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African American Grandparents'and Adolescent Grandchildren's Sexuality Communication

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Abstract

This exploratory study uses survey methodology to generate data on grandparent–grandchild sexuality communications and attitudes and feelings about these processes. The sample includes 40 African American grandparent–grandchild dyads for a total of 80 participants recruited from five churches. One open-ended question asks the participants about their willingness to use churches as venues in HIV prevention. Grandparents have more positive attitudes and feelings about sexuality communications than their adolescent grandchildren. Both grandparents and their adolescent grandchildren are receptive to the idea of using churches as venues in HIV prevention and provide recommendations about how a church-based sexuality program could be developed. The role of grandparents is constantly being redefined; therefore, we must continue to examine the needs of this population and the grandchildren they are raising. Nurses can build on the study's findings to develop church-based sexuality programs.

Keywords

African American grandparents; *adolescent grandchildren*; *sexuality communication*; *church*

Grandparents raising grandchildren represent a growing social phenomenon, with increasing numbers of grandparents providing permanent care to these children. An estimated 6 million children, or 1 in every 12, are now living in grandparent-headed households (American Association of Retired Persons, 2006), with 13% being African American, 8% Hispanic, and 4% Caucasian and Asian (United States Census Data, 2003). Yet youth of color who are living with grandparents are at particularly high risk for adoption of risky sexual behaviors and are vulnerable to HIV infection (Gillespie, Kadiyala & Greener, 2007). The reasons why grandparents assume the parenting role vary, but all result in additional responsibilities. One responsibility that grandparents are increasingly challenged with is sexuality communications (Brown et al., 2000; Goyer, 2005).

Research on grandparents raising grandchildren has examined stress with the caregiving role (Hayslip & Kaminski, 2005; Wiscott & Kopera-Frye, 2000), grandparent well-being (Goodman & Silverstein, 2002; Sands et al., 2000), and the mental and physical health and

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socioeconomic situation of these families (United States Bureau of the Census, 2000), but basically few studies have looked at how grandparents communicate about sexuality issues with their adolescent grandchildren (Brown et al., 2000; Mangxola, 2007). Yet youth of color who are living with grandparents are at particularly high risk for adoption of risky sexual behaviors and are vulnerable to HIV infection (Gillespie, Kadiyala, & Greener, 2007). Grandchildren raised by grandparents, primarily grandmothers, are more likely than other children to engage in unprotected sexual intercourse (Hayslip & Kaminski, 2005). Furthermore, because of past traumatic events and issues with their parents, these grandchildren are at risk for alcohol and drug abuse, low self-esteem, and rape (McGuigan & Pratt, 2001).

There is evidence that family involvement in sexuality communication reduces sexual permissiveness, the likelihood of adolescents engaging in risky sexual behaviors, and teen pregnancy (DiClemente et al., 2001; Sieving, McNelley, & Blum, 2000; Whitaker & Miller, 2000). Openness of sexuality communication fosters positive relationships in the family (Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Whitaker & Miller, 2000) and tailors age-appropriate sex education messages to children. African American mothers have been pivotal to discussions of sexuality issues with daughters (Cornelius, in press; Hutchinson et al., 2003; O'Sullivan, Meyer-Bahlburg, & Watkins, 2001), and fathers with sons (Cornelius & LeGrand, 2007). However, sexuality communication between grandparents and grandchildren is minimal. Because of generational differences, sex-related discussions between grandparents and grandchildren present a variety of challenges that grandparents may feel unprepared for (Brown et al., 2000). Complicating the problem is a lack of resources available to grandparents to prepare them for sex-related discussions with their grandchildren (Brown et al., 2000). To develop interventions to increase grandparents' sexuality communication, however, we must understand how they and their grandchildren communicate now. The research reported here therefore focused on the communication between African American grandparents and their adolescent grandchildren (11 to 13 years of age) in three areas: the process of communicating about sexuality, attitudes and feelings about the sexuality communication process, and willingness to use the church as a venue for HIV prevention.

Their views on the church as a venue for HIV prevention were requested based on the fact that churches have a visible presence in the African American community and grandparents use the church as a resource in raising their grandchildren. Although African American churches offer more health education programs than other ethnic congregations (National Council of Churches, 2007), the church has been underutilized in health promotion activities for adolescents (Campbell et al., 2000). In one survey of 6,037 churches, more than 65% reported offering health education programs, but only 8% reported offering health education programs related to AIDS (National Council of Churches, 2007). Coyne-Beasley and Schoenbach (2000) found that only 6% of Black clergy indicated that they would permit sexuality youth programs in their churches. Moreover, there is little evidence that interventions have been used to promote safer sex behaviors among adolescents (Hicks, Allen, & Wright, 2005; Peterson, Atwood, & Yates, 2002), though comprehensive church-based sexuality programs may be one of the most powerful weapons the African American community has against the spread of HIV.

