survivors' well-being and leads to adverse health outcomes through maladaptive coping of survivors who will seek solace in substance abuse and other harmful behaviors (Ahrens, 2006; Fontes & Plummer, 2010). In addition, several articles examine the re-traumatization that victims have faced when they approach the police and health practitioners who question their traumatic experiences (Basile et al., 2016; Gómez, 2021; Hakimi et al., 2018; Long & Ullman, 2013). The lack of support is also experienced in personal settings with family members and friends who may change their behavior towards survivors after learning of their experiences, resulting in the lack of attention and care provided by families in support of survivors (Ahrens, 2006; Dworkin et al., 2019; Slatton & Richard, 2020). As mentioned in the introduction, Black survivors are less likely to disclose their experiences of sexual trauma to both formal (i.e., police, medical providers, and social workers) and informal (i.e., family and friends) due to fear of re-traumatization due to not being believed or

experiencing victim-blaming) (Long & Ullman, 2013; Ullman & Lorenz, 2020a; Washington, 2001). From journalistic literature to scholarly writings, the silencing of the experiences of sexual trauma as a result of stigma has become a cultural norm within Black communities that communication scholars should examine (Ahrens, 2006; Robinson, 2002; Stone, 2004; Tillman et al., 2010).

Rape myths: Beliefs about sexual health and trauma

Sexually traumatic acts are legitimized by cultural norms, which become rape myths and stereotypical gendered discourses like "boys will be boys" or that only violent and unstable men are perpetrators of sexual assault. According to May (1990, p. 15), "A myth is a way of making sense in a senseless world. Myths are narrative patterns that give significance to our existence." Moreover, in health communication literature, myths about health are linked to further stigmatizing the illness and the patient (Burgoon & Hall, 1994). Rape myths provide meaning and normalize sexual violence or make sense of coercive sexual acts by blaming the victim or providing an excuse for the perpetrator's behavior. From a feminist perspective, rape myths are heteronormative and misogynistic scripts that lead to cultural expressions and patterns based on stereotypical images and dominant narratives about women, men, and nonbinary folks (Harris, 2018). In a meta-analysis, Suarez and Gadalla (2010) found beliefs about rape and sexual assault (i.e., rape myths) have been found to influence responses to disclosure of sexual trauma. Other studies with college students and female prison inmates have since confirmed an internalization of rape myths where survivors will either blame themselves or struggle to identify the experience as nonconsensual. (Hayes et al., 2016a; Heath et al., 2011;

Hockett, Saucier, et al., 2016; White et al., 1998). This study explores how acceptance of rape myths influences communicative behaviors about sexual health in general and sexual trauma specifically.

The conceptualization of rape culture for scholarly examination has led to the construct of rape myths, which Martha Burt (1980) operationalized as "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists" (p. 217). Burt (1980) established the first scale on Rape Myth Acceptance (RMAS). The scale includes items on stereotypical gender roles, sexual conservatism, adversarial sexual beliefs, and acceptance of interpersonal violence. Scale items include statements like "only bad girls get raped," "a woman should be a virgin when she gets married," and "many times a woman will pretend she doesn't want to have intercourse because she doesn't want to seem lose, but she's really hoping the man will force her" (1980, p. 222). A limitation with the RMAS is that it is not gender-neutral and only highlights the possibilities of men being the perpetrator and women being victimized (Suarez & Gadalla, 2010). Nevertheless, scholars have asserted that Burt's RMA scale provided a foundational contribution to the conceptualization of rape myths and the negative impact rape myth adherence has on survivors (Edwards et al., 2011a; Lonsway & Fitzgerald, 1995; Suarez & Gadalla, 2010).

Payne, Lonsway, & Fitzgerald (1999) followed up with more recent development of the Illinois Rape Myth Acceptance (IRMA) scale, which has been proven to be psychometrically sound and attempts to be gender-neutral. This scale has subscales that include predominant themes of trauma, including "He didn't mean to," "She lied," "she

asked for it," and "it wasn't really rape." For over forty years, dozens of peer-reviewed articles have used both RMAS and IRMA to examine the impact of rape myths on beliefs, perceptions, and behaviors related to sexual assault experience and disclosure, which has provided substantial literature on the antecedents and correlates of rape myth acceptance among various populations (Edwards et al., 2011a; Glace & Kaufman, n.d.; Hockett, Smith, et al., 2016; Suarez & Gadalla, 2010; Trottier et al., 2021). The scholarship that has examined rape myth acceptance has used populations that are predominantly college students or college-aged, youth, law enforcement, survivors (mainly those who identify as women or girls), offenders, and content analyses of media coverage (Deming et al., 2013; Hockett, Saucier, et al., 2016; O'Connor et al., 2018; Paul et al., 2009; Suarez & Gadalla, 2010; Trottier et al., 2021; Venema, 2019). In the populations described, rape myth acceptance is influential in how survivors are perceived, labeled, and supported (Burt, 1980; Peterson & Muehlenhard, 2004). Moreover, rape myth acceptance and perpetration or proclivity for sexual coercion perpetration are highly correlated (O'Connor, 2021; Trottier et al., 2021).

In a 2010 meta-analysis, Suarez and Gadalla analyzed 37 studies that used RMA to examine correlates of rape myth acceptance among demographic, behavioral, or attitudinal variables. While Suarez and Gadalla (2010) did not use Intersectionality as their theoretical framework, they did examine the studies that used feminist and structural violence theories as a conceptual framework. According to their analysis higher levels of other oppressive beliefs, such as ageism (ES =1.01, $p < .001$), classism (ES = 0.90, $p < .001$), racism (ES = 0.88, $p < .001$), and religious intolerance (ES = 0.82, $p < .001$) were

strongly associated with higher levels of RMA. Suarez and Gadalla's (2010) study provides important findings that describe the correlation between sociocultural attitudes and oppressive structures.

A consistent finding among studies examining rape myths indicates that gender has the strongest association with RMA, where men perceive rape victims more negatively than women (Burgess, 2007; Hockett, Smith, et al., 2016; Suarez & Gadalla, 2010). The influence of gender identity is partly due to the socialization of rape culture, which includes hostility towards women, traditional gender roles, and sexism (N. L. Johnson & Johnson, 2021). In addition, studies show that men are more likely to blame the victim because they are less likely to identify with female survivors of sexual trauma (Ferrão & Gonçalves, 2015). In a recent study, Grace and Klaufman (2020) recently used other scales, including DeKeseredy and Kelly (1995); and they found that men (cis and trans) reported more rape-supportive peer norms and lower prosocial consent attitudes than women and nonbinary students.

Based on Suarez and Gadalla (2010) analyses, individuals who coded as "men" and "White" had a lower RMA score than those who did not with a moderate effect size of (-.43, $p < .05$). This finding suggests that racial and ethnic social locations may be associated with rape myth acceptance. A much earlier study on rape myth acceptance among college students asserts that Black men may be more likely to accept certain myths about women lying about sexual assault as a defensive reaction to the stereotypes of Black men as perpetrators of sexual violence (Giacopassi & Dull, 1986). However, in a more recent study (Hayes et al., 2016b), racial identity was not a significant predictor of

rape myth acceptance. In general, the literature about rape myth acceptance does not present conclusive evidence of the influence of racial identity.

Another limitation of present scales for rape myth acceptance or rape-supportive beliefs is the lack of racially and ethnically specific items. The two most prominent scales for rape myths do not offer an intersectional lens beyond the gendered dimensions of rape myths. Based on an intersectional-ecological model, structural oppression and cultural constructions of sexual scripts provide context to rape myths. Black feminist literature asserts that the intersections of gender, class, and race lead to nuanced rape myths about Black women that are yet to be empirically investigated (White et al., 1998). This study seeks to contribute to the literature on rape myths from the perspective of Black parents.

Intersections of rape culture and systems of oppression

Critical race theory and intersectionality posit that racism, sexism, and classism, are not results of natural occurrence but are systemic; similarly, rape culture should be viewed from the complex interplay of historical, political, and structural oppression that influences individual and community beliefs, perceptions, and behaviors. The historical context of institutionalized racism through slavery and the Jim Crow era of segregation has compounded sexual trauma for Black families and survivors. Angela Davis asserts, "The fictional image of the Black man as rapist has always strengthened its inseparable companion: the image of the Black woman as chronically promiscuous. ... Viewed as 'loose women' and whores, Black women's cries of rape would necessarily lack legitimacy" (1983, p. 182). Furthermore, the experience of Black men being falsely accused of raping White women, which led to lynching and incarcerations of innocent

people (e.g., “Exonerated (Central Park) Five,” Emmette Till) has resulted in suspicion of accusers of Black men as perpetrators of sexual violence (Gómez & Gobin, 2020; Tillman et al., 2010). Even though less than 1% of reported sexual assault results in felony convictions, the National Registry of Exonerations found that a Black person convicted of sexual assault is three and a half times more likely to be innocent than a White person who has been incarcerated for sexual assault (Gross et al., 2017). Moreover, Hattery and Smith (2021) find that Black men are nearly seven times more likely to be wrongfully convicted for the rape of a white woman than the crime is to occur. Thus, the racist history of sexual assault in the United States makes the Black woman or girl an unlikely victim, and the Black man or boy presumed guilty.

In a discussion of global contemporary feminist advocacy Kalra and Bhugra (2013) examine sexual violence from an inter/cross-cultural perspective, asserting that “sexual violence is socio-culturally constructed” and is impacted by “male backlash for growing gender equality” (p. 246-247). Therefore, in line with Intersectionality, we should view rape culture as pervasive throughout all ecological levels of society but particularly at community and interpersonal levels that provide the family context for Black parents. Consequently, the context of racism is included in an exploration of rape myth beliefs among Black parents. Rape culture, the stigmatization of sexual trauma, and acceptance of rape myths is not unique to Black people; however, by utilizing Intersectionality, this study seeks to contextualize the larger structural and historical context of patriarchy and gender inequality and other structural factors that contribute to

the perceptions and beliefs of Black parents regarding victim-blaming and silencing concerning sexual trauma.

Parenting from the Margins: Cultural dimensions in Black communities and families

This section reviews literature that provides the cultural context for the community-level analysis of the influences of rape culture on Black culture and communicative behavior within Black families regarding sexual health and trauma. Health communication scholar Mohan Dutta's Culture-Centered Approach (CCA) encourages us to contextualize phenomena within communities' historical, social, and political-economic experiences, particularly in examining health disparities of marginalized communities (Dutta, 2007; Dutta, 2018). CCA also emphasizes the agency of the communities through empirical evidence resulting in appropriate prevention and intervention messaging for social and behavioral change. Dutta's culture-centered is in alignment with the Intersectional-ecological paradigm of this study.

The Black population in the United States is diverse and growing (Tamir, Budiman, Noe-Bustamente, & Mora, 2021). According to the recent survey data, 46.8 million (14% of the general population) people in the United States identify as Black, which is up from 36.2 million (13% of the general population) in 2000 (Tamir et al., 2021). The majority (87%) of the Black population identify as a single race, with 8% identifying as Black and other (mainly White), and 5% self-identified as Black Hispanic. The Black immigrant population rose from 7% in 2000 to 10% in 2019; the growing number of foreign-born Black people are mainly from the Caribbean and African

countries. The Black population that has earned at least a bachelor's degree has increased from 15% in 2000 to 23% in 2019. The Black population is one of the most economically divided groups in the U.S. (after Asians) (Kochhar & Cilluffo, 2018). There have not been significant increases in median household income since 2000. The median income among Black households is presently about $44 000, with about 54% of the Black population making under $50 000. Seventeen percent of Black households have a median income between $50,000 – $74, 999 and only 18% have a median household income of $75,000.

Intercultural and family communication scholarship has utilized Hofstede's dimensions to examine cross-cultural differences in communication styles across nations, and families, particularly when it comes to conflict (Ting-Toomey, 2015; Shearman & Dumlao, 2008). In addition, several studies that examine cross-cultural contexts of sexual health and sexual trauma have also applied Hofstede's conceptualization of culture (Kalra & Bhugra, 2013; Kamimura et al., 2016; Lehane, n.d.; V. K. Luthar & Luthar, 2002a; Mallory et al., 2019). The following subsections situate Black culture based on Hofstede's theory of cultural dimensions (Hofstede, 2001, 2011). The three constructs that will be discussed are (1) power distance, (2) masculinity versus femininity, and (3) collectivism versus individualism. These dimensions will not be operationalized as individual constructs within the analysis; however, they provide the socio-cultural context for communicative behaviors, beliefs, and perceptions of Black parents that will be explored and analyzed in this study.

Power distance: marginalized parents

It is essential to explore how cultural dimensions influence family communication about sexual health, particularly for nondominant cultures that may engage in assimilation and acculturation to fit the status quo (Kim et al., 2020). Hofstede's definition of power distance includes the extent to which the less powerful or nondominant members of society, an organization, or institutions (including family) have accepted and expect an unequal distribution of power. Cultures are examined on a spectrum from small to large power distance, with small power distance seeking a more egalitarian society where the misuse of power is criticized and ideally held to account, and significant power distance indicating that "hierarchy means existential inequality" (Hofstede, 2011, p. 9).

From an Intersectionality perspective, examining the beliefs and behaviors of Black parents is studying a historically marginalized population of subordinated and nondominant groups with power differences within social identities and categories. This history includes structural inequality and policies that have led to racist stereotypes of the "welfare queen" and "deadbeat dads." For many Black parents, the context of parenting while Black in America means external and internalized racist assumptions of yourself and your children influence the care and guidance to your children (Peters, 2002; Watts-Jones, 2002). Furthermore, racism, in the form of racism-based trauma, racist microaggressions, and racial discrimination, is a significant stressor that negatively impacts health outcomes for Black people and families (Moody & Lewis, 2019; Saleem et al., 2020; M. T. Williams et al., 2018). Public health scholarship has examined racial

trauma by developing various measures, including a perceived discrimination scale to analyze the effects of racism and discrimination on health outcomes and disparities (D. Williams & Cooper, 2019; D. R. Williams et al., 2010; D. R. Williams & Mohammed, 2009).

Several studies have explored how structural and interpersonal experiences of racism influence how parents socialize their children to prepare for racism and cope amid racial violence and trauma (Anderson et al., 2019; Anderson & Stevenson, 2019; Condon et al., 2021; McNeil Smith & Landor, 2018; Opara, 2018a). Kendell (2020) identifies this as "survival parenting" and asserts, "For marginalized parents, every decision carries the additional risk of their children being impacted by someone else's bias" (p. 241). In a recent study with Black mothers of preschool-aged children, Condon and colleagues (2021) found that an increase in parenting stress is associated with perceived racial discrimination. Anderson and colleagues (2018) assert that "To protect their children from the negative emotional and physiological health outcomes associated with racial encounters, Black families have utilized racial socialization (RS)." (p. 27). Thus, Black parents carry a unique burden of worry about racist encounters for their children while preparing them for the stressor of racism-based trauma.

Hofstede's power distance dimension provides the context of racist paradigms that historically deemed Black parents unfit and disempowered. The lived experiences of discrimination marginalize Black parental figures and their children. Still, while Black parents may experience being in a less powerful position in society, the expected role of authority with their children to provide health information is critical to this study. The

intersections of subordination and power in the experiences of Black parents lead to complex and conflicting experiences that may influence interpersonal communication between parent and child.

As mentioned earlier, sexual trauma within Black communities should be contextualized within the history of slavery and the manifestations of everyday racism. Therefore, racism-based trauma intersecting with rape culture contributes to the macro-level of the model in this exploratory study. Nevertheless, racism-based trauma and the effects on parental communicative behaviors need more exploration. Thus, this study includes the perceptions of racism-based discrimination of Black parents as an antecedent to their communicative behaviors regarding sexual health and trauma.

Collectivist expectations of Black parents

Hofstede's cultural dimension of collectivism and individualism is a spectrum that identifies how cultures view the self in relation to others. On one end of the spectrum, individualistic nations and cultures are defined by their right to privacy, and a value of self-determination. Within the westernized countries, the extension of oneself is to the immediate nuclear family, and not much larger than that. Conversely, collectivism is an identifier of cultures with a "we" consciousness and emphasize belonging to community with preference on the needs of the group over the individual, which is seen in African and Asian countries (Asare & Sharma, 2014; B. Kim et al., 2020).

Scholars of Black family life in America have identified that while the United States is more of an individualistic nation, African Americans and others who identify with the African diaspora are more collectivist in perception and behavior (Allen &

Bagozzi, 2001; McAdoo, 2007, 2001; Marchand et al., 2019). According to scholarship on Black communication and identities, Black culture is deeply rooted in communal and social cohesion (Jackson, 2004). The collectivism among Black communities is both a cultural connection to African nations, and because of being a marginalized group in the U.S. due to historical structural racism, which has required a "pulling together" mantra to survive post slavery oppression through Jim Crow Law and discrimination. Furthermore, within a collectivist culture, the raising of children is seen in communal practices, as childrearing is also the responsibility of the extended family, especially grandparents, aunts, and uncles of biological parents (McAdoo, 2002; McWright, 2002). Collectivism is communicated in Black communities through the "extended family" or the "village" with neighbors, religious communities, and other social connections.

In collectivistic cultures, sexual assault as a highly stigmatized experience brings shame to the individual and the family, resulting in the silencing of the survivors for the sake of the collective (Jacques-Tiura et al., 2010; J. L. Kim & Ward, 2007). In addition, studies have found that the level of privacy and concealing the experience of survivors, particularly children, has led to intra-racial trauma where the protection of a male family member, or trusted male friend, or spiritual leader is more important than the justice and healing of the survivor (Gómez & Gobin, 2020; Tillman et al., 2010). The historical roots of sexual assault as a weapon of institutionalized racism impact the present-day context of the expectation to the stigmatized experiences within the family, and the larger Black community, as a sign of loyalty (Collins, 2004; Gómez, 2019). Pierce-Baker emphasizes that,

> For Black women, where rape is concerned, race has preceded issues of gender. We are taught that we are first black, then women. Our families have taught us this, and society in its harsh racial lessons reinforces it. Black women have survived keeping quiet, not solely out of shame, but out of a need to preserve the race and its image. In our attempts to preserve racial pride, we black women have often sacrificed our own souls. (1998, p. 84)

Nevertheless, scholars with an intersectional and Black feminist lens have discussed collectivism within Black culture as both a barrier and an opportunity for social support for survivors of sexual trauma (Ullman & Lorenz, 2020b). Based on the communal nature and collectivist characteristics of Black cultures, there is a sense of informal social support that Black survivors seek from their community that extends beyond the nuclear family even within the historical context and pressure of silencing Black women's pain (Hakimi et al., 2018; Tillman et al., 2010; Ullman & Lorenz, 2020). However, there seems to be a limit to the communal support because these sources do not always provide the supportive communication that survivors need, leading to re-traumatization risks due to disbelief or victim-blaming. Therefore, based on the literature, the cultural dimension of collectivism and how this influences the discourse about sexual health and trauma in Black families is a central theme in this study's examination.

Another cultural dimension, which is not included in Hofstede's dimensions but is relevant to collectivism, is religiosity, or the influence of religious identity and ideologies on community and cultural values. Historically, religion has been a prominent cultural marker of Black families and communities as sources of hope and inspiration in fighting

racial injustice (Mohamed, Cox, Diamant, & Gecewicz, 2021; Park et al., 2020). Places of worship , also known as the "Black church," have served as safe spaces for enslaved Black people to escape to the North, the racial solidarity and movement building during the Civil Rights era and continue to be a source of refuge (LaRoche, 2014). However, recent trends indicate that young Black adults are less religious and attend religious services less than older generations. Still, the "Black church" is considered a valuable site for cultural identification (Mohamed, Cox, Diamant, & Gecewicz, 2021)

There has been considerable scholarship on the role of the Black church to promote health education that influence health behaviors and positive health outcomes (T. T. Gross et al., 2018; Rowland & Isaac-Savage, 2014; Tucker et al., 2017). However, religious institutions have been identified as potentially harmful spaces where children are at risk of sexual abuse due to the perpetration of trusted clergy (Hauser, 2017). In addition, the patriarchal and heteronormative traditions marginalize women, and persons who fall into what is considered "sexual deviance," including those who get pregnant before marriage, get divorced, and identify as queer, homosexual, transexual, or nonbinary.

There is a complex relationship between the Black church and those who experience sexual trauma, with a tension between support and silence. Ministers and clergy are often recipients of disclosure and provide social and spiritual support. However, sometimes this denial of pain is through forms of religiosity that traditionally has demanded a silence of victims in the name of forgiveness or protection of powerful "spiritual" men, and the silencing of Black queer survivors due to homophobia within

religious culture (Bryant-Davis et al., 2012; Harris, 2020; Ward, 2005). Moreover, religiosity in family settings is a barrier to disclosing sexual trauma because of the shame and guilt associated with any sexual activity, even nonconsensual (Bryant-Davis et al., 2012; Ullman & Lorenz, 2020b). Interestingly, meta-analyses of rape myth studies did not identify religiosity as a significant correlate to rape myth acceptance (Suarez & Gadalla, 2010). Nevertheless, researchers and community leaders have argued that the role of the Black church, as a trusted institution in Black communities, has the potential to promote health literacy, influence healthy sex communicative behaviors, promote safe family environments, and provide support for survivors (Prins & Mooney, 2014; Rowland & Isaac-Savage, 2014; Tillman et al., 2010). Thus, this study explores the role of religion as a cultural marker in Black communities and parents' religiosity as an important construct within an analysis of Black parents' beliefs, perceptions, and behaviors regarding sexual health and trauma.

Intersections of Gender dynamics

According to Hofstede, cultures can be analyzed based on the "distribution of values between the genders" (2011, p. 12). Femininity is expressed within cultures by minimal social role differentiation between genders, for instance, in balancing family and work life. In addition, a matriarchal element is emphasized in more feminine cultures, with more women in elected political positions and mothers in decision-making positions regarding family size. Conversely, masculine cultures are more patriarchal, where work is emphasized over family, and fathers decide the number of children in a family.

Many Black families, based on this dimension, could be described as feminine because over a third (32%) of Black people live in households headed by women (compared with 6% in with male householders and 38% with a married couple) (Tamir, Budiman, Noe-Bustamente, & Mora, 2021). The complexity in female-headed households is that women who are single parents will hold traditional masculine roles. The legacies of enslavement and present-day mass incarceration have led to a disproportionate number of Black men being criminal-legal system impacted (Alexander, 2010). Moreover, historically, Black families identify with matriarchal family systems; even the extrafamilial support is likely to be matriarchal with the assistance of grandmothers and aunties raising children (Ahmeduzzaman & Roopnarine, 1992). This context does not give credence to the myth of Black fathers being absent from their families, which was debunked in a recent CDC report (J. Jones, 2013), but due to the socio-economic factors and history of structural oppression, many Black children are raised with one parent.

Intersectionality scholar Patricia Hill Collins (1998) examined the family as "a privileged exemplar of intersection," asserting that, "In the United States, naturalized hierarchies of gender and age are interwoven with corresponding racial hierarchies" (p. 65). The reality of many Black families is contrasted with the westernized heteronormative depiction of traditional gender roles of a masterful man with a submissive woman—thus framing Black relationships and families as dysfunctional (Davis, 1983; Collins, 2005). Furthermore, the matriarchal system within Black families is stigmatized from the dominant cultural perspective, mainly because the role of a single

mother as head contradicts the ideological construction of the family system as a site for social organization (Collins, 1998). In addition, Black men have been framed as the "other" in contrast to the manhood constructed around whiteness and heterosexuality. This study seeks to include the gender dimensions within an intersectionality paradigm by layering this dimension within the community-level influence of the Black church, exploring parents' beliefs and defined gender roles of masculinity and femininity about sexual health.

In summary, it is important to note that these dimensions are all socially constructed; moreover, this study investigates these cultural dimensions of Black families and communities as a heterogeneous population with varying degrees and experiences of these cultural factors.