Theoretical Framework

The Theory of Reasoned Action (Ajzen & Fishbein, 1980) and the Theory of Planned Behavior (Ajzen, 2002) provided the basis for exploring grandparents' and grandchildren's intent to communicate about sexuality, attitudes toward such communications, and beliefs about the use of the church as a venue for HIV prevention. According to these theories,

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grandparents' and grandchildren's sexuality communications are determined by their intentions, attitudes, and feelings about performing those behaviors. If grandparents and grandchildren have positive attitudes toward such communications and feel that communicating about sexuality issues, including HIV prevention, is relevant to their lives, they will initiate these discussions. Furthermore, if grandparents and grandchildren perceive that the moral underpinnings of religion are influential in these communications, they will involve church leaders in this process.

Design and Method

This article reports the quantitative findings from a larger mixed methods study titled "African-American Grandparents' and Their Adolescent Grandchildren's Issues, Barriers and Concerns About HIV Prevention" (Cornelius, LeGrand, & Jemmott, 2008). Quantitative data were collected with the HIV Risk Reduction Survey (HRRS) to generate information about the process and extent to which grandparents and their adolescent grandchildren were involved in sexuality communications. One open-ended question asked participants to write and discuss the use of churches as venues in HIV prevention. The study was approved by the university's institutional review board committee.

Setting

The study was conducted in private rooms at African American Protestant churches located in low-income sections of a city in Virginia. To ensure a representative sample, we sought churches with small to large congregations (100 to 3,000 members). The sample represented five churches from four different religious denominations (Baptist, Methodist, Church of God in Christ, and Presbyterian). At the time of the study none of these churches offered any HIV-prevention programs.

Sample

The sample included 40 African American grandparent–grandchild dyads, for a total of 80 participants. The adolescent grandchildren ranged in age from 11 to 13 years. All of the participants were required to speak and understand English and all of the grandparents were required to be the legal guardian of the adolescent grandchild participating in the study. On arrival, the participants were welcomed, provided an explanation of the study's purpose, and introduced to the research team. Grandparents signed consent forms and grandchildren signed assent forms. Thirty (75%) of the grandparent participants were grandmothers, who ranged in age from 48 to 79 years (mean of 64.5 years). The majority of grandparent participants were retired (83%), single (55%), and had not completed high school (52%). The adolescent participants were primarily female (75%) and in the seventh grade (73%). All of the participants were active church members (attended church activities one or more times per week).

Instrumentation

HIV Risk Reduction Survey—The HIV Risk Reduction Survey (HRRS), a 36-item questionnaire, includes questions about communicating on sexuality issues and attitudes and feelings about communicating on sexuality issues. The instrument was developed by the third author based on the theories of Reasoned Action (Ajzen & Fishbein, 1980) and Planned Behavior (Ajzen, 2002). The same survey was used for grandparents and adolescent grandchildren.

The HRRS assesses participants' sexuality communication process with nine statements, to which participants indicate their agreements on a 5-point Likert-type scale from *strongly disagree* (1) to *strongly agree* (5). Lower mean scores indicate greater agreement with the

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sexuality communication process; higher mean scores indicate more embarrassment or disagreement with the process. Eight additional items from the HRRS ask whether participants have discussed specific sexual topics (sexual intercourse, birth control, condoms, and HIV/AIDS prevention) with their grandparent or grandchild in the past 3 months. Response options for these eight items are *no*, *yes*, and *don't know*.

Five items on the HRRS assess participants' attitudes toward communications about sexual abstinence, teen pregnancy, HIV/sexually transmitted diseases (STDs), and the occurrence of a sense of bonding after such discussions. Participants indicate the extent to which they agree with the statements on a 5-point response format ranging from *strongly disagree* (1) to *strongly agree* (5). Higher mean scores indicate more positive attitudes toward the sexuality communication process.

Fourteen items on the HRRS assess feelings about abstinence, HIV/STD, and teen pregnancy. Participants indicate their feelings about these issues using 5-point response formats: *very bad idea* (1) to *very good idea* (5); *disapprove strongly* (1) to *approve strongly* (5); and *very hard* (1) to *very easy* (5). Higher mean scores indicate more positive feelings toward the sexuality communication process.