Parents' communicative perceptions and behaviors

The scholarship suggests that parents remain vital sources of health information and social support pertaining to sexual health and trauma. The population for this study includes parents who identify as Black or African American, who are racially marginalized, and whose parenting is contextualized by structural factors. In previous sections, the broader contexts of rape culture and community-level cultural dimensions provide the necessary historical, political, and social contexts for behaviors, beliefs, and perceptions. In this section, the literature review highlights the micro-level of the proposed Intersectional-Ecological Framework for this study.

Parent-child sexual health communication

As far back as the 1980s, social science scholarship has outlined the value and influence of parent-child communication on sexual health (Akers, Holland, et al., 2011a; DiIorio et al., 2003; Kuvalanka et al., 2013; Morawska et al., 2015; Padilla-Walker, 2018; Pluhar et al., 2008; Pluhar* & Kuriloff, 2004). These studies include exploration through both quantitative and qualitative analyses about the process of communication about sex, sexual risks, and sexuality, and how parents' communication styles, habits, and approaches predict children's sexual behavior (DiIorio et al., 2003; Flores & Barroso, 2017; Widman et al., 2019). In addition, several studies have found that parents are significant sources of sexual health information that influence children and adolescents' sexual behavior and perceptions of safe sex (Byers et al., 2008; Flores & Barroso, 2017; Pluhar et al., 2008; Vongsavanh et al., 2020). For example, Widman, Choukas-Bradley, Noar, Nesi, & Garrett (2015) reviewed 52 studies (over three decades) examining the effect of parent-adolescent sexual communication on adolescent behavior. The meta-analysis included more than 25, 000 adolescents and found a significant positive relationship between parent-adolescent sexual communication and safe sex, including condom and contraceptive use among youth (Widman et al., 2014).

Studies have shown that insufficient parent-child communication about sex is due, in large part, to parents' lack of access to information and "prevention programming" about sexual health topics (Prikhidko & Kenny, 2021a). Furthermore, parents may exhibit hesitancy to discuss sexual health beyond a basic introduction of anatomy for varied reasons, including a lack of information on sexual topics themselves—particularly more

taboo and stigmatized issues like sexual assault (Prikhidko & Kenny, 2021a; Vongsavanh et al., 2020). In addition to the gaps in the information given, parents generally feel "awkward" in discussing sexual topics with their children (Christensen et al., 2017). Parents are also unsure of the age to begin these conversations about sexual health. Most of the literature focuses on adolescents and asserts that parents' messages are influenced by the child's age or perceived developmental readiness (Byers et al., 2008).

The scholarship findings suggest that mothers are more likely to communicate with children than fathers. This finding is unsurprising considering the socialization of mothers and maternal caregivers as nurturers and teachers across cultures. Moreover, mothers are more likely to talk to their daughters; and when fathers do discuss with their children, they are more likely to speak to their sons than their daughters (Hutchinson, 2002; Hutchinson & Montgomery, 2007; Ohalete, 2007; Opara, 2018b; Pluhar et al., 2008; Wyckoff et al., 2008).

In addition, recent studies have indicated that using technology and social media is another challenge parents have to navigate in sex communication. For example, a recent study with U.S. high school students found it is uncommon for adolescents to talk with their parents about their digital sexual behaviors: sexting, pornography use, and online flirting/dating (Widman et al., 2021). Furthermore, studies have examined the influence of viewing pornography and internalizing harmful sexual scripts that objectify and perpetrate aggression against women (Henry & Powell, 2016; Oddone-Paolucci et al., 2000; Owens et al., 2012). Sexual violence in this digital age takes on many forms that parents may not feel equipped to discuss with their children.

The literature on parent-child sexual communication is marked by some limitations. Firstly, there is generally a small representation of racial and sexual minoritized populations of parents and children included in the research. In addition, there is a lack of an intersectional analysis when analyzing the experiences of vulnerable people, including Black families. Due to structural racism, Black children are at risk for unplanned pregnancy, STIs, and HIV infection. Often the analyses are limited to individual-level behaviors without critical analyses of ecological variables. Specifically for Black parents, studies suggest that parent communication about sexual risks, including HIV infection, is significantly aligned with the beliefs and behaviors among Black adolescents (Aronowitz et al., 2015; Cederbaum, 2012a; Opara, 2018a).

Cedarbaum's (2012) study with African American families and sexual risk communication with 12 mothers who were HIV-infected and their ten daughters provides critical information on the importance of open and honest communication resulting in more awareness of the potential adverse outcomes of risky sexual activity. Cedarbaum's study extends previous scholarship on parent-child sex communication by examining the Black families experiences with health challenges and how that influences sexual risk communication with their children.

Considering the previous section that reviews the research on religiosity within Black families, there is an inconsistency in the data that suggests Black parents' adherence to religious beliefs and their attendance to religious services influence their beliefs and communication about sexual topics with their children (E. Moore et al., 2015; Rose et al., 2014). For example, Pluhar, DiIorio, and McCarty (2008) found a positive

relationship between mothers who believed religion was essential to their lives and the frequency of sex communication with their children. In a study with African American young men who have sex with men (AAYMSM) found positive perceptions among their participants (youth and parents) about parent-child communication as sources of support and guidance sexual health communication with their parents (Rose et al., 2014). However, there were mixed feelings discssuing HIV/AIDS, sexual orientation and other "sensitive health issues." Moreover, Rose and colleagues (2014) found that parental religious beliefs was a barrier in communicating about sexual orientation Nevertheless, gaps remain in the literature, and this study aims to contribute by examining Black parents' sex communication behaviors in relation to other intersections and ecological layers.

Parental self-efficacy in communicating about sexual trauma

Studies found that parents' perceptions of themselves and their abilities to convey sensitive and well-informed messages (i.e., parental self-efficacy) to their children about sex as a significant barrier to sex communication (Christensen et al., 2017; Morawska et al., 2015). In many studies on sex communication, self-efficacy (Bandura, 1977, 1982) is included to assess the individual's confidence in their ability to perform desired behavioral or communicative change. In parent-child communication about sexual health, the parent's self-efficacy, or "confidence," examines their knowledge about sexual topics and their abilities to convey accurate information, particularly when it comes to children under 12 years old (DiIorio et al., 2001; Morawska et al., 2015; Pluhar et al., 2008). To the knowledge of the researcher, there have not been any studies that investigate parental

self-efficacy in communicating about sexual trauma. Included in this study is an exploration of Black parents' perceived self-efficacy regarding communicative behaviors regarding sexual trauma.

The scholarship suggests that parents are more likely to discuss sexual risk topics (i.e., abstinence/delaying sex, STDs, pregnancy, abortion, condoms/contraception) than sexual positive topics (i.e., dating/romantic relationships, sexual satisfaction, different types of sexual practices, choice of sexual partner, talking about sexual wants/needs) (Evans et al., 2020; Flores & Barroso, 2017). Parents may be inclined to discuss sexual risk topics because they are concerned with the potential long-term adverse effects of sexually risky behaviors.

In addition to parental self-efficacy, recently, Prikhidkho and Kenny (2021) found that "married parents talked more to their children about child sex abuse and possessed more knowledge about sexual abuse than single parents" (p. 6). However, it is important to note that their study did not investigate the specific behaviors of Black parents who were married or single and did not conduct analyses that included racial identity, marital status, and parents' communicative behavior. Therefore, this present study seeks to contribute to this recent finding by exploring how family settings and marital status in Black families may influence communicative behavior about sexual health and trauma.

Furthermore, there is a scarcity in the literature on parents' acceptance of rape myths. Deblinger et al. (2010) found that even when parents talk to their children about sexual abuse, they emphasize that strangers are the more common threat or possible offender. Parents being more likely to stress "stranger danger" in their communication

about sexual abuse and assault is consistent with the rape myth that most perpetrators are people that the survivor does not know; when in fact, most are well-known to the families of the survivors. Prikhidkho and Kenny (2021) recently surveyed 302 parents 54% Hispanic, 33% White/nonHispanic, 9% Black, 2% Asian, 2% nonidentified, with 90% mothers and 10% fathers in the sample. This study found that the social stigma of sexual abuse, including shame and victim-blaming, influences parents' awkwardness in talking to their children about sexual topics(Prikhidko & Kenny, 2021b). Moreover, they found that less than 50% of a sample of 302 parents talk about the potential risks of someone they know perpetuating some form of unwanted sexual touch or interaction.

The present study explores sexual trauma within a family setting and seeks to add to the literature on parents' self-efficacy and communicative behaviors about sexual health and trauma.

Parent-child sex communication: Limitations and Opportunities

Within these studies are significant variations in parent-child sex communication patterns based on demographic indicators, personal characteristics, knowledge and belief systems, and family relationships. Moreover, among the articles that include the experiences of Black parents and children, there are two overall limitations to the studies reviewed in this section that this study intends to address: (1) the lack of an intersectional framework analysis of the demographic and structural correlates of parent-child sex communication, and (2) the exclusion of sexual trauma and rape myths as a focal point within parent-child sex communication. Furthermore, there is a need to understand how Black parents perceive their abilities to provide information about sexual trauma and a

supportive environment, rather than the silencing of survivors that many scholars consider a consequence of rape culture and intersecting oppressions (Ahrens, 2006; Logan et al., 2015; Tillman et al., 2010).

Mendelson and Letourneau (2015) provide an insightful argument about the need to focus prevention and intervention efforts from a social-ecological framework, emphasizing the potential influence of training for parents to communicate effectively with their children about sexual health topics. Some scholarship about Black families provides evidence of parent-based sexual health interventions that are effective in increasing parent-child communication about sexual risk and influencing adolescent sexual beliefs and behavior (Akers, Yonas, et al., 2011; Aronowitz et al., 2015; Rose et al., 2014; Widman et al., 2019). However, recent studies call for more sex-positive communication within these interventions, particularly around consent (Evans et al., 2020; Hovick & Silver, 2019; Padilla-Walker et al., 2020). While this study does not include an intervention phase, it is critical to explore Black parents' perceptions, beliefs, and communicative behaviors around sexual health and trauma for future message development.

Considering critical interpersonal and family communication scholarship, Rossetto and Tollison (2017) provide a contemporary theoretical understanding of the kind of communication needed to both undue sexist scripts that maintain rape culture and to develop supportive messages for sexual assault. They make a critical assertation that family communication is an integral site to change heteronormative scripts about sexual and gendered identity. However, their construct of post-gendered family communication

needs an intersectional lens that dissects how patriarchy and racism lead to communication that reinforces myths specifically against Black people and other nondominant groups like survivors from Black queer communities, whose experiences have been muted or ignored. Nevertheless, the nexus of intercultural and health communication provides opportunities for theoretical discussions that challenge the status quo regarding parent communication about sexual health and trauma.

Summary of Literature

The literature provides the historical context and scholarly analysis of how rape culture and rape myths have been reaffirmed through the intersections of structural institutions, community-level cultural dimensions, interpersonal relationships, and individual beliefs in the lives of Black people. This study locates the family system, specifically parents and caregivers, with access to power to disrupt rape culture in everyday situations and contexts in our most private spaces. One aim of this study is to highlight the potential for parents and caregivers to recreate narratives about sexual health and trauma from victim-blaming to perpetrator accountability and support for survivors.

Regardless of racial or ethnic identity, survivors of sexual assault often face victim-blaming or not being believed because of rape myth acceptance (Abrams, 2018; Paul et al., 2009). Nevertheless, studies have found that Black women face harsher and less supportive responses to disclosure than White women, and for everyone Black woman who reports sexual assault, 15 do not. The fear and silencing of survivors are embedded within our society because of rape culture. Understanding the adherence to

rape myths and reducing the stigma associated with sexual assault is a critical objective for translational research and provides the necessary context for expanding theoretical frameworks for studying sexual violence. This study is built on the premise that open-discussion and intersectional messages about sexual health between parents and children play a role in dispelling rape myths, the disclosure of sexual assault to parents, and supporting healthy behaviors in the case of sexual trauma (Smith & Cook, 2008) (Burgoon & Hall, 1994).

Throughout the literature over the last three decades, there is little discussion about parents' communication about the possibilities of sexual trauma. While some studies on sexual assault disclosure mention the role of parents as sexual health information givers and social support providers in the context of sexual trauma, the communicative behavior of parents and caregivers is an understudied phenomenon, particularly in marginalized and vulnerable populations. This chapter contextualizes the body of literature on parent-child sex communication within the broader ecological layers of rape culture and cultural dimensions within Black communities and families. Based on the review of the scholarship, there is an opportunity to expand on the literature by exploring the intersections of structures, cultural influencers, and barriers to communicative behavior from parents about sexual assault and trauma.

This study aims to provide implications for determining and creating the conditions that may facilitate open sexual health communication and support for the disclosure and recovery of Black survivors of sexual trauma. Furthermore, applying these theoretical models and the overarching paradigm of Intersectionality will be effective in

translational research that can lead to interventions to decrease adherence to rape myths and increase sexual health communication among this population. The literature synthesized in this chapter provides the context for the research questions in this study outlined below.

Research Questions and Hypotheses
Phase 1
RQ1: What are common beliefs and perceptions about rape and sexual trauma observed by counseling professionals who work with Black families and survivors?
Phase 2
RQ2: Which demographic factors significantly influence rape myth acceptance scores? $H1_a$: Mothers will have lower rape myth scores (i.e., less acceptance) than fathers. $H1_b$: A relationship exists between parents who have experienced some form of sexual trauma and rape myth acceptance. RQ3: Which demographic factors significantly influence sexual health communication? (gender, education, family context, age of parent) RQ4: To what extent does the experience of sexual trauma influence parents' sex communication behaviors about sexual health? RQ5: To what extent does perceived discrimination influence Black parents' communicative behaviors about sexual health topics, rape myth acceptance, and perceived self-efficacy in discussing sexual trauma? RQ6: To what extent does religiosity influence rape myth acceptance among Black parents? $H2_a$: A significant relationship exists between parents' rape myth acceptance scores and communication about sexual topics with children. $H2_b$: There is a significant association between religiosity and parents' sex communication with their children. RQ7: To what extent do parents' perceived self-efficacy to communicate about sexual trauma influence their communicative behaviors about sexual health? H3: There is a statistical difference in perception of self-efficacy in sex communication based on gender identity of Black parents.
Phase 3
RQ8: What are critical themes of culture and family life that intersect in the stories parents share about their communicative behaviors and beliefs about sexual health and trauma? RQ9: How do parents describe (tell a story) their beliefs and communicative behavior about sexual health and trauma and children?

Chapter Three: Mixed Methodology - A Transformative Paradigm

This study identifies the phenomenon of parents' communication about sexual health and trauma as an essential precursor to destigmatizing sex and sexual trauma, providing openness and safe spaces for promoting healthy sexual behavior and disclosing sexual trauma. This chapter outlines the methodological framework as a mixed-methods study that utilizes a transformative paradigm.

Research exploring the communicative beliefs, perceptions, and behaviors about sexual health and trauma is ripe for Mixed Methods Research (MMR) because it is a "wicked problem" (Mertens et al., 2020, p. 9) and a multifaceted issue. Moreover, sexual health is an inherently interdisciplinary issue requiring transformative approaches (Mertens, 2007) to studying phenomena outside discipline and methodological silos (Maxwell, 2018). Furthermore, proficiency in MMR is seen as necessary for those committed to social justice and transformative work to end sexual violence (Sweetman et al., 2010; Testa et al., 2011). Testa and colleagues (2011) posit that,

> It is the combination or integration of the two approaches [quantitative and qualitative] known as mixed methods research that offers perhaps the best and most thorough means of understanding violence against women. … The resulting mixed methods approach is stronger than either method on its own and can greatly enhance understanding of violence against women. (p. 237)

Consequently, MMR is the preferred methodological approach by many sexual assault researchers because of the desire to assess both outcomes and process: the how, why, and under what circumstances are all critical approaches to grasp the nuances in the experiences of survivors and those that wish to support them.

Critical feminist researchers emphasize that there is no method that is in and of itself intersectional or feminist, and any study has the potential to conceptualize inequities in its methodological design, analysis, and implementation (Else-Quest & Hyde, 2016; Leavy & Harris, 2019) Moreover, Intersectionality and MMR scholars problematize the objective and interpretivist ontological dichotomy, and argue for the complexity of engaging with multiple ways of knowing through multilevel and multidimensional frameworks (Bauer & Scheim, 2019; Bowleg, 2008; Fehrenbacher & Patel, 2020; Greene & Caracelli, 2003; McCall, 2005; Moradi & Grzanka, 2017).

In critical family communication studies, Few, Demo & Allen (2020) assert that "With mixed-methods being guided by intersectionality tenets, there is great potential to increase the explanatory and predictive power of our research on both a microsystemic and macrosystemic level" (p. 340). Thus, for this study, the mixed methodological approach is grounded in a transformative framework (Sweetman, Badiee, and Creswell; 2010) with an Intersectionality paradigm and a mandate for social justice and systemic-level interventions (Alinia, 2015; Cho et al., 2013; Collins, 2009; Esposito and Evans-Winters, 2022).

Identifying the Power in MMR: A Transformative Emancipatory Paradigm

In the article "Transformation Paradigm: Mixed Methods and Social Justice"(2007), Mertens defines the transformation paradigm of mixed methods as "a framework for examining assumptions that explicitly address power issues, social justice, and cultural complexity throughout the research process" (p. 213). From the premise of the paradigm, the ontological assumption is based on a "conscious awareness" that reality is socially constructed (which falls in line with interpretivist assumptions), and that power is the variable that constitutes reality based on the context of privilege and inequity (Creamer, 2018; Mertens, 2007). Those that hold power make the decisions about research: the focus (i.e., defining the problem), questions, and methodological processes of inquiry and evaluation. Thus, to transform the hierarchical nature of research, the epistemological assumption of the transformative paradigm encourages an interactive experience with participants that will judge the translation and implementation of the findings.

The transformative-emancipatory paradigm of MMR seeks to design a methodology that utilizes participants in a participatory and interactive manner a participatory method or community involvement. The axiological assumption of transformative MMR is that the researcher develops and designs the study to advocate for human rights and social justice at all levels of society. The praxeological assumption of the transformative emancipatory paradigm mandates complex analysis that will enhance understanding of a phenomenon with translatable findings within the population's environment being investigated through collaborative efforts and community-level

interventions (Trickett et al., 2011). Therefore, the philosophical assumptions of the transformation paradigm of MMR meet the values and tenets of Intersectionality as a theoretical framework and the objectives of this research study.

The Intersectionality-Ecological framework developed for this study and the Transformative paradigm of MMR both involves an analysis of power. Foucault (1978) identified that "power is not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations" (p. 94). As stated in Chapter 1, conceptualizing power should involve structural and historical perspectives and the communicative aspects of power being expressed and manifested throughout ecological and relational layers. The differences in social constructions of reality, cultural complexities, and the power dynamics in the relationships that influence human behavior among this population are integral to this study.

The researcher has the power and privilege to design the research study; utilizing the transformative paradigm is imperative to center the experiences and needs of Black parents and survivors of sexual trauma. Thus, the researcher's positionality is examined with a survivor-centered analysis of the literature and the researcher's experience as a sexual assault advocate and Black parent (Gill, 2018). The community focus of this study provides an intra-categorical intersectional exploration of the diversity in experiences, behaviors, and perceptions of Black parents. In addition, while the researcher is a Black parent, there was an intentional objective to maintain "cultural humility" and develop a

collaborative relationship with community organizations that specifically work with Black parents (Fehrenbacher & Patel, 2020).

Based on proximity to George Mason University, the D.C., Maryland, and Northern Virginia communities were targeted for this study. Between March and September 2021, the researcher made several attempts to connect with many nonprofits in the DMV area. Based on the response and reception to the research proposal, the primary community partner for this project are directors from Edgewood/Brookland Family Support Collaborative, a nonprofit Washington, D.C. that focuses on economically disadvantaged families that are predominantly Black and Latino racial and ethnic backgrounds. Throughout the study's recruitment and data collection process, the researcher met with various managers and directors of this nonprofit seven times (approximately 2-hour virtual meetings each time) between July 2021 and January 2022. Due to the COVID-19 pandemic, these meetings took place virtually on Zoom. The presentation included a PowerPoint of the study purpose, design, and intentions for further engagement with community-based organizations post-dissertation. This nonprofit agreed to partner with the researcher in recruitment and potential translation of the findings in developing interventions for this community in Washington, D.C. Developing and maintaining community partnership is a critical step in designing interventions based on translatable data with community agendas and approaches (Dutta, 2018).

Study Description – Exploratory Design

According to Creswell and Plano Clark (2018), an “exploratory design is a three-phase mixed methods design in which the researcher starts with the collection and

analysis of qualitative data that is then followed by a development phase of translating the qualitative findings into an approach or toll that is tested quantitatively" (p. 85). This study has two qualitative portions at the front and back end of the study to ground the experiences of the population within the quantitative findings (See Figure 1). Utilizing an exploratory descriptive qualitative design provides information directly from those who are experiencing the phenomenon under investigation.

Furthermore, the transformative paradigm calls for a participatory design for the methodology (Creamer, 2018; Mertens, 2007). The transformative paradigm encourages the use of participatory design, or community-based participatory research (CBPR), to ensure that the beneficiaries of the study are directly involved from design to implementation (Fidler, 2010; Leavy & Harris, 2018; Mertens, 2005, 2009). CBPR emphasizes a reflexive partnership through community-based organizations or a culturally competent board or panel with "community understandings of a relevant concept" (Leavy & Harris, 2018, p. 162). Mixed methods researchers have called this approach a "participatory-social justice design" that involves a cyclical process of research and action stages (Creswell & Plano Clark, 2018).

Additionally, within health communication literature, participatory design is key to strengthening health behavior models, theory development, and successful health promotion interventions, particularly those that seek to be culturally sensitive (M. J. Dutta, 2018; Harvey & Afful, 2011; Kreps & Neuhauser, 2015). Kreps and Neuhauser (2015) posit a "user-centered design" is particularly useful when engaging vulnerable communities, and a user-centered design includes the active involvement of "audience

members." Moreover, building trust and credibility with the community is paramount for developing tailored messages and strategies to improve health behaviors for marginalized populations. In mixed-methods studies, Mertens emphasizes (2007) the importance of building and maintaining trust in a cyclical model "because researchers are responsive to the needs of the communities, and communities witness the power in both qualitative and quantitative data" (p. 224). Following the social justice mandate of Intersectionality, including aspects of participatory designs, in this study reflects the need for another level of accountability to the population.

Research Design

This three-phase study was conducted between Fall 2021 and the beginning of Spring 2022 (See Figure 2). The Institutional Review Board (IRB) at George Mason University approved the study in October 2021. Phase 1 included two online synchronous focus groups with five practitioners in the fields of social work and family counseling and therapy in Black communities, referred to as an "advisory panel." Phase 1 was completed by the beginning of November 2021. After Phase 1, the survey was revised based on the recommendations from the advisory panel. The second phase was an online questionnaire with Black parents with children between the ages of 2 and 24. This survey was administered between December 2021 and January 2022. Finally, Phase 3 included virtual synchronous focus groups over Zoom with parents based on recruitment from taking the survey or snowball sampling from the researcher's network.

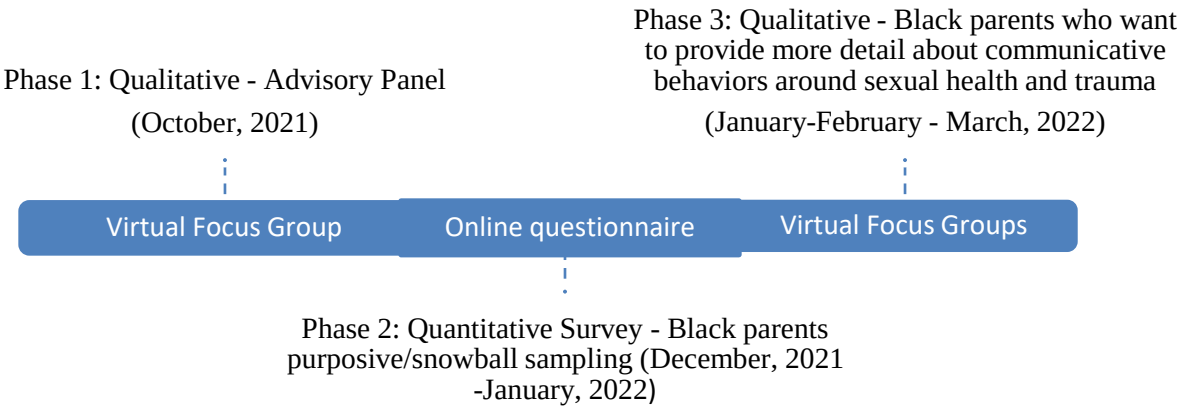

Figure 2: Mixed Methods Plan

Reflexivity

Black feminist scholar-activist bell hooks, in her inspiring work, "Feminist Theory: from Margin to Center," describes her experience as a Black woman growing up in the 60s and her standpoint of being exposed to white social life as an outsider from within (Black women would clean the houses of White people and watch their children), while going back home to living on the margins of a small town in Kentucky: *"Living as we did—the edge—we developed a particular way of seeing reality. We looked both from the outside, and in from the inside out. We understood both"* (2000, p. xvii). This way of seeing, or orientation, can also be described as Intersectionality, which is the organizational lens for this study. As a Black woman in academia, this position of "marginality" has influenced my identity as an inside-out/outside-in social science researcher (Tuhiwai Smith, 2012). According to Dutta, 2018, "Reflexivity brings forth questions of power, who has it and who does not, and the ways in which power plays out in the production of expertise and knowledge" (p. 245). My sense of shared responsibility

comes from my reflexive stance as inside-out, outside-in—as a Black woman in academia, I hold a marginalized position. Yet, as a researcher in Black settings, I have the power to design and interpret the investigations about phenomena that is sensitive and challenging.

Reflexivity is embedded within the mandate for translational research with a motive for social change. Feminist theorists and methodologists Leavy and Harris assert, "we must critically interrogate our own positions within the research process and let go of the false idea that we are the all-knowing authority" (2019, p. 7). Decolonized and post-Black feminist Intersectionality meta-paradigms encourage constant reflexivity and mindfulness about social scientists' assumptions and the researcher's positionality in each project (Alexander-Floyd, 2012; Pasque & Pérez, 2015; Tuhiwai Smith, 2012). My practice for continuous reflexivity began with the first discussion with my chair about my proposed research questions for the dissertation, which began in Spring 2021. After that, I started a research journal (Esposito & Evans-Winters, 2022) and would take notes after every meeting with each committee member. In addition, I created various analytical and reflective memos based on continuous reading and early data analysis during data collection across all three Phases. In addition, after meeting with community leaders, I recorded sentiments immediately following to capture the meaning of these purposeful meetings.

My decision not to disclose my unwanted sexual experiences is intentional. Firstly, sexual trauma is pervasive. Secondly, survivors do not need to divulge this information to warrant compassion or credibility to do this work. These two reasons are

the context in which I identify as a researcher whose scholarship intends to be survivor-centered.

Reflexivity is an ongoing process and requires accountability from peers, committee members, participants, and the communities I intend to serve through my research (Wigginton & Lafrance, 2019). I believe that the process of reflexivity has enhanced data collection and analysis of the research findings through an ongoing awareness of my positionality of being “inside-out” or “outside-in” in each Phase of this study.

Chapter Four: Mixed Methods Results

This chapter outlines the specific methods and results in separate sections for all three Phases. In addition, in line with MMR, in Chapter5, the discussion will explore the interaction between findings in each phase of the study. MMR scholars call this "interpretative comprehensiveness," an identifying marker that explores the interaction and independence of the different methods and results within the research (Creamer, 2018). This approach also meets the overall objective of this study as exploratory based on a meaningful integration of the phases of the study design to present interpretation and meta-inferences.

The guiding research question for all three phases is

> *How do intersections of social categories, such as, race, class, and gender, influence Black parents' a) beliefs, b) attitudes, and c) communicative behavior regarding sexual health and trauma?*

Phase 1: Advisory Panel of Black Parenting Practitioners

The first phase of this mixed-methods exploratory design is to engage with those who work directly with the target population of Black parents and caregivers, an "advisory group" (Dutta, 2018), to provide context from the perspective of practitioners and to increase cultural relevance of the instruments in Phase 2 and 3. For example, a critical objective of convening the advisory panel was to review the rape myth scale instrument for Phase 2 to be culturally relevant. In addition, to contribute to developing the group guide in Phase 3, the advisory panel was asked to discuss the beliefs and behaviors they observed in Black parents about communication about sexual health and trauma. Therefore, this phase seeks to provide data for the following research question:

> *RQ1: What are common beliefs and perceptions about rape and sexual trauma observed by counseling professionals who work with Black survivors/communities?*

Participant Recruitment

The recruitment in Phase 1 was purposive sampling utilizing the researcher's network of social workers, health care practitioners, sexual assault advocates, and community leaders that work directly with Black parents and caregivers. These requirements for inclusion met the needs of a user-centered design with a transformative paradigm, as discussed in the previous chapter.

Participants.

There were two focus groups with five participants, "advisory panelists," two women and three men. Further information on their professional and educational background and disclosed demographic information is presented in Table 1.

Table 1

Demographic information of Phase 1 Participants

Participant No. & Pseudonym	Professional Title, (Years of Experience), and Educational Background	Social Identity Disclosed	Pronouns	Black Parent/Caregiver (Y/N)
Advisory Panel 1				
1 -Mike	Directory of Interpersonal Violence center at a university, (10 years), B.A.	Black man, heterosexual	He/they	N
2 -Kelandria	Professor of Social Work (25+ years), PhD	Black woman, heterosexual,	She/her	Y
3 Russell	CEO of nonprofit family services; (30+ years), MSW	Black man, heterosexual	He/him	Y
Advisory Panel 2				
4 Vanessa	Licensed Clinical Marriage and Family Therapist, and Registered Nurse (25+ years)	Black woman, heterosexual	She/her	Y
5 Samuel	Consultant – President of nonprofit family services; (30 years), MPH, MSW	Black man, heterosexual	He/him	N

Procedure

Once an expert indicated an interest in the study, the researcher sent an initial email to confirm their interest with information about the study. Then the researcher sent

a follow-up email a day before the focus group was sent with the consent form and the Zoom information to join the focus group. As a result, two focus groups (one with three participants and the second with two participants) met at the end of October and the beginning of November 2021. Each focus group met virtually on Zoom for approximately 90 minutes. At the beginning of the focus group, participants were directed to the chat box for the link to a brief 1–2-minute questionnaire to capture demographic information administered through Qualtrics, presented in Table 1.

After participants filled out the demographic survey, the moderator reviewed the consent form to allow for questions. Confidentiality was stressed at the beginning of the focus group. Once all advisory panelists acknowledged their understanding of the study and procedure of the focus group, the recording began, and each panelist gave verbal consent on record. Due to the sensitive nature of the study, discussing the risks of the conversation was important even though the participants engage daily with these topics with their clients and students. Nevertheless, building a platform of safety and rapport was an essential measure that took place in the first portion of the focus group and was facilitated along with introductions. One of the ways to increase connection among the advisory panelists was to encourage them to turn their cameras on, which allowed for the focus group to provide an in-person connection in a virtual setting.

After the focus group was complete, the researcher read through the transcription generated through Zoom videoconferencing software while listening to the focus group discussion to correct any mistakes in the transcription and deidentified the transcripts. Then, in line with the participatory technique, the researcher sent the transcripts back to

the groups with a summary of the quotes likely to be included in the results section. This process allowed participants to expand on their statements or ask any clarifying questions. The focus group was based on a semi-structured guide, allowing participants to add any information they felt was pertinent to the study's overall objective.

Phase 1 Results

The main objective of Phase 1 was to gain information from practitioners who served as an "advisory panel" based on a CBPA. The advisory panelists had well over 20 years of experience on average. They provided deep insight into the population of Black parents and families and the topic of sexual health, specifically sexual trauma. In addition to their expertise, it was imperative to get feedback and recommendations about the Illinois Rape Myth Scale (IRMA) as a measure in Phase 2.

The data analysis for Phase 1 used Critical Thematic Analysis (CTA) (Lawless & Chen, 2019). This form of analysis was chosen based on the critical epistemology of this mixed-methods study (Esposito & Venus, 2022). Lawless and Chen (2019) assert that "Qualitative researchers have a unique opportunity to elicit shared experiences under interpretive lenses and move to critical methodologies that interrogate power" (p.97). This section provides the results of Phase 1, which includes an exploration of the data from the advisory panelists about what they perceive to be the dominant beliefs, behaviors, and perceptions of Black parents regarding sexual health and trauma.

Coding Process

During the focus groups, the researcher kept memos of initial thoughts and reactions to what the advisory panelist was sharing; these first impressions and interpretations were shared with her chair, who met weekly during the data collection phase of the study. These memos were used as a reference once initial coding took place. The Zoom software provided initial transcripts for each focus group, and the researcher reviewed and edited for accuracy and de-identified using numerical identifiers. Each

transcript was linked to Atlas.ti 22 for data management, coding, and analysis. This “cleaning process” also led to identifying initial codes.

Once transcripts were cleaned, the researcher shared them with participants through individual emails (to continue to protect their privacy from other participants) with a two-week response time for their feedback. This data cleaning and sharing process support the researcher's desire for transparency, trustworthiness, flexibility, and reflexivity throughout the coding process and analysis (Esposito & Evans-Winters, 2022; O'Connor & Joffe, 2020; Tracy, 2020).

The first phase of the Critical Thematic Analysis (CTA) includes "open coding," or inductive coding, based loosely on Braun and Clarke's (2006) development of thematic analysis and Owen's (1984) criteria for "repetition, recurrence, and forcefulness." Repetition refers to the *meaning* of the message (i.e., code) that can be interpreted as the same. Recurrence is the "specific occurrence of keywords or phrases" (Lawless & Chen, 2019, p.95). Finally, forcefulness is a coding tool that indicates the importance of a message based on the participant's tone, volume, inflection, and other nonverbal cues. For example, forcefulness was displayed within the focus group setting when the panelists communicated intense agreement either through a nonverbal head nod or a "Hmm."

Open and closed coding.

During the initial coding phase, the researcher identified codes that were as close to the actual text of the transcript as possible while looking for discursive patterns (Lawless & Chen, 2019). Then, using Atlas.ti as a management tool, the researcher developed a code list using in vivo coding, identifying a code that comes

directly from participants' words or "frames of reference" (Esposito & Evans-Winters, 2022). This first phase resulted in over 120 initial codes. While the frequency of codes is not essential to CTA, the frequency of a code was instrumental in identifying the first level of the three criteria of repetition, recurrence, and forcefulness.

The next step was axial coding or the second coding cycle that further reduced the codes into larger coding groups based on interpreting the patterns throughout the discourse among the focus groups. During the "closed-coding" phase, Lawless and Chen further guide us "to consider how the patterned results are connected to larger social ideologies, linking frequency and forcefulness to the influence of dominant social discourse" (p.96). In more traditional thematic analysis, this phase continues the inductive development that leads to the broader codes based on the initial open-coding phase (Creswell & Poth, 2018; Tracy, 2020). The closed-coding led to more comprehensive codes identified as critical themes discussed below in the analysis.

Data Analysis and Results

CTA and constructions of thematic analysis, axial coding, and the interpretation of the codes are nonlinear and iterative processes (Breen, 2006; Creswell & Poth, 2018; Tracy, 2020). Using CTA, themes were defined based on thoroughly examining the codes about the advisory panelists' perspectives that reflected discourses that were repeated, reoccurring, and forceful throughout the data. Next, critical patterns and themes were identified representing Black parents' perceptions, beliefs, and behaviors about sexual health and trauma. Further inductive examination of the results utilized the theoretical concepts from the Intersectional-Ecological Framework introduced in Chapters 1 and 2,

particularly the various contextualization of power (some codes and subthemes are bolded for emphasis). See Table 2 for an outline of the open, closed phases, and critical themes identified. Finally, there is a summary of the recommendations from the advisory panel that were integrated into Phases 2 and 3

Table 2
Two-Step Coding Process for Advisory Panel

Open-coding What was repeated, recurrent and forceful in the texts?	Closed-coding What ideologies, positions of power, or status hierarchies are recurring, repeated, and forceful?	Themes Findings/Interpretations
• Community protection of Black men, protection by survivors (generally women and children)	• Protection from systemic oppression; • Racialized experiences of sexual trauma within American history, • Structural violence through the criminal legal system	• Theme 1: Protection as a response to perceptions and beliefs regarding sexual trauma among Black parents
• Conservative religious viewpoints about sex, sexuality, and sexual trauma.	• Patriarchy, • Sexism, • Collectivism	• Theme 2: Rape myths based on racist and sexist ideologies
• Increasing self-efficacy from fear-based to communicating about sexual health based on knowledge and experience of sexual trauma.	• Parenting as nondominant, minoritized; • Power distance (i.e., hierarchical status of parents)	• Theme 3: Parents' sexual health communicative behaviors

Theme 1: Protection as a response to perceptions and beliefs regarding sexual trauma among Black parents.

The advisory panel first shared the beliefs and perceptions they regularly encounter in their practices and engagement with Black parents. Many of these beliefs fit within broader victim-blaming tropes discussed in Chapter 2's literature review. However, there was forcefulness regarding the pervasive victim-blaming within Black communities and the historical context of this communicative behavior.

Vanessa, a licensed family therapist, shared that when speaking with parents of boys – she has heard on multiple occasions that "someone will cry rape." The fear of false accusations was discussed throughout the focus groups with advisory panelists. This fear based on historical atrocities rooted in white supremacy continues to influence the perceptions about rape, especially regarding the Black men and boys being accused as perpetrators of sexual violence. When I asked a follow-up question about why this is the case, panelists affirmed that the history of lynching Black men in America based on White women accusing them of rape had left an indelible mark on Black parents and the community in general. In the first advisory panel, Mike, who works at a university center to address campus gender-based violence, stated,

> *You know this history of black men being falsely accused of sexual assault and rape in ways that, of course, were incredibly violent and …that's still a very real thing, the threat of a criminal legal system in targeting all of us [Black people] but specifically black men and unique ways.*

Panelists in the other focus group suggested that the fear of false accusations creates a [cultural] block – a refusal to face the fact that sexual trauma is often intra-racial, and the perpetrator is likely to be someone the victim knows. These perceptions and beliefs result in internal struggles to accept that perpetration is often within the community. Once again, Mike offers the following interpretation:

> *Recognizing and acknowledging the ability of men in our community that we love, …, their ability and capacity to cause harm. … which I think is two-sided, one I think it's always difficult to accept it, somebody that you may love and care about could potentially hurt somebody.*

The discussion of the **protection** of Black men was repeated among advisory panelists as behavior that often leads to potential victim-blaming. For example, Samuel stated that girls are frequently asked *"what did you do to provoke this [sexual assault]?! And boys are asked "Is this really true?" or "did this really take place?"* This suggests that boys accused of sexual assault are often given the benefit of the doubt. Moreover, there is a desire to protect Black men from being accused that even survivors feel responsible for, while forfeiting protecting themselves. Kelandria, a professor of social work and practitioner, identifies this dilemma:

> *Individual protection mm hmm what does that mean for corporate family or my [the survivor's] protection and well-being. 'Family first,' right?! We hear this narrative about family first. What does that mean for me as an individual victim or survivor, do I put the family first and not share family business.*

Furthermore, this protective behavior also connects to the **fear of calling the police** on Black men. When I shared the statistics of the low disclosure among Black women survivors of sexual trauma, panelists provided insight that the lack of reporting connects to the fear of what could happen next. The advisory panelists repeatedly stressed that the mistrust of law enforcement should be included in the context of why Black families do not disclose to anyone, primarily legal authorities. The fear of the criminal legal system was shared among all the panelists in the first focus group, and the vulnerability of criminalization of Black people. In Kelandria's words:

> *What does that [disclosure] look like for black folk and black community …we already have less power, less control and the fear of reporting.*

Mike offered the following:

> *A mother of a child who has been sexual harmed may say 'I don't want the COPs to hurt my you know, the father of my children.' It's also 'how is this going to impact my family.'…Because you know they provide income to this household right, and so I think that you know people who experience violence, and especially the most vulnerable, which includes you know black women. [They] are making all of these different considerations of you know of needs, you know just basic hierarchy of needs…*

In the same conversation, another panelist, Russell, a director of an organization that supports families in high-density urban areas, gave his perspective based on clients who are parents that fall within a low-income socioeconomic status facing multiple marginalized social locations and identities.

It's the fear of getting it out as Kelandria was saying; and what's going to happen if it goes outside [the family or community] you know?! If this is reported, then, 'am I bad mother a bad father,' you know, does this mean 'i'm going to jail now, because a failure to protect from the child welfare' You kow that's the first thing my parents think about from [name of city] is 'I am going to get charged because of the failure to protect?"

Russell continued talking about the messaging that uses the fear of the criminal legal system within this context of sexual violence to manipulate disclosure behavior.

Going back to that element of power in the White house or the hood. that element of power and control still exists, whether that's the uncle who's molesting who says, 'if you tell.You know i'm going to harm you or i'm going to harm your parents or, if you do that, you know it's gonna mess up the whole family… If the person is perpetrating [abuse] they give that message 'you don't want mommy and Daddy to go to jail you don't want to be taken away,' like I said that messaging.

Russell's statement also connects to Kelandria's comment about protecting the family from scandal. In response to Russell's comment, Kelandria asked a rhetorical question that addresses one of the major themes of the study,

So are we saying, then, that silencing for us, meaning black folk, could be an act of protection [intentional pause] and perseverance, and survival? for the sake of the family and because of that fear factor, you thought that keeping your mouth was the best way to do it in internalize it and just push through.

This initial advisory panel was the first time during data collection that silence was identified as a communicative behavior of victims, and silencing as an **act of protection and even survival** from a familial and cultural perspective. Russell affirms Kelandria's question and comment, speaking as a child who experiences abuse, "Where am I going to live, if I tell them [the police] they take me away from my family away from my siblings."

In a later panel, Vanessa also discussed **silencing as internalizing blame as the victim**. Panelists repeatedly discussed victim-blaming that happens from the victim, the family, and close community of the victim, especially if it is a young girl. In an earlier panel discussion, Mike asserted that often the blame is put on the girl (i.e., victim),

> *I've heard something about you know 'they have been too fast,' you know she shouldn't been out there, you know entertaining the things that they were entertaining whatever that may be, so I you know I think the best way to simplify, that is a form of victim-blaming*

Other participants agreed with Mike's statement. The phrase "too fast" refers to perceived hypersexuality and is used in the Black vernacular. This idiom connects to the misogynistic theme that it is the girl's fault, either because of her behavior or appearance. Kelandria stated, "*well she shouldn't have been wearing this or that, or if she hadn't been doing this …*" This gendered victim-blaming also connects to the **lack of accountability of male perpetrators** and **community protection**, as Kelandria notes:

Whether it's our husbands our fathers or grandfather's or our sons, it is the black woman's responsibility to protect him, that is, the perception right. Regardless of his level of innocence or guilt.

Several panelists noted that Black men with "status" or "power" are seen as targets for an accusation of sexual assault. Mike brought up the example of Kobe Bryant and how some people would say,

'*Why does he have to rape! He's so and so'... And I think that speaks to a misconception of rape as being something about sex rather than something about power, you know*.

A discussion of accountability followed the statements about community protection, where the "church" was perceived as a safe place for disclosure. However, panelists also shared that disclosure of sexual trauma to a church leader did not always lead to support for the survivor. For example, Kelandria said:

I think that could speak to the intersectionality piece.You know, if we add in the spiritual religious component it just gets even more convoluted.Because do we share and hear messages of forgiveness. And accountability, what does that look like?!

In a critical moment of forcefulness, Russell responded,

You want to talk about a silent button! ... I don't want to over generalize and put all churches, but typically. [they will say] 'Okay, we come let's meet let's pray about this because, maybe it didn't happen like that… and we can give some counsel and the Lord … And I am a Christian, but I believe that there's another

side to the church in addition to you know that spiritual piece, and I just thought about silence --that talk about silence --that is one place --- 'not deacon so and so… he's a stalwart in the church… oh no, it must be a mistake! Yall need to get her some counseling.'

Panelists shared that the **Church**, as a beloved community space--traditionally known as a place of comfort and safety, is not safe for survivors of sexual trauma. Mike agreed with these sentiments adding the element of the abuse of power that leads to harm and said,

I think in any space or institution in which there is hierarchy this will inevitably make some people who are not at the top of the hierarchy, that includes a lot of our children and young people who have experienced abuse within the Church.

Thus, the advisory panelists highlighted that **silencing is an act of protection while simultaneously harming the victim**, and their loved ones, when there is a lack of accountability. Furthermore, the panelists repeatedly and forcefully discussed the Church as a complicated space for Black families. Kelandria said:

You know, so you open pandora's box when you talk about religion in the context of gender, power, control, sexuality, and anything related to sex really.

As mentioned in an earlier quote, panelists emphasized that the "church" generally does not discuss sexual topics, or other stigmatized health issues, as Russell articulated:

When you get to certain topics like mental health, especially in our Community, a community of color --we don't really want to touch [on those issues] and we definitely don't want it [disclosure about abuse] to get out.

Theme 2: Rape myths based on racist and sexist ideologies.

While most of the conversations with the panelists discussed male perpetration of sexual violence, many of the panelists highlighted that there are many boys and men who have been victimized but have nowhere to talk about it. Particularly, when I showed the participants the list of rape myths, one that all panelists agreed needed to be included was the myth about men being raped. Panelists also discussed the roots of rape myths connected to stereotypes of hypersexuality and the sexual violence that some men may be exposed to while incarcerated. Kelandria discussed in a follow-up phone conversation and shared that among the myths that are pervasive about sexual trauma is that **Black men are not allowed to be victims**,

In our community, girls are blamed for the abuse, but the boys are seen as gay or weak if they admit that they were abused by an uncle, or a man in the church…

Emphasized by all advisory panelists was the lack of conversation and attention to boys and men as victims of sexual trauma; in other words, "men cannot be raped." Vanessa mentioned that the experiences that have been shared with her are often from grown men who disclose later in life the abuse they experienced with women perpetrators but were too ashamed to admit it. Russell and Mike shared their experiences listening to other men about their first sexual activity being with an older woman as a “rite of passage.” Below is a segment of that conversation between them,

Russell*: yeah I remember those conversations with guys who you know I mean it was, it [sex with an older woman] was almost a rite of passage for some boys in some communities. It's a badge of honor … 'yeah it was my teacher or my "girlfriend" who thought I was cute man, and so she schooled me.' And it was never looked at, as 'I was violated, because you know I'm a minor. … Well, I really didn't consent –-didn't really know—but hey man she taught me, so I got my skills from that.*

Mike*: Those [experiences] come into play into how we view ourselves, and particularly the idea of Black men not being able to be raped, because of our sexual deviance, and that we always want sex. Not only do we always want sex, but we have supposedly some type of physical, sexual prowess, which prevents us from being violated in that way.*

Panelists shared that the myths surrounding men as victims connect to other myths about sexual violence. The advisory panelists suggested incorporating a rape myth on the scale that "a man can only be raped by another man," which includes the misperception that women cannot be perpetrators of sexual harm to a man.

Theme 3: Parents' sexual health communicative behaviors.

Vanessa shared that Christian families she sees in her clinical work follow **rigid traditional gender scripts**, including "*Girls should wait to have sex*" and "*Boys can be promiscuous… but don't get a girl pregnant*." All panelists agreed that parents do not

have regular conversations with their children about sexual health in general. Vanessa elaborated about the gender scripts connecting it to fear of premature sexual activity:

Black parents don't teach dating.

We don't talk about what dating is. …If I give you permission to date, I give you permission to have sex.

Samuel concurred with Vanessa,

An important example is around how parents may talk about the purpose of marriage, and "courting "as the highest standard. But it is important to mention that youth of today find these ideas to be outdated and irrelevant.