One open-ended question asked the participants to write and discuss their feelings about using the church as a venue in HIV prevention. Additional items ($n = 6$) were added to the survey to assess the demographic characteristics of the sample, including age, gender, race or ethnicity, marital status, grade in school, and religion. Cronbach alpha coefficients for the grandparent HRRS were .72 for sexuality communication, .70 for attitudes toward the sexuality communication process, and .82 for feelings about sexuality communication. Cronbach alpha coefficients for the grandchildren HRRS were .70 for sexuality communication, .72 for attitudes toward the sexuality communication process, and .78 for feelings about sexuality communication.

Results

Sexuality Communication Process

Table 1 shows the mean scores for grandparents and adolescent grandchildren on the sexuality communication process. Significant differences were noted in the groups' perceptions that talking about sex would encourage sex ($t = -4.160$; $p = .01$), they did not talk about sex in their family ($t = -8.413$; $p = .01$), and sex is too dirty to talk about ($t = 3.874$; $p = .01$). Grandparent responses were typically more positive than those of their grandchildren; they thought that talking about sex would not encourage sexual behavior and that sex was discussed in the family. In contrast, many grandchildren did not talk or were too embarrassed to talk about sex with their grandparents.

When asked whether they had discussed specific topics in the past 3 months, a greater number of grandparents than grandchildren recalled discussing sexual intercourse (13 vs. 1), birth control (15 vs. 2), AIDS and HIV prevention (13 vs. 0), condoms (32 vs. 9), having a condom when going out (15 vs. 9), and teaching their grandchildren about condoms (27 vs. 3).

Attitudes toward the sexuality communication process—Table 2 gives the groups' mean scores on attitudes toward the sexuality communication process. Significant differences were noted in attitudes toward discussing sexual abstinence and the likelihood of getting AIDS/STD ($t = 2.10$; $p = .48$), the likelihood of getting pregnant ($t = 2.526$; $p = .01$), and a sense of bonding when discussing sexual abstinence with their grandchild ($t = 2.742$; $p = .008$). Adolescent grandchildren had less positive attitudes toward discussing sexual

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abstinence than their grandparents and equally agreed with their grandparents that they do not listen when discussing sexual abstinence.

Feelings about the sexuality communication process—Table 3 provides the groups' mean scores on feelings about the sexuality communication process. Grandparents had higher mean scores than their grandchildren, indicating more positive feelings regarding the sexuality communication process. Grandparents' views were significantly more positive in regard to discussing HIV/STD prevention ($M = 4.6$), teen pregnancy ($M = 4.6$), and sexual abstinence ($M = 4.7$).

There was no significant correlation between grandparents' ($r = .72$; $p = .526$) and grandchildren's ($r = -.046$; $p = .344$) process of communicating HIV prevention and their feelings about the communication process. However, there were significant correlations between grandparents' ($r = .251$; $p = .025$) and grandchildren's ($r = .253$; $p = .013$) process of communicating HIV prevention and their attitudes toward the process.

The Church as a Venue for HIV-prevention Communication

The grandparents agreed that a church-based comprehensive sexuality program was needed. They noted that AIDS is a disease with lifelong health consequences, and safer sex and HIV-prevention messages need to be repeated at home, at school, and at church. One grandparent wrote, “We need to talk about sexuality issues more with our kids. My daughter is HIV-positive and I am raising her children as a single grandparent. I need help. The pastor could discuss these issues using the Bible as a template. He knows about the problems I am encountering raising my grandchildren.”

The grandchildren said that if a church-based sexuality program was developed, they would attend and bring a friend if a younger adult presented the content. They felt that a program like this should be “real” with candid discussions about the consequences of risky adolescent sexual behavior and peer pressure. One adolescent wrote, “A church-based sexuality program should contain messages about what is good and bad about having sex. Actually, there is nothing good about having sex. … However, when you have that strong, strong relationship and are ready to settle down, then maybe yes, but not now.”

Participants all felt that if a church-based sexuality program was developed it should include age-appropriate curricula, videos, culturally specific HIV-prevention information, youth speakers, and opportunities to meet HIV-positive individuals. They said that educational and skill-building sessions should be organized for both grandparents and adolescents to increase their self-efficacy with the sexuality communication process. Church leaders should be involved with program development and implementation. Participants indicated that there would be greater participation if a Church-based sexuality program was conducted over time, with short sessions (1 to 1½ hr) and follow-up.