The advisory panelists repeatedly stated that for many parents, their behavior is replicating what and how they learned about sexual health themselves, particularly **parents' sexually traumatic experiences**: Kelandria put it this way:

Do we [researchers/practitioners] ask how they[parents] learned about sex, like even engage with how they learned about sexuality? Do we ask what is their awareness or knowledge regarding sex, sexuality, and sexual orientation? Because if they are forced into this situation, like maybe their first [sexual contact] awareness of it shapes their lifelong perspective about it. …Is it the trauma or the joy that they may have associated with sex and sexuality?

Kelandria further disclosed that her initial experiences were not healthy because of her adverse childhood experiences, including sexual trauma.

In response to what the experts have experienced as communicative behavior of parents and caregivers, the advisory panelists shared the nuances behind sexual health

communicative behaviors of parents and the various cultural and individual experiences that influence the range of openness and silence surrounding sexual health and trauma. Based on their expertise, all panelists stated that parents need more education about sexual trauma. Russell provided rich context about supporting parents' self-efficacy regarding communicating about sexual health and trauma: recommendation.

> *Families are the best experts as it relates to [their children]… [ask] parents, … what support do they need? 'What would have been helpful for you to understand your body differently or to understand the whole concept of sexuality?' Because, I mean it's not a topic in most households … and I think a lot of it [communication] is reactive. … having the conversation with parents about their comfort level and -- and I'll use the word* ***confidence*** *to be able to either talk about their own experience and then be able to be willing to like I said* ***self disclose****, …*

Conversely, Samuel encouraged parents to

> *"…assess what your kids know. Ask questions, 'tell me what you know about (fill in sexual topic). You [parents] gotta learn from them [children]…and learn new things."*

Samuel emphasized the importance of parents talking with their children about what they know and what they have been exposed to by allowing the child to lead the conversation. Samuel also emphasized that *"social media accelerates the conversation with sexting, cyberbullying, and catfishing.*" Vanessa agreed and shared examples she has had to navigate with her clients, like boys sending "dick picks" and videos of girls and young women being forwarded to others without the sender's consent. Samuel continued and

shared that for many children, their "*core belief system [about sex] come from social media*." The advisory panelists stressed that most parents are unaware of how early their children are exposed to sexual content in this Digital Age. Samuel stated, "Social media has a lot of information but no discussion," and emphasized that parents need to be aware of what their children are learning, not just from friends or at school, but on social media. All participants believe that **social media** can present opportunities to start conversations with their children, but parents must be open and educated.

As discussed throughout these focus groups, the advisory panelists forcefully repeated the importance of parents and caregivers regularly talking with their children about sexual health and trauma as a means of protection and support.

Recommendations for Phase 2 and 3

One of the main objectives of seeking an advisory panel was to adjust the rape myth scale based on their expertise that is culturally informed. All participants recommended shortening the scale by identifying the items that felt repetitive about drinking and women's behavior. As mentioned above, they also stated that including a myth about men being raped is critical. Finally, advisory panelists used more gender-inclusive language within the wording of each item. However, they did not identify any other culturally specific rape myths.

They suggested that in Phase 3 focus groups with parents we discuss more about black men being falsely accused of rape. The advisory panel also examined parents' confidence levels in discussing sexual health and trauma with their children. This recommendation was utilized in the final version of the self-efficacy questionnaire.

The primary goal of utilizing the expertise of the advisory panelists was to gain further insight beyond the scholarship into the experiences of working with Black parents regarding communication about sexual health and trauma. Moreover, the advisory panelists' expertise demonstrates this study's translatable and community-based agenda. Lastly, this first phase of the mixed-methods study foregrounds the analysis of the 3-phase study. The intersections and triangulation of findings are discussed in Ch.5.

Phase 2: Survey of Black Parents' beliefs, perceptions, and communicative behaviors

The second phase of the sequential design of the mixed methods study was a survey administered through a snowball and purposive sampling of Black parents, who are older than 18 years old, with children between the ages of 2-24 years old. This questionnaire included a section on demographics and self-report measures about sex communication behavior, rape myth beliefs, perceptions about confidence to communicate about sexual trauma (i.e., self-efficacy), and religiosity. After reviewing the feedback from the advisory panelists in Phase 1, the survey was shortened. In particular, the rape myth scale was revised based on recommendations from the practitioners in Phase 1.

Participant Recruitment

After receiving approval from IRB, a flyer developed by the researcher was shared via text, email, and social media outlining the study description and the participant requirements. Phase 2's sampling technique included a purposive sampling procedure to target Black parents and caregivers, followed by snowball sampling to maximize the response rate. Once someone completed the survey, they were asked to share the link or QR code with other Black parents in their network. In addition, the community partners assisted in recruiting Black parents that live within the residential areas of Washington D.C. To supplement recruitment, the researcher contracted with Qualtrics to find additional participants during January 2022. All data collection for Phase 2 was finalized by January 30, 2022.

The requirements for participation included: 1) being at least 18 years old, 2) self-identify as Black, African American, or of African descent living in the United States, and 3) be a parent or caregiver of children 2-24[3]years old (toddler, adolescents, and young adults).

Participants.

Black parents ages 18 or older with children between the ages of 2-24 were recruited through a snowball sample (N= 59) and Qualtrics recruitment (N= 417). The survey included items measuring demographic and individual characteristics, attitudes and beliefs regarding sexual harm (i.e., rape myths), perceived abilities to communicate about sexual trauma, and general sexual communication behaviors between parent and child. After removing incomplete surveys (and surveys that did not pass the attention checks designed in the questionnaire by randomizing the response options), and 3 participants who indicated that they did not have children, the effective sample size is N=457(n = 408 from Qualtrics, and n = 49 from the snowball).

Participants were asked "What gender do you identify as?" as an open-ended question, and 169 (37%) identified as a 'man,' and a majority, 278 (60.8%), identified as a 'woman.' The average age was 36.84 years old (*SD* = 10.17). All participants identified as Black, African-American, or a descendant of Africa (a requirement to qualify as a participant in the study). Moreover, participants were asked if they identified as any other race or ethnicity, and 74 (16.2%) indicated that they identified with another race or

[3] Studies show that parents can start talking to their children about appropriate touch as early as 2 years old, and the age for adolescence and youth goes up to 24 years old. https://apps.who.int/adolescent/second-decade/section2/page1/recognizing-adolescence.html See also D. Siegel (2015) *Brainstorm: the power and purpose of the teenage brain, An Inside-Out Guide to the emerging adolescent mind, ages 12-24*

ethnicity, including White, Native American, Asian, Hispanic, or Latino/a/e. In addition, participants were asked if they, or their parents, identify as an immigrant, and only 10.9% of the sample indicated that they are from an immigrant community, including Nigerian, Jamaican, and Trinidadian, among other countries in the Caribbean.

Almost half (n = 225, 49.2%) of the participants indicated that they have only one child, 138 (30.2%) had two children, 59 (12.9%) indicated three children, 23 (5%) participants said they had four children, and 12 (2.6%) parents said they had more than five children. Participants resided in 46 out of the 50 states in the United States, with New York (7.4%), Texas (7.7%), and Georgia (8%) having the most participants across the country.

In terms of household income, 85 participants indicated they made less than $10, 000 per year, 106 respondents indicated they made between $10,000 - $29,000 per year, 112 between $30,000 - $49,999, 68 between $50,000 - $69,999, 37 made $70, 000 – $89, 000, 31 between $90, 000 - $149, 999, 17 reported $150,000 or more, (with 1 missing). 241 (46.8%) participants reported living in an urban area, 158 (34.6%) living in a suburban area, and 79 (17.3%) were people who indicated they lived in a rural area. The majority of participants, n = 259 (56.7%), indicated that were employed full-time, 34 (7.4%) self-employed, another 45 (9.8%) participants were employed part time, while 62 (13.6%) were unemployed and looking, and 18 (3.9%) were unemployed but not looking for work, and 25 (5.5%) identified as disabled, 9 (2%) students, and 5 (1.1%) retired.

As far as religious affiliation is concerned, the majority (80%) of the participants identified as Christians (n = 367), followed by “Other Religion” (n = 70), Muslim (n =

11), Jewish (n = 5), and Buddhist (n = 4). Other religious options included Agnostic, Atheist, and other descriptions including 'spiritual.' See Table 1 for more socio-demographic information of the sample.

Table 3
Sociodemographic Characteristics of Participants (n=457)

Variable	*n*	%
Gender		
Woman	278	60.8%
Man	255	37%
Missing ??	10	2.2%
Sexuality		
Heterosexual	397	86.9%
Bisexual	37	8.1%
Homosexual	12	2.6%
Prefer not to say	7	1.5%
Other	4	0.9%
Relationship Status		
Never Married	175	38.5%
Married	160	35.0%
Living with partner	71	15.5%
Divorced	29	6.3%
Separated	9	2.0%
Widowed	7	1.5%
Education		

High school graduate	145	31.7%
Some college	117	25.6%
Associates	53	11.6%
Bachelors	84	18.4%
Post-graduate level	52	11.4%
Less than high school	4	.9%
Living arrangements with children		
Both parents and children	217	47.5%
Single-parent – full custody	148	32.4%
Single parent – partial custody	46	10.1%
Blended families with children	28	6.1.%
Other (separated, grandparents, uncles, aunts)	18	3.9%

Procedure

The Institutional Review Board (IRB) at George Mason University approved the consent form and all research procedures in October 2021. The first page of the survey included a consent page of the questionnaire that provided information about the study and further resources regarding sexual trauma and mental health. Following consent, the participants were asked three questions to verify the requirements to participate in the study.

- *Are you 18 years or older?* (Yes, continue; No –end of survey response.)
- *Do you identify as Black, African-American, Afro-Caribbean, or a Black-African immigrant?"* (Yes, continue; No –end of survey response.)

- *Do you identify as a parent (biological or adoptive) or a primary caregiver of children between the ages of 2 and 24?* (Yes, continue; No – end of survey response.)

The time to complete the survey was approximately 15-20 minutes, with several participants pausing and finishing their responses later. All data collection took place on Qualtrics v. 27 software.

Participation involved completing a close-ended survey questionnaire designed to measure parents' sex health communication behaviors, beliefs about rape (i.e., rape myths), perceptions about their abilities to communicate about sexual trauma with their children, and parent communication styles. Given the length of the survey, participants were also provided with attention check questions that re-arranged the answers to the matrix questions for scales to verify they were paying close attention and reading each question rather than simply answering randomly or as quickly as possible. At the end of the survey, participants were provided with information on mental health and sexual trauma resources and psychological support should participants have desired to talk with someone further. In addition, participants from the snowball sample were asked if they wanted to join a follow-up focus group. Only at the end of the survey were participants asked if they wanted to enter the details to enter a drawing to receive a $20 gift certificate. Participants interested in entering the drawing were directed to another two-item survey for them to enter their contact information, which was not linked to their survey responses. The follow-up focus group was not an option for participants that were recruited through Qualtrics and were incentivized directly through a Qualtrics contract.

Measures

For this study, existing instruments were examined as examples of the best scales in the field. In addition, The instruments used in this study measure: (a) rape myth acceptance, (b) frequency of parent-child communication of sexuality, and (c) perceived discrimination. In addition, parents' perceptions of self-efficacy in discussing sexual trauma with their children and parents' religiosity were all adapted based on previous research on the specific topic of sexual health and trauma. Because the present study is exploratory, the measures were chosen as a starting point to inform the research design of the current study; however, some of these scales were developed many years ago and not explicitly designed for the population or the topic of this study. Consequently, the scales were adapted to fit the population and purpose of the study.

Sexual Trauma experience of parents. Sexual assault has been defined as any form of unwanted sexual experience. To measure *Sexual Assault History,* four questions were included in the survey about sexual trauma, described broadly as "any unwanted sexual experience," including "forced penetration." The questions were adopted from the Bureau of Justice Statistics (BJS), "Draft Instrument for Measuring Campus Climate Related to Sexual Assault" (2016). This instrument has been validated and is widely used across college and university campuses in the United States. The first general question asks participants, *"Based on this definition, have you experienced any form of unwanted sexual contact?" ("Yes/No/ I'm not sure")*.

Prior to conducting bi-variate statistical tests and Pearson correlations discussed in the next section, each scale was tested for reliability. Using Cronbach's alpha, a scale

is generally considered adequately reliable with an alpha value of 0.7 or above. All of the scales used in this study indicated medium to high reliability.

Rape myth scale. This study used the shorted Illinois Rape Myth Acceptance Scale (IRMA) (McMahon & Farmer, 2011; Bendixen & Kennair, 2017) to examine rape myth acceptance. This eight-item scale includes items from the original scale, "If a girl is raped while she is drunk, she is at least somewhat responsible for what happened" and "Victims who do not fight back have not been raped." In addition, six items were added based on the suggestions of the advisory panel in Phase 1 and based on the University of Richmond's Center for Awareness, Response and Education (CARE)[4] to include myths that were more gender inclusive language, for example, "person" instead of "girl," and myths about perpetrators "*Men/boys can't be raped or assaulted, unless by another man/boy"* and *"People who commit sexual assault are mentally ill or abnormal perverts."* All 14 items were combined to form a single index representing respondents' level of rape myth acceptance. Participants were asked to rate their level of agreement based on a Likert scale of 1 "strongly disagree" to 5

strongly agree" (M = 2.24; SD = .92; α = .92).

The Sexual Communication Scale. (SCS): Somers & Canivez's (2003) scale has been used to explore children's perception of their parents' communication about sexual health topics. To date, it is the most comprehensive scale that examines sexual communication. For this study, the scale was modified for parents' communication and includes 20 topics. matters. The item "love/marriage" was separated into two items. In

[4] See http://prevent.richmond.edu/prevention/education/rape-myths.html

addition, “consensual sexual behavior”, and “pornography” were added based on the scholarship on sexual trauma (Foubert et al., 2011; Wright et al., 2020). Participants were asked to indicate how often they discuss these 24 topics with their children on a Likert scale between 1-5 (‘never’ to ‘a lot of times’). (M = 1.34; SD = 1; α = .97).

Self-efficacy to communicate about Sexual Trauma scale. Based on the literature and discussions with the researcher’s chair and committee members, self-efficacy was operationalized with a four-item scale. (4 items). Items included in the self-efficacy scale are, “I feel confident in my ability to talk to my child(ren) about the risks of sexual trauma,” and “I know which general kinds of resources to use to talk to my child(ren) about sexual trauma.” Participants were asked to indicate their level of agreement with each statement on a Likert scale between 1-5 (strongly disagree to strongly agree). (M = 3.85; SD = 1.04; α = .86).

Everyday discrimination scale. (EDS) Williams, Yu, Jackson, & Anderson (1997) Racial discrimination is multifaceted and complex. Nevertheless, for this study, it is important to explore how parents perceive their experiences of discrimination and how their perceptions may interact with their parent-child communication about sexual assault. EDS has been validated in several studies (G. Kim et al., 2014; Krieger et al., 2005; Taylor et al., 2004). Participants were asked to indicate how often they experienced discrimination. This scale includes 10 items. Examples are: “*People act as if they are afraid of you,*” and “*You are called names or insulted*.” The scale is: Almost every day; At least once a week; A few times a month; A few times a year; Less than once a year; Never. The follow-up question: What do you think is the main reason for these

experiences? (e.g., race, gender, or sexual orientation). Participants ordered their main reasons with 1 being the foremost reason. (M = 1.59; SD = 1.31; α = .94).

Considering that this study explores how parents/caregivers communicate with their children, the perception of how their children will experience racism or discrimination may influence their communicative behaviors or health beliefs and perceptions regarding sexual health and trauma. Therefore, one **worry item** about "unfair treatment" was adapted from **Krieger and colleagues'** study on health and racism (2005) on a Likert-type 4-point Likert scale: 4-Most of the time 3-Some of the time 2-Rarely 1-never. The question states: "*As a Black parent and caregiver, how much do you worry about your children experiencing unfair treatment because of their race, ethnicity, or color?"* (M = 2.14; SD = 1.41).

Adapted Religiosity Scale. This study developed a religiosity scale based on items from the Santa Clara Strength of Religious Faith Questionnaire (SCSORF) (Plante & Bocchinini, 1997). Four items from SCSORF were used, including *"My faith is extremely important to me,"* and two items based on specific context for this study were added, including, "*My religious beliefs guide me in how I discuss sexual topics with my children*" Participants indicated their agreement based on a Likert scale (1 strongly disagree to 5 strongly agree). (M = 3.69; SD = 1.05; α = .90).

Phase 2 Results

The aim of Phase 2 is to build on the themes in Phase 1 and the literature about sexual health communication, which asked the question: *RQ1: What are common beliefs and perceptions about rape and sexual trauma that pertain specifically to Black parents and survivors?* Phase 2 of this study sought to explore, from a quantitative perspective, potential relationships between demographic variables and correlations between sexual communication, rape myth acceptance, religiosity, perceived discrimination, and parents' perceived self-efficacy in communicating about sexual trauma. The following research questions and hypotheses were posed for this phase of the study guided by the overarching research question: *How do intersections of social categories, such as race, class, and gender, influence Black parents' a) beliefs, b) attitudes, and c) communicative behavior regarding sexual health topics including sexual trauma, abuse, and rape?*

Moreover, the following results are based on the research questions and hypotheses developed based on previous scholarship and Phase 1 of the study.

Research Questions and Hypotheses

Rape Myth Acceptance based on Demographic Variables.

RQ2: Which demographic factors significantly influence rape myth acceptance scores?

H1a: Mothers will have lower rape myth scores (i.e., less acceptance) than fathers.

Gender was coded as a dichotomous variable for woman (i.e., mother) and man (i.e., father). An independent samples *t* test was conducted to determine whether there

was a difference rape myth acceptance based on the gender of the parent. Levene's Test for the Equality of Variance was not significant ($F = 2.14$, $p > .05$), so values for Equal Variances Assumed were used. Results confirmed the hypothesis and showed a significant effect for gender, with mothers reporting lower rape myth acceptance ($M = 2.13$, $SD = .879$) than fathers ($M = 2.43$, $SD = .955$), $t(445) = -3.326$, $p = .001$, $d = -.324$. See Table 3 below for individual means and t-test scores for each item based on gender.

Table 4

Results of *t* Test Results for Gender of Parent and Acceptance of Rape Myths

Rape Myth	Mother		Father		*t*(445)	*p*	Cohen's *d*
	M	SD	M	SD			
1- If a girl is raped while she is drunk, she is at least somewhat responsible for what happened	1.7	1.15	2.23	1.39	-4.35	.000	-.424
2 - When a girl is raped, it's often because the way she said "no" was unclear.	1.69	1.18	1.97	1.37	-2.29	.023	-.223
3 - If both people are drunk (or used drugs), it can't be rape	1.84	1.29	2.32	1.33	-3.78	.000	-.368
4 - It shouldn't be considered rape if a guy is drunk (or used drugs) and didn't realize what he was doing	1.73	1.25	1.95	1.33	-1.69	.09	-.165
5 - Victims who do not fight back have not been raped.	1.59	1.12	1.98	1.33	-3.35	.001	-.327
6 - A rape probably doesn't happen if a	1.57	1.07	1.91	1.26	-3.04	.002	-.297

victim doesn't have any bruises or marks							
7 - A lot of times, girls who say they were raped often led the guy on and then had regrets	2.04	1.32	2.66	1.36	-4.77	.000	-.465
8 - A lot of times, girls who claim they were raped have emotional problems	2.47	1.46	2.69	1.36	-1.608	.109	-.157
9 - People who commit sexual assaults are mentally ill or abnormal perverts.	3.28	1.49	3.27	1.42	.015	.988	.001
10 - A person who has really been assaulted will be hysterical after the assault	2.86	1.37	2.91	1.39	-.400	.689	-.039
11 - Sexual assault is provoked by the victim's actions or behaviors (including dancing or provocative dress).	1.96	1.35	2.51	1.40	-.4.087	.000	-.398
12 - Girls/women lie about sexual assault as an act	2.67	1.36	3.09	1.29	-3.196	.001	-.312
13 - Boys/men cannot be raped or assaulted, unless it is another boy/man,	1.64	1.19	1.85	1.33	-1.779	.076	-.174
14- Rape is an impulsive, uncontrollable act of sexual gratification.	2.76	1.61	2.63	1.55	.789	.425	.078

To analyze the differences between parents' rape myth acceptance based on their education level, the variable 'Education' was recoded into three groups: (1) less than high school (*n*=149), (2) some college and Associates(*n*=170), and (3) Bachelors and post graduate level (*n*=136). A ONEWAY Analysis of Variance (ANOVA) was conducted to explore whether there were differences in rape myth acceptance based on parents' educational levels. The Omnibus F test was significant, F (2, 452) =3.96, p = .020, η_p^2 = .017. However, Levene's Test for the Homogeneity of Variance was significant, so Games-Howell post-hoc tests were used to test for mean differences between groups. There was a significant difference (p =.01) between parents whose highest level of education was a high school diploma or less than high school *(M* = 2.42, *SD*= .93) and parents with some college or an Associates degree *(M* = 2.14, *SD*= .76), but there was no significant difference between either of those educational groups with parents who had a bachelor's degree or postgraduate degree *(M* = 2.19, *SD*= 1.04).

$H1_b$: A relationship exists between parents who have experienced some form of sexual trauma and rape myth acceptance.

Participants were grouped into two groups based on their answers to the four questions about an "unwanted sexual experience": Yes, Maybe, and No. If a participant indicated Yes, or Maybe to any of the four questions they were grouped into the "Yes, sexual trauma experience group." If they answered "No" to all four questions they were in the "No sexual trauma experience group." Out of 447 participants, 304 (68%) said they had some sexual trauma exposure, 70.4% (214) of those with sexual trauma exposure identified as a woman/mother.

An independent samples *t*-test was conducted to determine whether there was a difference in rape myth acceptance based on exposure of sexual trauma of the parent. Levene's Test for the Equality of Variance was significant ($F = 3.87$, $p = .05$), so equal variance was not assumed. The hypothesis was not confirmed because a significant relationship was not found between those who had some sexual trauma experience (M= 2.28, SD=.95) and those who did not indicate that they experienced unwanted sexual contact ($M = 2.17$, $SD = .84$), t (321) = 1.16, $p = .25$, d =.11.

Sex communication behavior based on Demographic Variables.

RQ3: Which demographic factors significantly influence sexual health communication? (gender, education, and family context)

An independent samples *t*-test was conducted to explore if there was a difference in sex communication behavior based on the gender of the parent. Levene's Test for the Equality of Variance was not significant ($F = 1.11$, $p > .05$), so values for Equal Variances Assumed were used. The results did not show a significant difference in sex communication behaviors based on the gender identity of the parent, t (445) = 1.36, p >.05. Moreover, the means of both mothers ($M = 1.39$, $SD = 1.13$) and fathers ($M = 1.25$, $SD = 1.06$), were low in sex communication behavior.

A ONEWAY ANOVA was conducted to determine whether there were differences in sex communication behavior based on parents' educational levels. The Omnibus F test was not significant, F (2, 452) =.69, p >.05. Levene's Test for the Homogeneity of Variance was not significant. The means based on education level are as follows: parents whose highest level of education was a high school diploma or less than

high school *(M* = 1.26, *SD*= 1.1), parents with some college or an Associate's degree *(M* = 1.35, *SD*= 1.14), parents who had a bachelor's degree or postgraduate degree *(M* = 1.41, *SD*= 1.06).

To analyze the differences between parents' sex communication behaviors based on their living arrangements with their children, a ONEWAY ANOVA was conducted. The Omnibus F test was significant, F (4, 452) =4.59, p = .001, η_p^2 = .039. But Levene's Test for the Homogeneity of Variance was significant, so Games-Howell post-hoc tests were used to explore differences between groups. There was a significant difference (p =.005) between single-parent partial custody *(M* = .99, *SD* = .88) and two other groups: single parents with full custody *(M* = 1.55, *SD*= 1.19), and blended families *(M* = 1.79, *SD*= .99). However, no significant difference was found between these groups and both parents *(M* = 1.22, *SD*= 1.08), or "other" (which included grandparents, aunts, and other caregivers who had full or partial custody of children) *(M* = 1.15, *SD*= .99).

RQ4: To what extent does the experience of sexual trauma influence a parents' sex communication behaviors about sexual health?

An independent samples t-test was conducted to find out whether there was a difference in sex communication based on the sexual trauma exposure of the parent. Levene's Test for the Equality of Variance was not significant (F = 1.52, p >.05). A significant difference in sex communication was found between those who had some sexual trauma experience (M= 1.44, SD=1.12) and those who did not indicate that they experienced unwanted sexual contact, (M = 1.21, SD = 1.06), t (454) = 2.91, p = .004, d =.29

Correlations among the study variables.

The next set of research questions explores the relationships between variables in the study that explore rape myth acceptance, sex communication, self-efficacy, worry about racism impacting their child, and their own perceived discrimination. The results from Pearson's correlations of these variables are included below, including the means, and standard deviations.

Table 5

Descriptive Statistics and Correlations for Study Variables

Variable	*n*	*M*	*SD*	1	2	3	4	5	6
1. Rape Myth Acceptance	457	2.24	.92	_					
2. Sexual Health Communication	457	1.34	1.1	.08	_				
3. Religiosity	457	3.69	1.05	.10*	.16*	_			
4. Perceived Discrimination	455	1.59	1.31	.32**	.26**	.01	_		
5. Self-efficacy	457	3.85	1.04	-.09	.23**	.13**	.07	_	
6. Worry about children's experience of racism	455	2.14	1.41	-.08	.14**	-.01	.30**	.06	_

*$p < .05$. **$p < .01$

RQ5: To what extent does perceived discrimination influence Black parents' communicative behaviors about sexual health topics, rape myth acceptance, perceived

self-efficacy in discussing sexual trauma, and worry about their children experiencing racism?

A significant positive relationship was found between perceived discrimination and general sex communication, r=.26, p<.001. Perceived discrimination accounts for approximately 7% of the variance in the sex communication scores. A significant positive relationship was found between perceived discrimination and rape myth acceptance, r=.32, p<.001. Perceived discrimination accounts for approximately 10% of the variance in rape myth scores. However, there was no significant relationship found between perceived discrimination and perceptions about self-efficacy in communicating with children about sexual trauma, *r*=.07, *p*>.05. In addition, a significant positive relationship was found between parents' worrying about children's experiencing racism and sex communication behavior, *r*=.14, *p* =.004. Parents' worry about racism accounts for approximately 2% of the variance in parents' sex communication scores.

RQ6: To what extent does religiosity influence rape myth acceptance among Black parents?

A significant positive relationship was found between religiosity and rape myth scores, r=.10, p<.03. Religiosity accounts for approximately 1% of the rape myth acceptance scores variance.

$H2_a$: A significant relationship exists between parents' rape myth acceptance scores and communication about sexual topics with children.

This hypothesis was not confirmed because there was no significant relationship between rape myth acceptance scores and sex communication frequency scores among parents, r=.08, p>.05.

$H2_b$: There is a significant association between religiosity and parents' sex communication with their children.

A significant positive relationship was found between religiosity and sex communication, r=.16, p<.001. Religiosity accounts for approximately 3% of the variance in the sex communication frequency scores.

RQ7: To what extent do parents' perceived self-efficacy to communicate about sexual trauma influence their communicative behaviors about sexual health?

There was a significant positive relationship between self-efficacy and sex communication behaviors among parents, r=.23, p<.001. Self-efficacy scores accounted for approximately 5% of the variance in scores of sexual health communication among parents.

The final test examined gender differences in perceptions of self-efficacy in parents communicating with their children.

H3: There is a statistical difference in perception of self-efficacy in sex communication based on gender identity of the parent.

Even though the mean is slightly higher for mothers' self-efficacy (M = 3.87, SD = 1.07) in communicating about sexual trauma than fathers (M = 3.8, SD = 1.02), a t-test did not result in a significant difference, t (445) = .67, p > .05.

Phase 2 Summary

The questionnaire among 457 Black parents across the United States yielded significant findings that corroborate and contest the critical themes of the advisory panelists in Phase 1. The statistical analyses in Phase 2 found that mothers have significantly less rape myth acceptance than fathers, but they do not communicate substantially more than fathers about sexual health topics. However, parents' education level has a somewhat significant relationship to rape myth acceptance. Moreover, parents who had sexual traumatic exposure (mostly mothers) communicated more about sexual health than parents who did not indicate sexual trauma.

Parents' religiosity and perceived discrimination correlated with rape myth acceptance and sexual communication frequency. However, sex communication frequency and rape myth acceptance were not associated. The perceived self-efficacy to communicate about sexual trauma was generally high among all parents, with no statistical gender differences, and was correlated with sex communication behaviors. These are some of the highlights of statistical findings that will be discussed further in Chapter 5. Moreover, in Chapter 5, there is an extensive discussion of these results in connection to Phase 1 and 3 based on the theoretical model used for the study and previous scholarship, followed by the limitations and strengths of this mixed-methods study.

Phase 3: Black Parents' Sexual Health Communication Focus Groups

This phase of the study seeks to center the lived experiences of Black parents through focus group discussion. This phase is essential to the transformative mixed methods paradigm and is in line with the theoretical underpinnings of Intersectionality, which "takes a core claim that lived experiences are important sources of data" (Esposito & Evans-Winters, 2022, p. 27). Examining the stories, narratives, and messages of parents and caregivers is part of a critical qualitative approach to exploring the lives of marginalized and underrepresented populations in social sciences (Arczynski et al., 2018; Heath et al., 2011; Johnson et al., 2014; Shaffer et al., 2018; Wilkin & Ball-Rokeach, 2006; Willink et al., 2014). Furthermore, a focus group discussion is the best fit for a study that desires to collect data about experiences and cultural values in under-researched communities and recall critical moments that may be stigmatized or shamed in other settings (Reisner et al., 2018; Wellings et al., 2000). This method seeks to provide a platform to explore critical themes within the messages parents share with their children about sexual health and trauma. In addition, this phase offers the last exploration of this study that seeks to provide insight into the overarching research question about parents' communicative behaviors, attitudes, and beliefs about sexual health and trauma. The following research questions guided the instrument development and analysis for Phase 3:

RQ8: How do parents describe (tell a story) their beliefs and communicative behavior about sexual health and trauma and children?

RQ9: What are critical themes of culture and family life that intersect in the stories parents share about their communicative behaviors and beliefs about sexual health and trauma?

Participant Recruitment

Sampling and Recruitment Strategy.

This phase consisted of purposeful sampling (Esposito & Evans-Winters, 2022), and participants were eligible if they self-identified as (1) Black, African American, Afro-Caribbean, or of African descent, (2) 18 years or older, and (3) a parent or caregiver of the child(ren) between the ages of 2-24 years old. The participant recruitment for Phase 3 included two strategies: (1) recruitment from Phase 2, and (2) snowball sampling from community partner and researcher's network of parents. Participants that completed the survey in Phase 2 saw a link at the end of the survey that allowed them to sign up to join a focus group. This link to a separate survey protected their anonymity of responses to the survey. Participants were asked to enter their contact information and availability, and the researcher sent them a text message or email to join upcoming focus groups. Four participants from the sample joined through this strategy. Most participants joined by receiving a recruitment flyer from the researcher's network via local churches, schools, and barbershops in Maryland, Virginia, and Washington D.C. Other participants were

invited from previous participants and indicated their interest by emailing or texting the researcher to join a focus group[5].

Participants.

There were six focus groups (three for mothers, three for fathers) and one interview with a father that was part of another focus group where other participants did not show up. There were 21 participants in total, 10 mothers and 11 fathers. Out of the 21 participants, one mother figure did not have full legal custody of children, but she is an older sibling that takes care of her younger siblings regularly due to her father passing away. One of the fathers, while his son was only two years old at the time of the focus group, shared as a father figure for many children as a football coach and mentor. Parents indicated their number of children based on partial or full custody. At the beginning of each focus group, the researcher asked participants to fill out a brief demographic questionnaire. The questionnaire allowed parents to indicate how they would like to receive their honorarium of $25; four parents did not receive an honorarium because they chose "other" and wrote "no token needed" or something similar.

Table 6
Demographic information of Phase 1 Participants

Pseudonym	Mother/Father	No. of children	Education	Socio-economic status/Area	Marital Status	Sexuality

[5] It was not a requirement for participants of Phase 3 to also fill in the questionnaire from Phase 2, but the researcher sent the link to the participants from the focus groups.

Pseudonym		Mother/Father	No. of children	Education	Socio-economic status/Area	Marital Status	Sexuality
FG1							
1.	Karla	Mother	7	Some college	Working Class/Suburban	Married (blended)	Heterosexual
2.	Rhonda	Mother	3	Bachelors	Working Class/Urban	Married (blended)	Heterosexual
FG2							
3.	Elisa	Mother	1	Bachelors	Working Class/Suburban	Married	Heterosexual
4.	Mufaro	Mother	3	Professional degree	Middle Class/Suburban	Married	Heterosexual
5.	Faith	Mother	1	Professional degree	Middle Class/Suburban	Married	Heterosexual
6.	Tamara	Mother	2	Professional degree	Working Class/Urban	Never Married	Heterosexual
FG3							
7.	Nandi	Mother	1	Professional degree	Poor/Urban	Never Married	Heterosexual
8.	Tanesha	Mother	3	Bachelors	Middle class/suburban	Married	Heterosexual
9.	Lanette	Mother	5	Bachelors	Working class/Urban	Separated (Blended)	Bisexual
10.	Shanae	Mother	3	Bachelors	Middle Class/Suburban	Married	Heterosexual
FG4							
11.	David	Father	3	Professional degree	Middle Class/Suburban	Divorced	Heterosexual
12.	Reginald	Father	2	Professional degree	Middle Class/Suburban	Married	Heterosexual
13.	Garrett	Father	1	Bachelors	Middle Class/Urban	Married	Heterosexual
FG5							
14.	Steven	Father	5	Professional degree	Middle Class/Urban	Married (blende	Heterosexual

Pseudonym	Mother/Father	No. of children	Education	Socio-economic status/Area	Marital Status	Sexuality
					d)	
15. Tyler	Father	3	Some college	Working Class/Suburban	Married (Blended)	Heterosexual
16. Charles	Father	2	Some college	Middle Class/Urban	Married	Heterosexual
FG6/Interview						
17. Rashid	Father	3	Some college	Middle Class/Urban	Divorced	Heterosexual
FG7						
18. Jackson	Father	4	Professional degree	Middle Class/Suburban	Married	Heterosexual
19. Bruce	Father	2	Doctorate	Middle Class/Suburban	Married	Heterosexual
20. Kevin	Father	2	Professional degree	Middle Class/Suburban	Married (blended)	Heterosexual
21. Timothy	Father	3	Doctorate	Middle Class/Suburban	Married	Heterosexual

Procedure & Instrument

Focus groups were conducted virtually on Zoom videoconferencing between January and March 2022, following Phase 2. Once a participant confirmed their interest and availability for a focus group discussion, the researcher sent an email with the consent form to read before joining the focus group. The aim was to get at least three participants for each focus group; however, one focus group had only two participants, and another focus group became a one-on-one interview. In addition, participants were separated based on their gender identity as mothers or fathers. The aim was to conduct at least two focus groups for mothers and two for fathers; however, due to low participation rates within each focus group, the researcher conducted more focus groups until there was data saturation (Esposito & Evans-Winters, 2022).

Due to the iterative nature of qualitative methods, the last focus group with Black fathers who are clergy (pastors or bishops) was purposefully sought out as "critical case sampling" (Esposito & Evans-Winters, 2022, p. 77). The results of Phase 1 and 2 and research memos of the previous focus groups identified the salience of religious identity and ideologies in the parents' lives, particularly Christianity. This final focus group served two purposes for this design as they are all fathers of children between 2-24 years old, and they also spoke about the intersection of being faith-based community leaders in Black communities. While not included in the initial plan of the study design, the focus group with the pastors provided a full-circle experience for a community-based participatory design that connected directly with the advisory panelists (Phases 1) and parents (Phase 3).

Rapport and Confidentiality.

Each focus group was approximately one hour, with additional time for introductions and closing remarks (e.g., participants volunteering information to stay in touch with other participants) which was not recorded in the transcripts. Building rapport was the initial goal of the researcher so that parents would become comfortable sharing details about communicating with their children. Since sexual health and trauma are sensitive topics, some may argue that a one-on-one interview may lead to more reliable data collection. However, a focus group setting provides a platform for sharing insights and experiences with others that otherwise may not come up in a one-on-one discussion, even with stigmatized and taboo issues (Sweetman et al., 2010; Wellings et al., 2000). At the beginning of each focus group, there was a brief introduction to the study's objectives and rules of engagement in discussing sexual trauma (Reisner et al., 2018; Williamson et al., 2020). Then, participants were given time to ask clarifying questions about the consent form or share any other concerns before providing consent to an audio and video recording. Participants were also allowed to keep their cameras off—though it was encouraged to turn them on to create an environment as close to the in-person procedure of traditional focus groups.

The consent form outlines the expectations of confidentiality and data storage on a password-protected drive. It was also important to clearly state that the researcher could not protect information from being shared by other participants within the focus group but that creating a setting of trust and respect for other participants' information was integral to the process. In addition, as part of the protocol, sources of information and

support were shared if any participants were feeling distressed or uncomfortable due to the nature of discussing sensitive topics (Williamson et al., 2020). It was imperative to create a safe, non-judgmental space for all participants; the hope was to develop a sense of community as parents while sharing similar experiences. Participants were not directly asked about their experiences of sexual trauma; nevertheless, several participants felt comfortable disclosing their sexual trauma history as part of their narratives. Four open-ended questions were used to create the flow of conversation within each focus group.

Phase 3 Results

Phase 3 concludes this mixed-methods study and provides supplementary and complementary data to Phases 1 and 2 to answer the overarching research question. The parents in this group had children within the 2-24 years-old range of this study. The results in this section discuss a Critical Thematic Analysis (CTA) of parents' beliefs, behaviors, and perceptions in communicating about sexual health and trauma with their children. As referenced in Phase 1, CTA is a critical qualitative method with intent for social justice purposes (Cannella & Lincoln, 2015; Lawless & Chen, 2019). Moreover, CTA adds the element of seeking out socio-ecological or macro-micro intersections, like socio-economic and gender dynamics, within the discourse (i.e., transcripts) and teases out issues of power and other embedded ideologies in the text. CTA is a fitting framework for the analysis because it meets the overarching aim of this study, which is to critically explore the beliefs and communicative behaviors of parents with marginalized identities and social positions.

Coding Process

Similar to other variations of thematic analysis, CTA outlines a two-cycle coding process, the first cycle of substantive or open-coding, and the second cycle is the more theoretical phase that interprets the data beyond description or closed-coding (Glaser, 1998; Lawless & Chen, 2019; Saldana, 2021). Since this phase builds on the codes of Phase 1 with the advisory panelists, the researcher began analyzing the larger coding groups while being open to new in vivo codes appearing throughout the data. Phase 3 process of coding was iterative in a cyclical manner but also moved back and forth

between the results from Phases 1 and 2 and the researcher's journal with the interpretations between focus groups (Esposito & Evans-Winters, 2022). This flexibility provided a deeper understanding of explicating meaning from the data.

Once all focus group discussions were completed, the data was integrated for an intersectional analysis that meets the axiological objective of the transformative paradigm that seeks to promote social justice through the implementation of research findings (Esposito & Evans-Winters, 2022; Mertens, 2007; Sweetman et al., 2010). While the numbers of participants are not a measure of the validity of qualitative research, it was essential to take notes while conducting the focus groups and examining the memos to get a sense of saturation.

As the single coder for the study, the researcher read through the transcription generated through Zoom videoconferencing software while listening to the focus group to correct any mistakes in the transcription. During the coding process, the researcher did several readings of the transcripts, along with re-watching the recordings, in a "data analysis spiral" (Creswell & Poth, 2018). Using Atlas.ti as a management and data analysis tool, the open-coding portion of the analysis resulted in 22 codes. After the closed coding cycle, the codes were reduced into critical coding groups or themes.

Data Analysis and Results

The data from the focus groups were analyzed using CTA (Lawless & Chen, 2019). The themes shared in the results below reflect what was repeated, reoccurring, and forceful throughout the focus groups with parents. It is important to note that some of these findings in the parent focus groups are similar to those in Phase 1, with the advisory

panelists' predictions based on their experiences, beliefs, behaviors, and perceptions of parents. In addition, because this was the third phase of the mixed methods study, these themes are a continuation of analysis between all three Phases to provide one integrated analysis, which is discussed in Chapter 5.

The analysis speak directly to the themes and variables discussed in Phases 1 and 2, including (1) parental beliefs about sex, including rape myths or victim-blaming, and the role of religious belief-systems, (2) perceptions of self-efficacy and barriers in communicating about sexual trauma, and (3) their reflections on their communicative behaviors about sexual health and trauma. In conclusion, there is a consistent thread of the **meta-theme of protection** throughout these themes**.** This meta-theme builds on the findings from Phase 1 that identified silence as protective communication.

The results below reflect themes across all focus groups, and subthemes are included in the results to identify smaller yet salient coding groups. As included in the demographic table above, all the parents had at least some college education and identified with a Christian religious background—even though there was variation in how parents presently identified or practiced their faiths. Table 5, below demonstrates the critical thematic analysis, including the open and closed cycles of the focus group transcripts. Furthermore, some individual codes are bolded for additional emphasis within the results.

Table 7

Critical Thematic Results of Parents' Focus Groups

Open-coding	Closed-coding	Critical Themes
1. Intergenerational tensions 2. Intentional communication 3. Religious terminology/framing 4. Gender identity of the child 5. Black Church 6. Conflicted relationship with religion	• Culture of silencing • Religious ideologies	• Theme 1 - Intersections of cultural beliefs about sexual health
1. Safe environment for disclosure 2. Openness 3. Parents as protectors 4. Needing to survive 5. Communal responsibility 6. Safe zones 7. Risk of sexual abuse among boys 8. Disclosure of sexual trauma 9. Social injustice 10. Negative stereotypes 11. Feeling powerless 12. Fear of wrongful accusation	• Hierarchical status of the parent • Openness and transparency • Self-efficacy within the family setting	• Theme 2: Perceptions of protection regarding sexual trauma
1. Consent 2. Technology and social media 3. Traditional gender scripts 4. hope	• Parenting as nondominant, minoritized person • Protection of children as vulnerable	• Theme 3: Safety through Protective Behaviors

Theme 1: Intersections of cultural values and beliefs about sexual health.

Most parents began their narrative about their sex communication with their children by recalling what was shared with them by their parents and caregivers. Parents often humorously stated that all they heard was "don't do it!" or "don't get pregnant!" They believed this was their parents' approach because of the intersections of conservative religious and cultural influences on family communication.

The influence of religion and other family values.

Across all focus groups, parents shared that their belief system, predominantly based on Christian ideologies regarding premarital sex and virginity or "purity," influenced their approach to sex communication. While parents in the focus groups shared similar beliefs with their parents, their belief-system and conformity to religious ideologies have changed to some degree.

Rhonda*: So I come from a heavy, religious background, my parents both Baptists. And so, because we had that strict background, a lot of Baptist churches, Christian churches, Baptist Christian churches, black at that, really did not get too deep into sexuality. It was almost fire and brimstone, almost as if like, just don't do it, just don't!*

David, a father of three boys under twelve years old, shared that even though he has not had a conversation about sexual intercourse, he plans on discussing sex from the perspective of the Bible. While he says he grew up in a "conservative West Indian household," he shared that he will be more realistic about his children's sexual activity while being transparent about his own when they are older. He stated, "*but I think on top*

of that, I just say I prefer if you know you waited till [marriage] but or older: and you know that's the way they taught in the Bible…"

Shanae, who had her first child in college, talked about the influence that religion had on her mother's response to her pregnancy. Shanae felt her mother was ashamed of her because she had a child before marriage. Similar to other participants across the focus groups, Shanae discussed **intergenerational tensions** between her as a mother, and her mother, as the grandmother, in talking about sexual topics with her children. Shanae's narrative resonated deeply with the three other moms in the focus group.

> *Shanae: [My mother]says "why are you telling them that stuff?!, … they need to just focus on school, why are you forcing them to want to do that stuff?" and I said "no I'm not forcing them to do anything if I don't tell them somebody else will." …I think it was just a combination of things you know, possibly just the religion old school and fear …of me, making the same mistakes that she …*

Throughout the focus groups, parents shared that they desired to break generational behaviors and beliefs that silenced communication about sexual health topics. For example, some of the parents in the focus group felt that the past generation's religious beliefs were potentially harmful to their children. Charles, who has two children, one in eighth grade and another in college, shared his experiences of needing to protect them from his mother's communication (who lives with his family) about sexual health because of heteronormative beliefs.

> Charles: *My daughter had questions early on and just from my intuition, I could tell that she was pretty much fluid in terms of who she liked. And I really had to*

practice what I preach in terms of, you know, what I know about gender constructs and things like that, so. And the same with my son … and I'm trying to let them know that … homophobia is really heightened in my immediate family, and I just want to protect them from, I want to protect them from their family mostly, and I want to protect them from anything else, you know, anywhere else in the world.

Another intersection with generational differences in beliefs about sexual health and sexuality **ethnic-cultural diversity** that participants would share. The narratives around the influence of ethnicity came from parents who identified as Afro-Caribbean or African immigrants, who believed that their ethnic background was much more conservative than American culture. For example, a mother of three children under ten years old shared that she has not had an open conversation with her children about sex, primarily because no one modeled it for her, and the "taboo" perceptions about sexual health are perpetuated in her generation as well.

Mufaro: I think for me it's definitely culture [from Africa] and even just you know my upbringing and modeling by my family it's just the taboo, we just don't talk about it… I think a lot of us Africans perpetuate our culture without understanding the inner knowledge and context you know. That's the biggest problem that's why we perpetuated behaviors and we don't even realize it's a problem.

A few parents in the focus groups discussed that while their parents were deeply religious, some of them were open about sex and even framed sex as a pleasurable

healthy activity. Parents in the focus group were intentional about changing the sexual communication approach they were raised with by their parents. However, most of the parents indicated that teaching children about sexual health through religion/or religious values is a matter of protecting them. The power of religious beliefs and cultural norms in communication about sexual topics continues to resonate with how parents presently view sexual health in this first theme and connects to the sub-theme about the role of the Black church as an influential cultural institution.

The Black church: an extension of Black families.

Jackson, a pastor, believed that fear and shame were not used in his communication with his children, even while using **religious terminology like "pure" to mean virginity** when speaking with his son, a freshman in college**.** Moreover, this father highlights another intersection between the **gender identity of children** and the values placed on their sexuality because of racialized and gendered identity.

> Jackson: *One of the times I asked him, okay So are we still pure, … and he said he wanted to wait , but I also make him aware of the temptations and also give them instructions of how can you not put yourself in situations that you're going to be tempted: So the dynamic of having boys and girls is different because you live in a society to where as black men, you know with the media and everything else that promotes doing that.*

Jackson shared sentiments repeated by other parents throughout the focus groups regarding media depictions of Black men as hypersexual, and he intentionally addressed the stereotypes with his son.

Some parents mentioned that religious framing often leads to an unhealthy view about sex in general. Moreover, the lack of communication that most parents grew up with created an atmosphere of silence. Consequently, many parents in the focus groups shared that they did not go to their parents regarding sexual health, sexuality, or sexual trauma, which the parents in the focus group were trying to prevent with their children by being more open and transparent.

Another father-pastor stated his perspectives about how family communication cyclically influences church culture.

> Bruce: *You know the **Black Church** really is an extension of the black family and many of us know that in black families that sexual trauma was suppressed. That cover up you know mentality, you know, has really infiltrated you know the Church and because of that, you know we see the results of it, we see the brokenness you know we see the mistrust.*

In the same focus group, another father-pastor repeated the viewpoints about the complex and harmful experiences perpetuated in religious environments by people with power.

> Timothy*: Also, unfortunately, [the Church as an institution] helping to perpetrate the abuses through the leadership and those in positions of power. We [pastors] all on this [Zoom call] are familiar with some type of violation that we've heard with some of our members that happened from a person in position or that had some kind of trust, we all know those stories so. I think we have perhaps in some*

respects earned the reputation, because we have not been as forthright and we've had we have the violations within the Black Church.

Many parents shared viewpoints of a **conflicted relationship** with their religious backgrounds and places of worship regarding their belief systems about sexual health. While most parents discussed Bible-based beliefs about sex and sexuality, they deliberated about wanting their children to feel comfortable discussing sexual health with them in ways they did not feel with their parents in previous generations. Throughout the focus groups, the Church as a cultural institution within Black communities was forcefully discussed as something parents intentionally addressed. Moreover, the father-pastors stated that they believed their role was to tackle some of the "church harm" that induced mistrust between the younger generations and the Church.

Rape myths were not explicitly discussed, maybe due to the forms of suppression and silencing of sexual communication mentioned above. However, it was clear that the rigid sexual scripts and gender norms and expectations are still among the beliefs of many parents within the sample. Furthermore, some of these beliefs were exposed when parents began to share how they communicated about sexual trauma, which will be discussed in the theme below.

Theme 2: Perceptions of protection regarding sexual trauma.

While most parents shared a high degree of confidence in their abilities to talk with their children about sexual health, most parents felt they needed tools and support to discuss sexual trauma, particularly the fathers. When parents were asked how they communicated about sexual trauma, their body language would change, with a lot of

sighs and pauses indicating some discomfort and reflection on the seriousness of the topic. There was consensus across all the focus group discussions that parents should be the ones children can come to if their children are sexually harmed. However, participants had many conversations about what creates a **safe environment for this disclosure**. Though interested in more strategies and resources to engage in these conversations, parents demonstrated some shared/common strategies, which are sub-themes below: Protective narratives, disclosure, and fear-based in sexism and racism. Parents also shared their fears of their children possibly being exposed to sexual trauma, and how they are navigating those fears.

Protective narratives.

The "good touch, bad touch" narrative reoccurred throughout all the focus groups. Some parents acknowledged that discussing body parts and who could see their children naked or help them a bath or get dressed was all included in the sexual health conversations for children under twelve years old, with some parents starting as early as three years old. Moreover, parents forcefully stated that as parents they want to be the first and primary person that they children come to about any issues surrounding sexual health and trauma. One mother disclosed within the focus group that she had been sexually traumatized. She suggested this was the main reason she has talked to her children regularly about sexual trauma and encouraged other mothers within the focus group to be open with their children if they had experienced any sexual harm,

> *Lanette: And what made it easier for me is that I used my sexual trauma as a way of being able to **openly communicate** with all [of my children] …I had to let them*

know like sex ain't the end of this, like you have to tell me. … nobody outside my house could tell me what was going on with the people in my house, you better come and tell me first. Like it was across the table in all aspects, whether it was in school and you got in trouble, you better call me first … give me the heads up.

Another mother shared that her experience of child molestation by a family relative has influenced how much she talks to her children about sexual trauma. Furthermore, this statement speaks directly to the broad perspective of parents seeing their efforts as protection and them as **protectors**. Moreover, parents discussing their protective behaviors resonates with the concept of social support, as Karla described.

Karla*: The parent is supposed to be standing as the protector right so many times we fail at doing that, and it's really bad when the parent is the offender because that's the real trouble comes in, because then the kid doesn't know who to go to you know. I know people from my mom's time you know who, when they told their parents, the mother didn't believe them. So I knew that and when I told my mom my sister had to come with me -- she's the one who convinced me to go and tell my mom that this was happening to me: … we went together, you see, support is really, really critical you know.*

All the parents forcefully stated that they would believe their children if they ever disclosed being sexually harmed. However, one mother said sometimes children are not believed, or they are blamed. Tamara disclosed her experiences of child sexual trauma growing up in a single-parent household and the economic vulnerability that intersects with sexual trauma.

Tamara*: You know, [I was] like five or whatever, not knowing what's happening to you or whatever [my] Black mother, who is supposed to protect you or whatever… And so, how she chooses to respond in that moment will determine really like, in my opinion, like what happens to the child and how [the child] thinks about herself for the rest of her life. And that's what happened to me. And so, that is why I'm such like a hardcore advocate honestly, because there's too much damn secrecy in Black households … There's a sense of 'I need whatever is being provided, and I'm going to dismiss my child because like we need this to survive'.*

Tamara's experience forcefully identifies how the need to "survive" provides context to Black parenting and communicative behaviors about sexual trauma. For those parents who identified as single parents, or in blended families, the safety of their children around other adults they did not know well was of great concern, and the motivation to talk to their children regularly about the risks of sexual harm.

Disclosure of sexual trauma: It takes a village.

The protective stance of parents often led to discussions about how to promote disclosure or help-seeking for their children and those in their community. Steven, a father who also coaches his daughter's basketball team, shared that as a mandatory reporter he has the conversation about sexual trauma several times with his children and the children he coaches. His narrative provides insight into the **communal responsibility** that many of the Black parents in the focus group felt for other children besides their

own. His perceptions of his communicative abilities to discuss sexual trauma were influenced by these experiences.

> Steven*: if it's in my power, because anything I can do to make sure that you're straight (i.e., 'safe'), just just let me know. because even like my girls who play basketball, some of them, their dads are not in their lives, … it gives the girls somewhat of a space to where they can talk to me … and that's where those* ***safe zones or soft zones****, as I call them, …and this for the boys too, because I never want to, I never want to perceive that it only happens to girls. But if something is going on in your house that, you know, that you need an adult to help you with. … because in my job, I am a mandated reporter.*

In addition to Steven identifying himself as a protector and a "soft zone," his statement also alludes to a code and rape myth about boys repeated throughout the focus groups. The **risk of sexual abuse among boys** was one rape myth that reoccurred throughout the focus groups, particularly among the parents who had boys; they needed to communicate to their sons that sexual abuse is not only about girls as victims and boys as perpetrators.

Disclosure of sexual trauma is where the safety of one's village became a sub-theme to parental efficacy. Several parents shared that they are comfortable with their children talking to other "trusted" relatives and even close friends of the family who can become "soft places," as Steven calls it, for children to be open about such sensitive issues. Out of all the participants, the father-pastors had the most experience with disclosure of sexual trauma from members of their church congregations.

Timothy*:[receiving disclosure about sexual trauma] it breaks your heart … they're trusting they're confiding in you, so you are being the support and let them know this is not your fault, this was not your fault, you did not ask for this… and help to encourage them to have the conversations with their parents, and most of them did not … have these conversations (with their parents). …but one thing we do know, we know how to provide comfort and support … hear, listen, comfort, refer [to a medical professional or social worker].*

In the same conversation, another father-pastor shared that he later trained to become a licensed family therapist because of the exposure to intimate partner violence and sexual abuse of children within his church congregations; he felt he needed more skills to support his community. Moreover, this pastor's "experience with sexual abuse" has motivated his communication with his children.

Conversely, in another focus group, Karla shared her experience with her church and alerted that sexual harm can happen in "safe zones." Moreover, when people try to disclose, Karla warned that they may be met with victim-blaming.

Karla*: I don't care how much we love each other, we can't allow certain things to happen … And if you allow it… you are allowing it to go on and to not be addressed…you're saying that, you know, well we handled it this way. but what about the damage to the other person? To the victim? because you get people that say 'you lead them on or they shouldn't have been dressing like that. or you know she was too close to him or he was too close to her.' … and so it's like they're turning it around on the victim.*

Karla's statement connects to how victim-blaming is a form of unsupportive communication for the victim while protecting the image of the community. Furthermore, the same village that should be protective can be harmful. In a critical moment, Karla connects the complexity of being harmed by someone you love, which advisory panelist Michael discussed as a cultural barrier that often hinders disclosure and supportive communication.

Fear for negative stereotypes based on intersections of racism and sexism.

Throughout the focus groups, the protective communication of parents would have a gendered tone, particularly around the societal challenges they felt their Black sons were vulnerable to. Shanae spoke about her concern about overwhelming their children by discussing the topic of sexual harm too early. Moreover, her narrative demonstrates the intersections of worry about Black children that Black parents regularly have about **social injustice** in a recent discussion with her 9-year-old son,

> Shanae: *The whole, you know, cops and Black boy conversation, and we just having these different conversations with him, and one night he just got overwhelmed, and he was just like, 'I can't do this, this is just too much, this is too much.' You know because we had the #metoo conversation, and, you know, and then I had the conversation about you know not letting him go, you know, places with older people, and you know, … and he just broke down crying because he was overwhelmed by all of the requirements and conversations and the do's and the don'ts and the world that we live in.*

There was a moment of collective support between focus group participants when Shanae shared her son's response to the **"Black boy conversation."** The other mothers in the group nodded in agreement and compassion and commended her bravery in having such conversations.

In another focus group with fathers, a younger father of a two-year-old shared future concern for his son being **negatively stereotyped** because of his physique. Parents often discussed negative stereotypes contributing to their fears and **feeling powerless** to prepare and protect their children.

> *Garrett: I do get a bit nervous because uh so, me and my wife, … you know when he does go to school, he will be in like a mixed school, there will be Black, White, Latino, probably all different races. ... So like if my son does end up growing up and he's like, you know, close to the same size as I am, but he can be the nicest person in the world, but just the optics of him being a Black male, and that larger Black male at that, there's always that little bit of* ***fear*** *that people are going to have in seeing him having never met him.*

Overall, the participants in this study described a high perception of self-efficacy, similar to the data found in Phase 2. However, there were still many moments where parents expressed hesitancy in discussing the risks of sexual harm and other intersecting fears of how to protect their children from other forms of trauma and bullying. Moreover, parents repeatedly shared that they had to have difficult conversations to emphasize protection, including how to engage with the police.

Theme 3: Safety through Protective Behaviors.

The final theme focuses on communicative behaviors shared throughout the focus groups with parents. The previous themes of beliefs and perceptions build the cultural context to explore what parents said or did concerning sexual health and trauma. The communicative behaviors discussed below provide more details about the tone of protection parents often use in their communication about sexual health and trauma and how systemic oppression intersects and heightens their children's vulnerability.

Identifying safe people and being safe.

Many participants discussed growing up in single-parent households or blended families with parents who shared custody. According to the parents, some family settings became barriers to safe and open communication about sexual topics. Conversely, being a single-parent was the motivation behind certain protective behaviors toward children. For example, Nandi, a single-mother who experienced sexual trauma, said that she did not trust most people around her adopted daughter (who was her goddaughter) and around her son, who has autism and is nonverbal. She described her house as the "**circle of protection**" when speaking to her children about sleepovers.

> Nandi: *'Once you go outside that circle, I can't protect you when you're out in the street. Somebody can seriously hurt you… So, the only way I can protect you is if you're within the circle. My son doesn't even spend the night over at his own father's house. You know, I know that's not the best way to handle something, but my son cannot tell me if somebody did something to him… So I just don't put him in a position.*

In Nandi's narrative, there was a tone of feeling powerless outside of her own home. She attributed this feeling to her own post-traumatic state, however, several mothers shared their reservations about sleepovers even at extended family homes because of the inability to protect their children from sexual harm.

Another mother, Shanae mentioned that she discusses appropriate sexual behaviors for her nine year old son connected to fears of false accusations, [*I told my son], 'we're not hugging girls in the class, right now, right now, no. Because anything can be misconstrued, or anything can happen.*

There were many examples similar to that of Nandi and Shanae's when parents had to explicitly discuss appropriate behaviors beyond the elementary conversation of "good touch, bad touch," which many shared with their children between ages three and five. Another father, Rashid, a barber, shared a lot about his community responsibility to have "tough conversations" with boys about sexual health and respect for girls and women. With his son, who is a student-athlete, Rashid said he had multiple conversations with him since he was around five years old, but now that he is a senior in high school, Rashid is more concerned,

> Rashid: *I stay close to him. So yes we've sat down and I told him about, you know, what we've discussed about the ins and outs of sex, not just the the safeness of sex, but because he's an athlete,and people see him coming up in a different way than other folks, you now have to be cautious of how you move.*

Rashid described being worried about anything jeopardizing his son's future because male athletes must be more cautious than other boys based on the perceived risk of sexual assault allegations.

The more difficult conversations about sexual trauma and being careful of inappropriate touching or contact with other children were framed with parents' perceiving their parental role to protect their children through open communication that was often uncomfortable.

Gender-based Communication: consent and double standards.

As mentioned in earlier quotes, another primary reason for parents to discuss sexual trauma was to discuss the topic of **consent** with their boys and fear of false accusations. Concerning this fear was the frustration repeated by parents that felt **technology and social media** hindered their communication efficacy, mainly when it came to seeing or sharing sexually explicit content or even video messages that could be considered inappropriate. A father of a teenage boy and girl shared his fear of his child's use of technology and the potential misuse of devices concerning sexual activity.

> Steven: *with my sixteen year old probably a year ago, I'm like 'yo Why you facetiming somebody when you just got out the shower? Like what's, you know, what's going on?!' ... I'm gonna have the COPs at my door or the mom saying that my son was flashing or trying to you know all kinds of stuff so. ...technology has opened up so many different avenues and doors for our kids positively and negatively to jam them up. And they don't see the harm in it.*

Particularly among the focus groups with fathers, there was a difference in communicative behaviors between parents and their children based on the gender identity of the child. The messages shared by these parents followed **traditional gender scripts**.

Charles: *Yes, and I know it's a double standard as nuanced as I, as I would as I think I am. Talking to my daughter was more of, more towards area of like abstinence, but for my son it was just like we're talking earlier, you always get to the point well if you find yourself, make sure you wear protection and all those other things.*

Conversely, in another focus group, Garrett shared that he communicates the importance of consent to his son in high school and other boys that he takes care of,

Maybe, something that [she's wearing is] provocative doesn't give you the right to just go up, and you know touch her do whatever anything like that, like you, can't just assume that, because she has on a tight skirt or a dress that she wants you to touch her and she wants that attention.

In a different focus group with fathers, Reginald shared that he did not receive a good model of how to communicate with his children about sexual health, which connects back to the silencing discussed earlier. However, he describes his communication with his daughters as open and trying to build trust.

Reginald: *I tell my girls you're not giving the same graces as other young ladies. … And you're watching cops slamming young girls like they are a grown man and might kill them, that means society doesn't respect your humanity as a woman, and in general….So I tell my girls…look at this society so let's be very careful*

when you're reading a guy understand he should be there for you, but the way we've been brought up in a society with each other at this more objects. … I have to be someone who they can trust and feel open to talk to me. I'm not sure if I'm just being protective

Reginald's communicative behavior depicts the intersections of gender and race as he forcefully describes the objectification he believes his children will experience as Black girls.

Communication that breaks the cycle of silence.

This sub-theme takes us back to the first theme about beliefs and the subtheme around generational differences. Several participants described wanting to "break the cycle" regarding **stereotypes of Black parents,** and the silence surrounding sexual trauma. Similarly to Steven's narrative above, Garrett (a football coach and high school teacher) shared that he is learning what to say to his two-year-old son because of his communication with his team members, specifically about his role as a Black father. In addition, Garrett shared his intentions to break the cycles of stereotypical images about Black men in general, not just concerning sexual health.

Garrett: Not just for my son, but even for the young boys are coach because. You know they always talk about Black kids not having a father figure …I want to break that cycle. So I want to be there for my son and, if I can you know help some of the young boys that I coach … like '[if] you have an issue you don't have anybody else to talk to, call me.' I could just be that for somebody to like, you

know, help break that cycle … and then we can officially get rid of the stigma of just you know Black fathers are just absent.

Across the focus groups, parents' communicative behaviors about sexual health topics reflected a protective position that they believed was embedded within their power as parents. Mothers and fathers believe they are the central figure in teaching their children about sexual health topics by being open and building trust. Many parents shared areas they would like to learn more about and enhance their effectiveness in communicating about sensitive issues, including sexual exposure online. Nevertheless, the parents in the focus groups all intended to communicate more frequently and build their communication skills to create awareness and an atmosphere of openness to foster dialogue with their children.

Even though many of the parents described the fears of communicating about sexual trauma, they would repeatedly state how important it was to continuously discuss sexual health and the risks of sexual trauma with their children. Moreover, an intersecting concern that parents would highlight is the effects of racism on their children and how their children would be perceived and treated. This worry did not, however, overshadow the power that parents felt they had in being able to instill critical value systems in their children regarding sexual health. One father's sentiments captured the spirit of the focus groups as they shared their parenting experiences,

Bruce: here's what gives me ***hope****. Like it's a scary time to be a Black parent but it's also like a great time to be a Black parent. And I say it's scary because you see the effects of white supremacy attempting to, you know, to like just roll back*

the gains, you know, of Black and Brown people, but then simultaneously you see Black people like coming into their own in a new, in a post Obama way…. hence why this topic [sexual trauma] is so important to me because you see your kids having so much potential, you want to make sure that nothing, you know what I'm saying, comes into that space to kind of steal that energy, that innocence, … so yeah, I'm excited about their futures generally, you know, broadly speaking.

Phase 3 Summary

The results in Phase 2 provide narratives of parents sharing their journeys from silencing to openness. Parents shared that because they wanted more communication from their parents, they intentionally approached the subject of sexual health with their children to foster openness and transparency. From the parents' perspective, the generational differences in using silence as protection, compared with how they continue to navigate the need to protect their children from the risks of sexual trauma, became the backdrop to their beliefs, perceptions, and behaviors.

This sample of Black parents provided reflections on the critical role of the Church as a cultural institution that extends many generations in Black communities. Parents are confronting their belief systems and engagement with their religious backgrounds as their children have increasing access to information beyond their control. In addition to the role of religious beliefs, the age and gender of the child were discussed among participants as a critical influence on their communicative behavior about sexual topics. In discussing sexual trauma, the parents throughout the focus groups would

emphasize some of their challenges of raising Black children in the context of racism and systemic oppression. Some of the narratives around sexual trauma included disclosure from the parents about their sexual trauma, parents as vigilant protectors, and the first line of defense and support in managing their children's sexual trauma exposure.

Moreover, parents shared that their experiences and perceptions of discrimination based on negative stereotypes place them in a position to protect their children, even while feeling powerless to control the environment. In summary, parents' beliefs, perceptions, and behaviors about sexual health and trauma are contextualized under a banner of protection. See Figure 2 for a model of the critical meta-theme, themes, and sub-themes from the last Phase of this mixed-methods study.

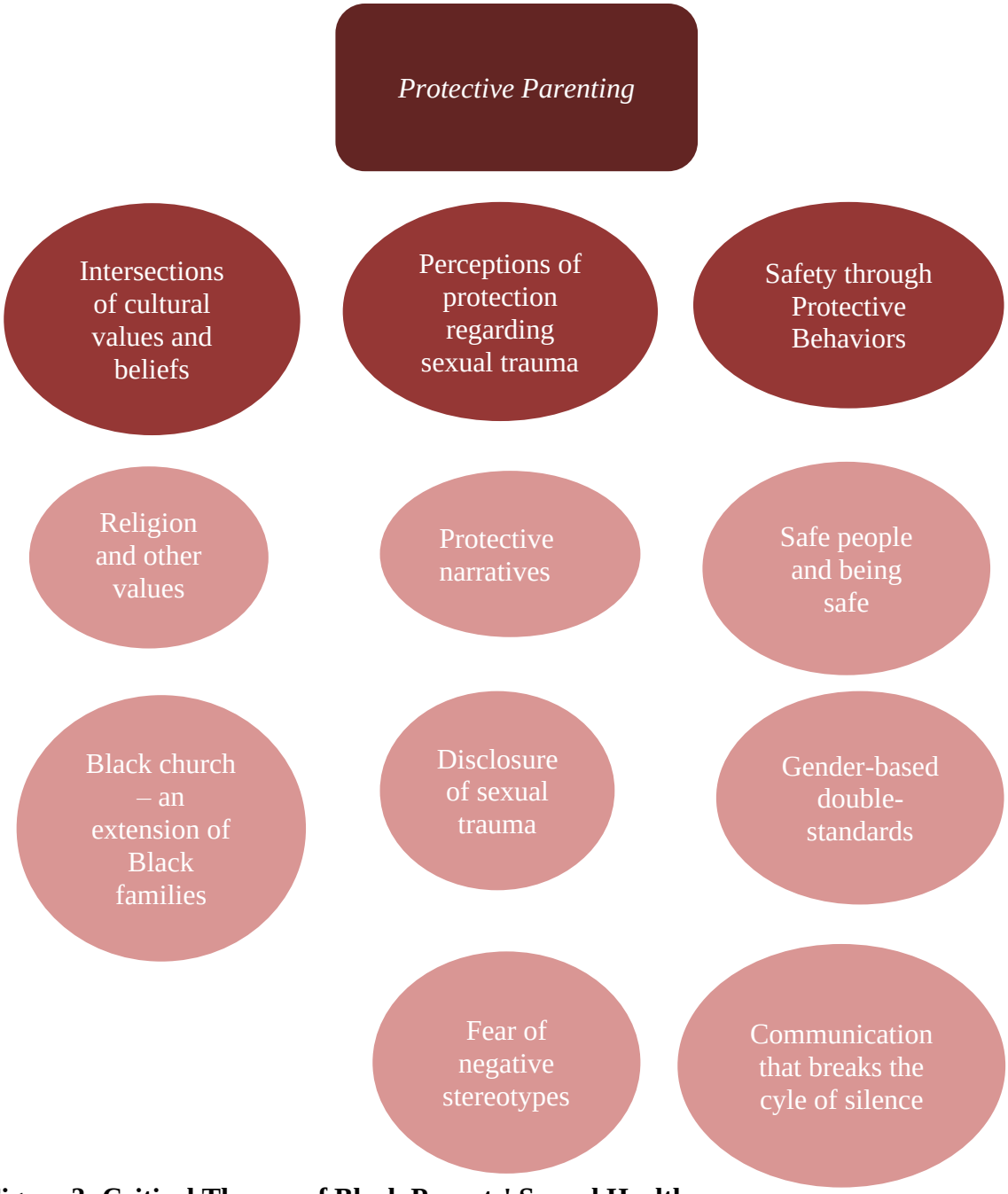

Figure 3: Critical Themes of Black Parents' Sexual Health

Summary of Mixed Methods Results

Table 8

Integrated Results Matrix exploring the Beliefs, Perceptions, and Communicative Behaviors of Black Parents

Outcome (dependent) Variables	Independent Variables	Phase 1: Advisory Panelists Focus Groups	Phase 2: Survey of Parents	Phase 3: Parent Focus Groups
Beliefs: Rape Myth Acceptance/Victim-blaming	Gender	Include the myth that states, "boys can't be raped, unless by a man."	Parents generally had low rape myth acceptance; however, mothers had lower rape myth acceptance than fathers. .	Parents repeatedly stated it is critical to include that boys can also experience sexual harm.
	Religiosity	Advisory panelists assert that the Church has influenced the silencing of sexual trauma.	Rape myth acceptance is positively correlated with religiosity	Parents identified religiosity as a critical barrier that has led to silence about sexual trauma and victim-blaming.
	Perceived discrimination	Advisory panelists asserted that Black women bear the brunt of victim-blaming to protect the community. The victim-blaming is	Rape myth acceptance is significantly correlated with perceived discrimination.	Protective parenting is connected to parents fear of children experiencing . In addition, parents

Outcome (dependent) Variables	Independent Variables	Phase 1: Advisory Panelists Focus Groups	Phase 2: Survey of Parents	Phase 3: Parent Focus Groups
		influenced by historical atrocities of false accusations against Black men.		fear false accusations and discuss this with their boys.
	Education levels of parents	n/a	Parents with less education had slightly higher rape myth acceptance than parents with some college and above.	Parents in the focus groups were highly educated and did not indicate high acceptance of rape myths.
Sex Communication Frequency/Behaviors	Gender of parents	Advisory panelists assert that parents are not discussing sexual health topics enough and that they are starting the communication too late.	In general, parents had a **low frequency** of sex communication. Fathers had a slightly lower frequency than mothers.	Parents perceive themselves to be more **open** with their children about sexual health topics than previous generations.
	Family living arrangements		Parents who live in a "blended family" had the highest frequency of sex communication, and **single-parents with partial custody** had	Single-parents indicated that they discuss sexual health and trauma with their children to protect them when they are

Outcome (dependent) Variables	Independent Variables	Phase 1: Advisory Panelists Focus Groups	Phase 2: Survey of Parents	Phase 3: Parent Focus Groups
			the lowest frequency.	outside the "circle of safety."
	Parental exposure to sexual trauma		**Parents with sexual trauma exposure** had a higher frequency in sex communication than parents without exposure.	**Mothers** who disclosed their sexual assault experiences identified as hyper-vigilant and not trusting even family members.
	Worry of children experiencing racism.		Parents' sexual communication frequency correlates significantly with their **worry** about their children experiencing racism.	Parents discussed their children experiencing racism and the intersections of gender concerning sexual **stereotypes** of hypersexuality.
Perceived parental self-efficacy discussing sexual trauma		The advisory panel asserts that parents need more tools and information to provide supportive environment for disclosure about sexual harm.	Parents have **above average perception of self-efficacy** in discussing sexual trauma. Parents' self-efficacy is	Parents request more tools to discuss sexual trauma and providing supportive spaces for their children. Parents feel a measure of

Outcome (dependent) Variables	Independent Variables	Phase 1: Advisory Panelists Focus Groups	Phase 2: Survey of Parents	Phase 3: Parent Focus Groups
			positively associated with sexual communication frequency	**powerlessness** about the **technological advances** and their children's exposure to inappropriate sexual images/activity.
	Parents' perceived discrimination		Parents' self-efficacy is positively associated with perceived discrimination.	Parents communicate about sexual trauma by discussing protective behaviors related to the **intersections of racism and sexism**.

Chapter Five

This study aimed to explore the perceptions, beliefs, and communicative behaviors of Black parents and caregivers about sexual health and trauma. Overall, the findings provide an illuminating exploration into silence(ing) as protective behavior around sexual health and trauma within Black families. This chapter presents a general discussion across all three Phases of this mixed-methods study and the theoretical implications of the findings. Finally, the study's limitations and directions for future research will be noted.

Theoretical Implications

The research questions in this study are guided by the Intersectional-Ecological Framework introduced in Chapter 1. The organization of this discussion will begin from the inner circle of individual parents' behaviors, perceptions, and beliefs, substantiating the mixed-methods study's main findings. Afterward, there is an analysis of the community-level interactions, with a final discussion about the societal influence of rape culture and other structural systems on Black family culture and communication.

Interpersonal and Intrapersonal Level

Beliefs

To the researcher's knowledge, this is the first study that explored rape myth acceptance and victim-blaming beliefs among Black parents. Parents' common beliefs

and perceptions about sexual health and trauma were explored throughout all three phases. One of the objectives of Phase 1, focus groups with advisory panelists who work with Black families as social workers or therapists, was to distinguish any specific cultural rape myths that could be added to the questionnaire in Phase 2. While the advisory panelists did not identify particular myths that exist only within Black cultures, they did discuss two primary false beliefs that they believed have influenced parents' communicative behaviors about sexual violence. Firstly, the advisory panelists shared that Black girls are often unbelieved or blamed for trapping a boy or man because they re [wrongly] stereotyped as a "fast girl." Black feminist scholarship asserts that the hypersexuality of "loose women" has a long history within Black communities and roots in slavery (Davis, 1983). Thus, the "fast girls" myth protects the perpetrator and the family at the victim's expense.

In addition to the victim-blaming of Black girls and women, the advisory panelists highlighted the need to protect perpetrators for the sake of the family and community. This finding supports the previous literature that discusses the low disclosure rates among Black women who may fear not being believed within the community (Hakimi, 2015; Ullman & Lorenz, 2020b; Washington, 2001). In addition, it supports scholarship exploring the intersection of racism and sexism resulting in the silencing of Black women survivors of sexual trauma, where disclosure is believed to be a form of cultural betrayal (Gomez, 2018; Ullman & Lorenz, 2020b).

The advisory panelists shared another false belief they believed is prevalent among parents: "boys/men cannot be raped unless it is by another man." This myth is

shaped by negative stereotypes of Black masculinity and the hypersexuality of Black boys. One of the contributions of this present study was to include this myth in addition to the shortened IRMA scale (McMahon & Farmer, 2011; Bendixen & Kennair, 2017). While there was a moderate acceptance of the adapted rape myth scale among Black parents, this specific myth had a lower acceptance. This finding indicates that the false belief that Black men and boys cannot be sexually victimized unless by another man is less accepted among Black parents than the advisory panel suggested. In addition, parents discussed this myth as something they feared would prevent their boys from disclosing because they believe the myth is prevalent in media portrayals of sexual violence, primarily with women and girls as victims. Several parents that participated in Phase 3 indicated that it is essential to understand that boys are at risk of sexual victimization, which should be communicated to their children. However, there may still be a covert endorsement of negative attitudes towards survivors that identify as boys/men and the continuation of beliefs that promote traditional masculinity ideologies.

The results in Phase 2 confirmed the results of previous studies (Burgess, 2007; Burt, 1980; Hockett, Saucier, et al., 2016; Suarez & Gadalla, 2010) that gender identity influence the acceptance of rape myths. The findings indicate that fathers were more likely to accept rape myths than mothers, particularly the myths that question whether the girl/woman is falsely accusing someone: “Girls/women lie about the sexual assault as an act.” It is important to note that this myth received one of the highest acceptance scores among mothers and fathers. Considering the historical context of false accusations against Black boys and men (Gómez & Gobin, 2020; Tillman et al., 2010), it is

unsurprising that this myth had higher endorsement than many other myths. Moreover, the themes in Phases 1 and 3 highlight that parents' belief about the risk of false accusation is integral to their protective communicative behaviors about sexual health and trauma.

Interestingly, the more education a parent had, the less likely they were to accept rape myths. This finding is a valuable contribution to the scholarship because most of the literature on rape myths involves college students (Hockett, Smith, et al., 2016; Suarez & Gadalla, 2010; Trottier et al., 2021). Furthermore, understanding the role of education and the endorsement of false beliefs about sexual trauma provides information for the family setting as a critical site for health communication and education about sexual health and trauma.

This study's quantitative and qualitative results indicated that religiosity and conservative belief-systems influence victim-blaming among parents. In Phase 1, the advisory panelists emphasized the role of conservative and traditional beliefs within Black families about sex and sexual health in potentially influencing rape myth acceptance. Phase 2 reported that parents with higher levels of religiosity positively correlated with higher acceptance of rape myths. This study's finding diverges with Suarez and Gadalla's (2010) meta-analysis, which found that religiosity was not significantly correlated with rape myth acceptance. While a few studies have examined the relationship between religiosity and rape myth acceptance (Edwards et al., 2011a; Franiuk & Shain, 2011), this study's results contribute to this scholarship from a historically religious culture, predominantly Christian. In addition, the scale adapted for

this study specifically asked parents if their religious beliefs guide how they discuss sexual topics with their children, and over half of the participants agreed. This study confirms previous literature (Edwards et al., 2011a) that the relationship between religious beliefs and rape myths is complex and vital to understanding the roots of patriarchal belief systems that maintain sexist scripts. Furthermore, results from Phase 3 demonstrate a generational shift in how religious ideologies influence parents' beliefs about the sexual activity of their children and sexual health in general. In addition to religious beliefs being a barrier, this study extends previous literature that found that Black parents reported a lack of health information to help them discuss sexual health with gay children (Rose et al., 2014). Parents in this study shared that they are more open-minded and even protective of their children from extended family members who adhere to religious beliefs about sexual orientation that may be harmful to their children. This finding may be related to the high education levels of parents in the focus group.

A novel finding regarding parents' beliefs is the relationship between rape myth acceptance and perceived discrimination among parents. Perceived discrimination in this study primarily indicated parents' perception of experiencing racism. Phase 3 illuminated the statistical relationship found in Phase 2, specifically parents reported their fear that sexual stereotypes would be forced on their children, not only based on their gender but intersectionally, specifically because they are Black girls and boys. Black feminist scholarship has long asserted that sexual trauma within Black families must be contextualized within the legacy of sexual violence stemming from chattel slavery through the present criminalization of Black bodies in the United States (Hill Collins,

2004; Davis, 1989; King, 1988; Pierce-Baker, 2004). This study provides baseline data regarding the ways in which parents make sense of sexual trauma in their personal and families' histories and how this interacts with victim-blaming embedded within the cultural beliefs and experiences of racism.

Perceptions

Previous studies of parental self-efficacy in sex communication explored several sexual health topics identifying self-efficacy as a predictive variable (Akers, Holland, et al., 2011b; DiIorio et al., 2001, 2003; Morawska et al., 2015). However, this is the first study that examines Black parents' self-efficacy, specifically in communicating about sexual trauma. This study found that Black parents generally had a medium to high average level of parental self-efficacy in communicating about sexual trauma with their children.

A significant finding from this study is that parental demographics, including family setting, did not correlate with parents' self-efficacy. In addition, parents' exposure to sexual trauma did not influence parents' self-efficacy in communicating about sexual trauma. While demographic locations did not significantly influence parents' self-efficacy, parents' religiosity was positively related. This study builds on previous research (Christensen et al., 2017) as it indicates that parents' adherence to a faith-based belief system positively influences parents' confidence with communicative behaviors about sexual health, specifically sexual trauma. In other words, religiosity can be explored as an intrapersonal communicative behavior that affects self-efficacy.

The self-efficacy scale in this study also included the perceptions of being able to provide emotional support. Parents in Phase 3 provided insight into these perceptions, specifically they indicated that while they would want more tools to support their children in case of a traumatic experience, their faith would help them comfort their children. Parents may feel more confident in being able to provide emotional support in case of sexual trauma because of their religious beliefs, thus heightening their sense of confidence. Nevertheless, the relationship between religiosity and self-efficacy needs more exploration and should be interpreted cautiously.

Concerning communicative behaviors, parents who felt more confident in their abilities to communicate about sexual trauma had a higher sex communication frequency than those who had less perceived self-efficacy. This finding supports previous scholarship on parental self-efficacy and sex communication (Christensen et al., 2017; Morawska et al., 2015); and it adds to the literature because of the specific population of Black parents. This finding also suggests that parents' ability to communicate about a stigmatized sexual topic enhances their confidence in speaking about sexual health in general. However, this finding is preliminary and requires more investigation, mainly because the frequency of parents' communication about sexual health and trauma was low, as discussed in the next section.

Within Phase 3, one of the areas where parents indicated the least amount of self-efficacy was technology and social media access. Many parents would shake their heads in frustration when someone brought up social media or devices. Technology-use seemed to be a critical area where more parents wanted more tools to navigate and support their

children effectively. Mothers spoke about the impact on self-esteem and body image, which are related to sexual health but often not considered sex topics. This finding is not surprising based on previous research that alerts us to the importance of understanding the susceptibility to misogynistic language and images, and the struggle to self-regulate technology-use among tweens and teens (Akers, Holland, et al., 2011b; Reid Chassiakos et al., 2016; Sanderson & Weathers, 2020). During the focus group discussions, parents repeatedly stated their frustration and fear with their children's use of smartphones, tablets, and video games.

Further studies should seek to understand how parents communicate about the safe use of social media in the context of the digital age to prevent exposure to sexual harm. Overall these findings are essential to a broader theoretical understanding of self-efficacy within the context of sexual health. Moreover, self-efficacy should be understood within socio-cultural layers and internal belief-systems that may influence individual confidence among minoritized communities.

Behaviors

The Intersectional-Ecological Framework proposed for this study uncovers how beliefs and perceptions interact with parents' behaviors regarding the communication about sexual health and trauma. Previous literature argues that parent-child sex communication is insufficient due to parental hesitancy, lack of information, and other social factors, including the gender identity of the parent and child (Christensen et al., 2017; DiIorio et al., 2003; Prikhidko & Kenny, 2021b). This study confirms previous

scholarship (Christensen et al., 2017; Morawska et al., 2015) regarding the low frequency of parents speaking to children about sexual health topics.

This study explored which demographic factors would significantly influence the frequency of sexual communication among parents. Most parent-child sex communication literature asserts that mothers are more likely to communicate about sexual health with their children than fathers across racial groups (DiIorio et al., 2003). However, while mothers had a slightly higher average frequency of sex communication than fathers, this study did not find a significant difference in frequency based on gender. Interestingly, many of the fathers who participated in Phase 3 shared that while they did communicate with their children about sex, it began later than when the mothers of their children started the conversation and often happened because of the mother's prompting. Furthermore, parents' education did not significantly influence the frequency of sex communication even though parents with at least a Bachelor's degree indicated a higher frequency than parents with less than a college degree. These findings offer additional evidence on the salience of common demographic indicators the literature discusses.

Another critical finding was that parents exposed to sexual trauma had a significantly higher frequency of communicating about sexual health topics than parents who did not indicate they had sexual trauma exposure. In Phase 3, this result was enhanced by the content shared by parents (all mothers) who disclosed they had experienced sexual violence. These parents said they would frequently discuss sexual health issues with their children. The communicative behaviors among these parents also indicated that they began talking with their children about sexual health in early

childhood, as early as three years old, as a method of awareness and prevention. These findings provide more context to the sexual experiences of parents and how this influences how much parents talk to their children about sex, particularly in the case of sexual trauma. Consequently, this study demonstrates the intersectional influence of lived experiences (i.e., sexual trauma) with demographic variables on sexual communicative behaviors.

The results of this study across Phases 2 and 3 suggest that parents' and children's living arrangements (family setting) influence the frequency of parents' sex communication. Parents who indicated that they lived in "blended families" communicated about sexual health topics more than any other group. This finding is an important contribution to the recent literature (Prikhidko & Kenny, 2021b), which found that married parents communicate about sex more than single parents. This study separated the "married" and "single" groups, creating more categories representing the families within the population. Moreover, this finding highlights intersections of family life, including living arrangements and diverse family contexts, and how this influences communication processes and individual behaviors (Few-Demo et al., 2014; Few-Demo et al., 2018).

In Phase 3, parents who did not cohabitate with their children's other parents repeatedly expressed how important it was to communicate to their children about sexual health and trauma because of the increased perceived risk they felt their children were exposed to when they were at the other parents' house. The intersection of family's living arrangement and parents' sexual trauma exposure was exemplified when one mother

shared her experience of being raped every summer by her cousins while visiting her father as a teenager. Another parent shared that he regrets not having the time to talk to his daughter during her early childhood about sexual topics because her mother had full custody. Thus, the living arrangements also influenced the protective framing of sexual health communication beyond the frequency of sexual health communication.

Pluhar et al.'s (2007) study with lower to middle-income Black mothers found religiosity to be approaching statistical significance with sex communication. This study with Black parents confirms that religiosity is correlated with sex communication frequency. Moreover, the sample in this study was dominantly Christian and indicated high religiosity, which reflects the broader population of Black parents. Furthermore**,** in Phase 3, parents shared how their religious background influenced their understanding of sex and sexuality from a Biblical framing, which also impacted the messages they shared with their children about sexual health. However, many parents identified in Phase 3 that they believe their parents' religious conservative beliefs about sex led to minimal communication about sexual health, and the power dynamics between parent and child encouraged silence about sexual trauma. Nevertheless, the parents in this study indicated a desire to communicate more frequently and openly with their children than they previously experienced with their parents.

Finally, a critical finding was that parents' perceived discrimination and worry about their children experiencing racism correlated with sex communicative behaviors. This finding is imperative to understanding the protective lens of Black parents' sexual health communication. Based on the results of Phase 3, parents' communicative behavior

about sex is often framed within the context of them being Black children, with the experiences of racism among parents influencing what they may anticipate around sexual trauma and the negative stereotypes of hypersexuality of Black girls/women, or false accusation of Black boys/men. Parents were acutely aware of racism as a threat to their children. Several parents, particularly the fathers, shared that they intentionally communicate with their children and other children they care for (e.g., coaches) to break the cycles of absentee fathers and stereotypical images of Black men. This finding also sheds light on the frequency of sexual health communication and the protective framing of the messages because parents may speak about topics they believe would prevent harmful experiences concerning sex rather than sexual health in general.

In this study, the individual and interpersonal level results highlight the intersections of parents' acceptance of rape myths, perceptions of their ability to communicate about sexual trauma, and their communicative behavior (both frequency and content)about sexual health and trauma. Based on the findings of Phase 3, parents' communicative behavior demonstrates their power in the relationship with their children as protectors, confidantes, and a responsibility to guide their children's sexual health activities and experiences. Critical to this population is religiosity and experiences and perceived risks of racism, which are socio-cultural factors that intersect with the community and societal level within this Intersectional Ecological Framework.

Community-level

The community-level analysis within this study is explored mainly through the qualitative portions of the study in Phases 1 and 3. The community-level contextualizes

the positionality of Black parents based on Hofstede's (2011) cultural dimensions, including power distance, collectivism, and gender values. While these dimensions intersect all ecological layers, a community-level discussion provides a socio-cultural narrative of the protective stance that frames Black parents' communication regarding sexual health and trauma.

As identified previously, institutionalized racism and experiences of discrimination have deleterious effects on health outcomes within the Black population (Hammond et al., 2016; Prather et al., 2018; D. R. Williams & Mohammed, 2009). Sexual trauma exemplifies the health disparities Black people experience as individuals, families, and communities. Parents' experiences and perceptions of racial discrimination influence the power they feel as nondominant parents. Black parents indicated high perceptions of worry for their children experiencing racism. This study provides insight into power distance as a cultural dimension from the perspective of systemic oppression. Beyond the results that indicated high amounts of worry, parents also shared that they are constantly worried about the negative sexualized stereotypes their children face because of their race and the intersections of gender identity. Based on the results of this study, there should be further examination of parents' perceived discrimination and worry of racial trauma for their children and the influence on health outcomes.

From an intercultural lens, Black cultural values align more with a collectivist orientation than individualism (Allen & Bagozzi, 2001; I. Kim et al., 2020). In Phases 1 and 3, the advisory panelists and parents identified silence as a community-level communicative behavior because of the collective experience of racism. Specifically,

there is a historical perspective of protecting men, the family, and the larger community – even at the victim's expense. In Phase 1, the advisory panelists shared insights about the intersections of institutionalized racism and the history of sexual violence within Black families. The panelists' observations in working with Black families are that beliefs about sexual trauma are a response to protecting the family and community rather than the survivor. The community-level exploration helps contextualize the processes by which silence has become a cultural norm based on the perception that it is more essential to save face or protect the collective's needs against structural violence over the individual's safety and recovery from sexual violence. Therefore, silencing the survivor is justified based on the fear of families being broken apart, or police mistreatment due to the involvement of the criminal legal system.

Within the cultural dimension of collectivism is the role of religion or the "Black Church." Religion cuts across all layers of the Intersectional-Ecological Framework, and arguably the Black Church has particular cultural influence at the community-level. The communal experiences of the Black Church provide a sense of identity and social support related to Black people's health outcomes (C.L. Park et al., 2009; J. J. Park et al., 2020; Ward, 2005). However, this study found that the culture of the Black Church, based on the narratives of the parents and father-pastors, has maintained and reinforced the silence of sexual trauma at a community-level. Moreover, the religious beliefs often reinforce patriarchal values that further increase marginalization for survivors, who may internalize blame and reduce disclosure. The father-pastors in Phase 3 acknowledged the history of "church harm," proposing that the Black Church as a community structure must prioritize

sexual health communication to prevent further harm and no longer protect perpetrators. Whether religious leaders or the Church as an institution can provide critical messaging to increase disclosure for improved health outcomes for survivors of sexual trauma and sexual health, in general, requires further investigation.

The power dynamics of collectivism also reinforce patriarchal ideals, leading to the cultural values of feminity and masculinity. As discussed in Chapter 2, Black families do not fit neatly into Hofstede's dimensions of masculinity and feminity because of historical and present socio-economic realities. Nevertheless, utilizing Intersectionality, we understand that the family is built on patriarchal social constructions of power and hierarchies, even in matriarchal-headed households. Consequently, these private spaces are unequal, particularly for children, women, and sexually minoritized people. As one parent shared, the need to survive (economically and socially) as a single mother negatively impacted her mother's response to her disclosure of sexual abuse. Thus, Black women and girls have been expected to protect the privacy and violence within families as a face-saving and community preserving against the wider societal systemic oppression.

The relationship between living arrangements and sex communicative behaviors is an important dimension that integrates intercultural and family communication. Black family life is often identified as matriarchal; however, the results in this study provide a nuanced view of how social role differentiation influences communicative behaviors. Parents with partial custody had the least amount of sex communication with their children, partly due to having less time with them. However, despite the element of time,

several fathers indicated that their sexual health communication was initiated by their wives, particularly for daughters. Moreover, this study supports previous scholarship that suggests parents still use traditional gender scripts in their sexual health communication (Berger, 2018; Cederbaum, 2012b). Another important finding is an intentional shift in the expectations of fathers for themselves to be more communicative with their children and to undue stereotypical narratives about Black fatherhood as unavailable.

At the community-level, the cultural dimensions provide an intersectional exploration that gives insight into individual and interpersonal behaviors, perceptions, and beliefs about sexual health and trauma. Black parents' protective stance is further intensified by survival mode as a community that has faced systemic oppression for hundreds of years in different forms. Consequently, protective parenting responds to the oppressive structures that threaten their children's futures. The experience of lacking power as a community has led to a cultural norm of silence to protect and preserve. However, the silence(ing) around sexual health and trauma has impacted further marginalization and sexual health disparities and inequities.

Macro Level

In her book, Black Sexual Politics, Patricia Hill Collins provides a historical understanding of the macro-level, asserting, "In American society, sexual violence has served as an important mechanism for controlling African Americans, women, poor people, and gays, and lesbians, among others" (2004, p. 216). This study's intersections of societal and institutional power include systemic oppression through racism, sexism, heteronormative values, and beliefs that produce and reproduce rape culture with specific

cultural implications for Black families. The Intersectional-Ecological Model provides a complex layout of how these layers continue to interact to promote silence around sexual health, victim-blaming around sexual trauma, and sexual health disparities that continue to plague Black people.

The scholarship on rape myths highlights that the stigma associated with sex results from the intersections of systems of oppression at the societal and institutional levels (Edwards et al., 2011b; Hockett, Saucier, et al., 2016; Suarez & Gadalla, 2010). As mentioned earlier, the intersections of patriarchy, heteronormativity, and racism (i.e., misogynoir) have unleashed layers of harm on individual survivors, the families, and communities of survivors. While parents indicated high perceptions of self-efficacy and a desire to be more open than their parents were about sexual health and trauma, the effects of societal threats of intersectional discrimination and injustice cannot be underestimated when exploring behavior. Parents are dealing with dialogic tensions of openness and protectiveness while managing feelings of power and powerlessness.

This study emphasizes that any investigation into the individual and interpersonal communicative perceptions and behaviors should also understand the complex interplay with larger socio-cultural, historical, and economic systems. This study demonstrates that for Black parents, their communicative behavior of protection is responding to the seemingly invisible pressure of systemic oppression in all forms, particularly but not limited to racism. In other words, Black parents' sexual health communication occurs within a larger context of "racial socialization" (Anderson et al., 2018). Moreover, the study exemplifies the relationship that cultural institutions (i.e., the Black Church) have

with larger institutions that reinforce problematic systems of inequality and power. The Black Church displays the complex intersections of racial identity, religious beliefs, structural oppression, and political ideologies.

Conversely, according to the themes in Phases 1 and 3, the institutional and cultural position of the Black Church is experiencing generational shifts that could have lasting cultural changes that influence beliefs and communicative behaviors about sexual health and trauma. Moreover, sexual rights and reproductive health policy are presently experiencing far-reaching and historic changes due to the recent U.S. Supreme Court official reversal of *Roe v Wade*. Thus, there is a necessity for further research to examine and implement strategies that can be helpful to Black parents and communities.

Findings from each phase of this study identify how power is situated, and the main proposal of the Intersectional-Ecological Framework is that individual behaviors and interpersonal communicative behaviors are influenced by socio-cultural dimensions, particularly for nondominant and marginalized populations. In addition, the theoretical implication is that there are multiple directions across and within the three main layers. The family is a critical site that displays the interactions and intersections across the layers that can reinforce various forms of hierarchal oppression and silencing, or disrupt the power imbalances and create healthy communicative behaviors.

Limitations, Strengths, and Future Avenues for Research

This study had many strengths; nevertheless, this study should be considered in conjunction with the limitations. Firstly, virtual focus groups have become a valuable tool for qualitative studies, particularly on sensitive topics (Sweet, 2001; Wettergren et al.,

2016). However, the main limitation was the inability to reach parents who did not have regular access to reliable internet. Still, participants that were able to use Zoom indicated an appreciation for the convenience of participating in a study in the privacy of their home, car, or wherever they felt most comfortable. In addition, the virtual focus groups added another layer of anonymity because participants could choose to keep their cameras off, even though the majority turned on their cameras.

One of the main challenges of the measures for rape myth is that IRMA does not provide any items about male rape victimization or myths related to the LGBTQIA+ community. One of the strengths of this study was to include a myth specifically about male sexual victimization and change some of the myths to be gender inclusive. However, this study did not have enough participants identifying with the LGBTQIA+ to explore this social identity or the intersections of sexual orientation and gender identity.

While rape myths have been studied for several decades, concern of the impact of what constitutes a socially desirable response further increases the limitation as a self-reported measure. In addition, more research is needed to examine myths related to stereotypes about Black masculinity and the victimization of boys, trans, and nonbinary folk.

Another limitation is the lack of religious diversity among the sample since most participants identified as Christian. While this reflects the larger population of Black people, the study did not have a significant sample size of parents identifying as Muslim (the second-largest religion for Black communities). Further research should seek out Black parents with Muslim affiliation to explore the differences to those with Christian

beliefs. Moreover, a growing number of Black people do not affiliate with any religion. Thus, there should be considerable effort to examine non-religious belief-systems and the influence on sex communicative behaviors, rape myths, and self-efficacy perceptions.

In addition, it is noteworthy to consider the lack of educational diversity among the participants in Phase 3; all participants had at least some college experience. Moreover, considering the significant differences in rape myth beliefs based on education in Phase 2, further research should include qualitative data from a sample with less educational attainment. Nevertheless, the diversity in family size (i.e., amount of children), marital status, and socio-economic status provide this study with critical examples of behaviors, perceptions, and beliefs that should be considered for further theorizing in intercultural and health communication.

A critical strength of this study was utilizing the Transformative paradigm for mixed-methods research (Mertens, 2007) by focusing on an understudied minoritized population and including an advisory panel as part of the culture-centered community-based approach. Any study that seeks to explore and examine health inequity within a minoritized community should understand that community's cultural values and historical context. Even amid a global pandemic that limited access to in-person connection building with community partners, a participatory method with a virtual design should be encouraged in future research.

This study points to an expansive research trajectory focusing on sexual communication within the family setting for critical intercultural health communication scholarship. However, the current study was primarily descriptive, and future studies

should seek to determine the theoretical significance of the proposed relationships among sexual health perceptions, beliefs, and communicative behaviors through experimental and longitudinal designs. In addition, this study utilizes Intersectionality as a theoretical framework (Alexander-Floyd, 2012; Cho et al., 2013; Collins, 1998) for family and health communication, which provides critical conceptual maps of how power is constituted and navigated based on how social positions and economic contexts interact with health behaviors. Specifically, the intersections of gender, education, and religiosity's influence on sexual beliefs and perceptions need further examination. In addition, sex communicative behavior needs to expand conceptualization and operationalization that move beyond frequency to analyze further the content and tone (comfort levels, positive or negative framing) of sex communication and educational messages.

The experiences of discrimination and parental worry for children's experience of racism are critical factors for Black people that can provide insight for other marginalized communities, specifically in the context of sexual trauma and disclosure of sexual harm. For instance, for Black families, based on the data in this study, the threat of being falsely accused of sexual harm is a form of sexual trauma that requires more exploration. These intersecting relationships open up many avenues for future research, particularly in how parents communicate about this form of parental worry resulting in protective behaviors to prevent victimization and false accusation of sexual trauma.

Going Forward

This study explored silence(ing) as a cultural marker of Black communities regarding stigmatized sexual health topics, particularly sexual trauma. This study provides evidence for growing literature in intercultural and health communication that identifies the family unit (specifically parents) as a pivotal site of intersections for social and behavioral change in response to sexual health inequities in marginalized communities. Culture is a response to life, and the cultural expectation for Black parents' response to sexual trauma has been to protect the family at all costs, often leading to a silencing of the survivor. While there have been generational shifts, this study demonstrates that Black parents are communicating from a place of stigma, as part of a nondominant group, and concern for racial injustice in their lives and their children's lives.

This study follows the tradition of Black feminists from Sojourner Truth to present-day iterations of Intersectionality that identify rape and sexual trauma as a result of systemic harm that manifests in community and interpersonal interactions. Critical research investigating reproductive and sexual health communication is particularly significant considering the present political climate. Moreover, centering populations at risk due to systemic discrimination and present health disparities should not be a scholarly trend but research that garners specific policy attention and sustainable funding support. Finally, this study's transformative paradigm mandates that future efforts should build on the budding relationships between practitioners and researchers to develop and

evaluate the implementation of survivor-centered programs and sex education services for minoritized families.

Appendix 1: Phase 1 Instrument

Advisory Panelists Focus Group Guide

1. Based on your professional experience, what are common beliefs and perceptions about rape and sexual trauma that pertain specifically to Black survivors/communities?
    a. Reading the rape myth scale, what items resonate with your professional experience as social workers, health practitioners, or community leaders?
    b. What items should be included that are culturally relevant?
2. What cultural beliefs, if any, have you observed to influence how Black parents/caregivers engage their children on matters of sexual abuse and forms of sexual trauma?
    a. How does the historical and present-day context of systemic racism influence Black parents communicative behavior (i.e., silencing) around sexual abuse and rape?
3. What communicative behaviors and messages would you encourage Black parents to exhibit to provide a supportive environment for sexual health and trauma?

(add research materials and instruments).

Appendix 2: Phase 2 Instrument

(FINAL) Black Parents and Sexual Health Communication - BPSHC

Start of Block: Consent Form

Consent

WELCOME to the study, "Black Parents and Caregivers' Communication and Perceptions about Sexual Health." Thank you so much for being interested in participating! First, we'd like you to read our Consent Form, which provides general background information about the study and contact details of the researchers if you have any questions. Please read through the information carefully and indicate your consent to participate when prompted.

PURPOSE
This research is being conducted to explore how Black parents and caregivers communicate with their children about sexual health. The survey will also ask demographic questions, your thoughts about racism, risks of sexual trauma, and overall barriers and benefits to discussing sexual health with your child(ren). This survey will take between 20-30 minutes to complete. This survey will not ask you to share your name or the names of your children.

RISKS
Some of the questions will ask about sexual and personal information.
The foreseeable risks include emotional discomforts while answering some of the questions. You do not have to answer any questions that you are not comfortable with, and you may exit the survey at any time. Please see a list of resources for mental wellness at the end of this survey.

BENEFITS
We hope that participating in this study will increase our understanding of better

communication with our children about sexual health. However, there are no personal benefits to you as a participant other than further research in this area.

CONFIDENTIALITY
The data in this study will be confidential. The copy of the survey results will be stored on a drive that only the investigators have access to and will be retained for at least five years after the study ends. While it is understood that no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your transmission. The de-identified data could be used for future research without additional consent from participants. The Institutional Review Board (IRB) committee that monitors the research on human subjects may inspect study records during internal auditing procedures and are required to keep all information confidential.

PARTICIPATION
You must be 18 years of age or older. Identify as Black, African-American, or someone of African descent. You must be a parent, guardian, or primary caretaker of a child between 2-24 years old. Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. After completing this survey, there will be a follow-up opportunity to meet virtually with other parents in a focus group. Please see the link at the end of the survey.

COMPENSATION
As a token of appreciation, there will be a random draw for 50 participants to receive a $20 gift card or electronic deposit (i.e., CashApp). At the end of the survey, you will see a link to enter your details to be considered to receive this gift. Under the U.S. federal tax law, you may have individual responsibilities for disclosing the dollar value of the incentive received on this study.

CONTACT:
Rochelle Davidson Mhonde is conducting this research at George Mason University. You may contact her at **rmhonde@gmu.edu** for questions or to report a research-related problem. The advisor of this study is Dr. Richard T. Craig, and you may reach him at rcraig@gmu.edu, 703-993- 1090. In addition, you may contact the George Mason University Institutional Review Board (IRB) office at 703-993-4121. irb@gmu.edu, if you have questions or comments regarding your rights as a participant in the research. IRBNet number: 1819897-1 The IRB has reviewed this study according to George Mason University procedures governing your participation in this research.

Consent CONSENT
I have read this form, I am 18 years of age or older, I am a parent or caregiver to a

child(ren) between 2-24 years old, and I identify as Black/African-American/African descent.
Do you consent to participate in this study:

- [ ] Yes, I consent to take part in this study. (4)
- [ ] I do not consent to participate in this study. (2)

End of Block: Consent Form

Start of Block: DEMOGRAPHICS

Demographics **Demographics** The first section of this survey will collect demographic data. None of this data can be connected back to your identity.

Age What is your year of birth?

_____

Gender What gender do you identify as? (Please write in)

_____

Multiracial Do you identify as another race or ethnicity in addition to Black?

- [ ] American Indian or Alaska Native (3)
- [ ] Asian (4)
- [ ] Hispanic or Latino/a/e (1)
- [ ] Native Hawaiian or other Pacific Islander (5)
- [ ] White (2)
- [ ] None (0)

Immigrant Do you, or your parent(s), identify as an immigrant?

- ○ No (0)
- ○ Yes, please state which country you, or your parent(s), migrated from: (1) _____

State In which state do you currently reside?

- ○ Alabama (1)
- ○ Alaska (2)
- ○ Arizona (3)
- ○ Arkansas (4)
- ○ California (5)
- ○ Colorado (6)
- ○ Connecticut (7)
- ○ Delaware (8)
- ○ District of Columbia (9)
- ○ Florida (10)
- ○ Georgia (11)
- ○ Hawaii (12)
- ○ Idaho (13)
- ○ Illinois (14)
- ○ Indiana (15)
- ○ Iowa (16)
- ○ Kansas (17)
- ○ Kentucky (18)

- Louisiana (19)
- Maine (20)
- Maryland (21)
- Massachusetts (22)
- Michigan (23)
- Minnesota (24)
- Mississippi (25)
- Missouri (26)
- Montana (27)
- Nebraska (28)
- Nevada (29)
- New Hampshire (30)
- New Jersey (31)
- New Mexico (32)
- New York (33)
- North Carolina (34)
- North Dakota (35)
- Ohio (36)
- Oklahoma (37)

- ○ Oregon (38)
- ○ Pennsylvania (39)
- ○ Puerto Rico (40)
- ○ Rhode Island (41)
- ○ South Carolina (42)
- ○ South Dakota (43)
- ○ Tennessee (44)
- ○ Texas (45)
- ○ Utah (46)
- ○ Vermont (47)
- ○ Virginia (48)
- ○ Washington (49)
- ○ West Virginia (50)
- ○ Wisconsin (51)
- ○ Wyoming (52)
- ○ I do not reside in the United States (53)

Skip To: End of Survey If 50 States, D.C. and Puerto Rico = I do not reside in the United States

Page Break

Sexuality Which term best describes your sexual orientation?

- ○ Heterosexual (1)
- ○ Homosexual (2)
- ○ Bisexual (3)
- ○ Other (4)
- ○ Prefer not to say (5)

Education What is the highest degree or level of education you have completed?

- ○ Less than high school (1)
- ○ High school graduate (2)
- ○ Some college (3)
- ○ Associates (4)
- ○ Bachelors (5)
- ○ Professional degree (J.D. etc) (6)
- ○ Masters (8)
- ○ Doctorate (7)

Employment Please indicate your employment status:

- ○ Employed full time (1)
- ○ Employed part time (2)
- ○ Self-employment (8)
- ○ Unemployed looking for work (3)
- ○ Unemployed not looking for work (4)
- ○ Retired (5)
- ○ Student (6)
- ○ Disabled (7)

Annual Income What was your income bracket last year (in 2020) from all sources before taxes? This includes all income from both formal and informal employment.

- ○ Less than $10,000 (1)
- ○ $10,000 - $19,999 (2)
- ○ $20,000 - $29,999 (3)
- ○ $30,000 - $39,999 (4)
- ○ $40,000 - $49,999 (5)
- ○ $50,000 - $59,999 (6)
- ○ $60,000 - $69,999 (7)
- ○ $70,000 - $79,999 (8)
- ○ $80,000 - $89,999 (9)
- ○ $90,000 - $99,999 (10)
- ○ $100,000 - $149,999 (11)
- ○ $150, 000 - $200, 000 (12)
- ○ $200, 000 and above (13)

Page Break

Relationship Status Please indicate your present relationship status:

- ○ Married (1)
- ○ Divorced (2)
- ○ Widowed (3)
- ○ Separated (4)
- ○ Never married (5)
- ○ Living with partner (6)
- ○ Prefer not to answer (7)

Neighborhood Type How would you describe your neighborhood where you live with your children?

- ○ Rural (1)
- ○ Suburban (2)
- ○ Urban (3)

End of Block: DEMOGRAPHICS

Start of Block: Children

X→ X→

Children How many children are you the parent or guardian for?

- ○ 1 (1)
- ○ 2 (2)
- ○ 3 (3)
- ○ 4 (4)
- ○ 5 (5)
- ○ 6 (6)
- ○ 7 (7)
- ○ 8+ (8)

End of Block: Children

Start of Block: Loop: Age and gender of the child

Age of child Please write the year your ${lm://Field/2} child was born:

_____

X→

Gender of child What is the gender identity of your ${lm://Field/2} child?

- ○ Girl (1)
- ○ Boy (2)
- ○ Other (3) _____

End of Block: Loop: Age and gender of the child

Start of Block: Living arrangments

Living Arrangements Please indicate your living arrangements with your child(ren) and their other parent/guardian:

- ○ Both parents and children (1)
- ○ Blended families with children (2)
- ○ Single parent - full custody (3)
- ○ Single parent- partial custody (4)
- ○ Other (please write in) (5)

_____

Additional family Do you have any other family members that live with you, besides another parent and your child(ren). Please write in.

_____

End of Block: Living arrangments

Start of Block: Sex Communication

SCS Using this scale about sexual health topics, please rate how much you have communicated with your child(ren) generally, even if you have children of different ages and genders:

	Never (0)	Once (1)	A few times (2)	Several times (3)	A lot of times (4)
1. Sexual reproductive system (“where babies come from”) (1)	○	○	○	○	○
2. The father's part in conception ("getting pregnant") (49)	○	○	○	○	○
3. Menstruation (“periods”) (27)	○	○	○	○	○
4. Homosexuality (28)	○	○	○	○	○
5. Nocturnal emissions (“wet dreams”) (29)	○	○	○	○	○
6. Masturbation (30)	○	○	○	○	○
7. Dating relationships (31)	○	○	○	○	○
8. Pornography (32)	○	○	○	○	○
9. Petting (“feeling up”) (33)	○	○	○	○	○
10. Sexual intercourse (34)	○	○	○	○	○
11. Birth control in general (35)	○	○	○	○	○
12. Whether you personally are using	○	○	○	○	○

birth control (36)					
13. Consequences of teen pregnancy (other than AIDS) (37)	○	○	○	○	○
14. Sexual transmitted diseases (38)	○	○	○	○	○
15. Love (39)	○	○	○	○	○
16. Whether pre-marital sex is right or wrong (40)	○	○	○	○	○
17. Abortion and related legal issues (41)	○	○	○	○	○
18. Prostitution/ Sex work (42)	○	○	○	○	○
19. HIV/AIDS (43)	○	○	○	○	○
20. Sexual abuse (44)	○	○	○	○	○
21. Rape (45)	○	○	○	○	○
22. Marriage (46)	○	○	○	○	○
23. Consensual sexual behavior (47)	○	○	○	○	○
24. Oral Sex (48)	○	○	○	○	○

Page Break

End of Block: Sex Communication

Start of Block: HBM

Self-efficacy The next set of questions are about your perceptions on the challenges in speaking to your child specifically about sexual trauma. Sexual trauma includes any form of unwanted sexual activity, including fondling, molestation, attempted sexual assault, or rape. Please read carefully and rate your level of agreement with each statement.

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
1. I believe that I know where to take my child(ren) if they experience any form of sexual trauma.	○	○	○	○	○
2. I feel confident in my ability to talk to my child(ren) about the risks of sexual trauma.	○	○	○	○	○
3. I feel confident that I would be able to provide the emotional support my child(ren) needed if they experienced any type of sexual trauma.	○	○	○	○	○
4. I know which general kinds of resources to use to talk to my child(ren) about sexual trauma.	○	○	○	○	○

Page Break

End of Block: HBM

Start of Block: RMA

IRMA-SF **Warning: The following statements are beliefs about sexual assault and rape. Please read each of the following statements carefully and rate your level of agreement with the statement (or something similar)**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
If a girl is raped while she is drunk, she is at least somewhat responsible for what happened (24)	○	○	○	○	○
When a girl is raped, it's often because the way they said "no" was unclear. (29)	○	○	○	○	○
If both people are drunk (or used drugs), it can’t be rape (32)	○	○	○	○	○
It shouldn’t be considered rape if a guy is drunk (or used drugs) and didn’t realize what he was doing (33)	○	○	○	○	○
Victims who do not fight back have not been raped. (37)	○	○	○	○	○

A rape probably doesn't happen if a victim doesn't have any bruises or marks (38)	○	○	○	○	○
A lot of times, girls who say they were raped often led the guy on and then had regrets (43)	○	○	○	○	○
A lot of times, girls who claim they were raped have emotional problems (44)	○	○	○	○	○
People who commit sexual assaults are mentally ill or abnormal perverts. (46)	○	○	○	○	○
A person who has really been assaulted will be hysterical after the assault. (47)	○	○	○	○	○
Sexual assault is provoked by the victim's	○	○	○	○	○

actions or behaviors (including dancing or provocative dress). (48)					
Girls/women lie about sexual assault as an act of revenge or guilt. (49)	○	○	○	○	○
Boys/men cannot be raped or assaulted, unless it is another boy/man, (50)	○	○	○	○	○
Rape is an impulsive, uncontrollable act of sexual gratification. (51)	○	○	○	○	○

End of Block: RMA

Start of Block: Religiosity

Religious Identity Please select the religion you identify with.

- ○ Christian (1)
- ○ Jewish (2)
- ○ Muslim (3)
- ○ Buddhist (4)
- ○ Other (Please Specify) (5)

_____

Page Break

Religiosity Please answer the following questions about your religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
My religious faith is extremely important to me. (1)	○	○	○	○	○
I spend periods of time in private religious/spiritual thought and reflection. (4)	○	○	○	○	○
I consider myself active in my faith or church. (5)	○	○	○	○	○
My faith impacts many of my decisions. (6)	○	○	○	○	○
My religious beliefs guide me in how I discuss sexual topics with my children (8)	○	○	○	○	○
I raise my children to share my religious beliefs. (9)	○	○	○	○	○

End of Block: Religiosity

Start of Block: Sexual Assault Victimization

Sexual Assault This section asks about times when you may have experienced unwanted sexual contact or sexual trauma. In these questions, an unwanted sexual experience is sexual contact that you did not consent to and that you did not want to happen. Remember that sexual contact includes touching of your sexual body parts, oral sex, anal sex, sexual intercourse, and penetration of your vagina or anus with a finger or object.

	Yes (2)	Maybe (1)	No (0)
Have you ever experienced any form of unwanted sexual contact? (4)	○	○	○
Have you ever experienced unwanted touching or grabbing of your sexual body parts (e.g. butt, crotch, or breasts)? (5)	○	○	○
Have you ever been in a position where you were unable to provide consent because you were incapacitated, passed out, unconscious, blacked out, or asleep? (6)	○	○	○
Have you suspected that someone has had sexual contact with you when you were unable to provide consent or stop what was happening because you were passed out, drugged, drunk, incapacitated, or asleep? This question asks about an event that you think (but are not	○	○	○

certain) happened (7)

Page Break

Racism-based stress In this section, we ask about possible discrimination that you may have experienced in your life. In your day-to-day life, how often do any of the following things happen to you?

	Never (11)	Less than once a year (15)	A few times a year (14)	A few times a month (13)	At least once a week (12)	Almost everyday (16)
You are treated with less courtesy than other people are. (11)	○	○	○	○	○	○
You are treated with less respect than other people are. (12)	○	○	○	○	○	○
You receive poorer service than other people at restaurants or stores. (13)	○	○	○	○	○	○
People act as if they think you are not smart. (14)	○	○	○	○	○	○
People act as if they are afraid of you. (15)	○	○	○	○	○	○

People act as if they think you are dishonest. (16)	○	○	○	○	○	○
People act as if they're better than you are. (17)	○	○	○	○	○	○
You are called names or insulted. (18)	○	○	○	○	○	○
You are threatened or harassed. (19)	○	○	○	○	○	○
You have been followed around in stores. (20)	○	○	○	○	○	○

Discrimination - B Please arrange the options, in order of importance, based on what you feel is the main reason for these experiences:

_____ Your Gender (1)
_____ Your race or ethnicity (2)
_____ Your sexual orientation (3)
_____ Your economic status (4)

Page Break

Racism-worry How much do you worry about your child(ren) experiencing unfair treatment because of their racial identity?

- ○ Never (19)
- ○ Sometimes (20)
- ○ About half the time (21)
- ○ Most of the time (22)
- ○ Always (23)

End of Block: Racism-based stress

Start of Block: FCP

Start of Block: Other

Other Thank you for filling out this survey. Please leave any comments that you would like to share about communicating about sexual health with your children.

_____

End of Block: Other

Start of Block: Focus Group link

Join Focus Group

Would you like to enter your details to be included in a random selection to receive a $20 gift of appreciation, or to learn about the next phase of this study? Remember that your survey response will remain anonymous and not connected to any identifiable information.

○ Yes, I would like to enter my details to be included in a random draw to receive $20. (4)

○ No, I do not want to submit my contact details to be included in a random draw for $20. (5)

Skip To: End of Block If Would you like to enter your details to be included in a random selection to receive a $20 gift o... = No, I do not want to submit my contact details to be included in a random draw for $20.

Link To enter your contact details for the random selection of $20, or to learn about the next phase of the study, click on this link.

End of Block: Focus Group link

Start of Block: Resources

RAINN
Thank you so much for your participation!

Please see information and resources to learn more about sexual health and trauma.
AMAZE (Digital content on sexual health topics) - *amaze.org*

LOVE IS RESPECT - *loveisrespect.org*
STOP IT NOW! (Child sexual abuse prevention education and advocacy) - *stopitnow.org*
Rape, Abuse & Incest National Network (RAINN) - *http://www.rainn.org/*

National Sexual Assault Phone Hotline (RAINN) 1-800-656-HOPE (4673)
National Suicide Prevention Lifeline 1-800-273-TALK (8255) (Press 2 for Spanish)
These services are available 24 hours a day, 7 days a week. Callers can connect free of charge to the phone hotlines and will be directed to local agencies in their area.

Individuals can also connect with trained hotline staff online through a secure chat messaging system.

End of Block: Resources

Appendix 3: Phase 3 Instrument

Parents' Focus group guide

- Have you had the sex "talk" with your children?
    - Please share your experiences discussing sexual health with your child(ren)?
    - What challenges have you experienced in talking to your child about sexual health and trauma?
- What do you think has influenced how you talk to your children about sexual health and trauma?
- Did/do you feel prepared to talk to your children about sexual trauma?
- What would help you have more effective conversations with your children about sexual trauma?

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Biography

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