Discussion

The HIV epidemic has drastically changed the structure of the African American family. With a steady increase in African American grandparent-headed households, it is not easy to overlook the problems their adolescent grandchildren encounter. Yet little research has focused on how grandparents communicate about sexuality issues with their grandchildren. The current study is one of only a few that has examined sexuality communication, attitudes, and feelings toward this process among African American grandparents and their adolescent grandchildren.

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Consistent with previous research, in this study grandparents were more positive than their grandchildren about the sexuality communication process (Cornelius et al., 2008). As in other studies, many of the adolescents did not recall specific sexual topics (sexual intercourse, birth control, condoms, and HIV/AIDS prevention) as the focus of grandparent–grandchild sexuality communications (Henry J. Kaiser Family Foundation, 2001). Feelings of embarrassment could have contributed to the adolescents' lack of recall about the sexuality communication process. These findings are of particular concern because the adolescents who show a lack of recall of the family sexuality communication process are more at risk for infection.

Not surprisingly, there were significant differences in the way these grandparents and their adolescent grandchildren felt about discussing sexuality issues. The grandparents were more positive about the process than their grandchildren. The grandchildren may have felt uncomfortable because of generational differences. However, if sexuality communication is introduced at an age-appropriate level with routine discussions, then children will develop positive attitudes toward this process with their sexual partner, peers, and family.

If church-based interventions are designed for grandparents and their adolescent grandchildren, cultural, then familial, influences must be taken into consideration. Extrafamilial influences, such as the pastor and Church, will be instrumental in the development of a church-based sexuality program. It may be necessary to assist church congregations to integrate morality, spirituality, and sexuality issues in program development.

To date, there has been very little research on the problems that African American grandparents have in communicating safer sex behaviors to their adolescent grandchildren. Although this study is an important first step in identifying these problems, several study limitations should be noted. First, the sample included only grandparents and grandchildren who were active church members; therefore, the findings cannot be generalized to those who are not active members of a church. Second, participants were not randomly selected; thus, there may have been some bias in the sexuality communication responses. Third, the current findings only account for group responses; analysis of differences in individual dyads would have been valuable but this was not possible because of the way data were collected.

Nevertheless, because of its focus on the sexuality communication process of grandparents and their adolescent grandchildren, the study provides important insights into the state of family communication, particularly intergenerational family communication, among African Americans. The results suggest that grandparents may need assistance in deciding what and when to discuss sexuality topics with their grandchildren so that they are not embarrassed by these discussions. Although the present findings have opened up an important area of research, additional studies using larger and more representative samples would add to the generalizability of these findings.

One of the topics examined in the sexuality communication process was sexual abstinence. Research indicates that sexual abstinence programs have not been effective in producing statistically significant changes in adolescents' sexual behavior (Hauser, 2004). This finding emphasizes the participants' recommendation that a church-based sexuality program should be for “real” and include safer sex information for sexually inactive and active teens.

The Theories of Reasoned Action and Planned Behavior can be used to guide the development of a “real” church-based sexuality program. Knowledge, attitudes, beliefs, and behavioral intents for a church-based sexuality program addressing abstinence and safer sex practices will need to be examined. Full support of the pastor, youth ministers, parents, grandparents, and children is essential for program development and implementation. A

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committee of church leaders, adults, and youth should be formed to critique the curriculum and recruit facilitators to work with the youth. The premise of such a program could be based on the words of Jan Platner of Planned Parenthood Federation of America, Inc. (2008):

> If you want to save my soul, you'll teach me about abstinence.
>
> If you want to save my life, then you'll teach me how to use a condom.

Biblical scriptures could be used to initiate sexuality discussions. Educational sessions should focus on assisting individuals to establish healthy relationships, practice assertiveness skills, learn to love themselves, interpret scripture, and make responsible sexual choices. The impact of television and rap music on adolescent sexual behaviors should be discussed. Lastly, computer technology such as the Internet and mobile phone text messaging could be used to enhance the delivery of safe-sex messages.

As the role of grandparents is constantly being redefined, we must continue to examine the needs of this population and the grandchildren they are raising. In light of growing concerns about teen pregnancy, sexually transmitted diseases, and AIDS, identifying extrafamilial sources for HIV prevention, such as churches, and developing interventions to increase open communication among grandparents and adolescent grandchildren are urgently needed to reduce HIV infection rates among adolescents.

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Table 1

Sexuality Communication Scores

Communication Item	**Group *M***	***SD***	***t***	***p***
Embarrassed to talk about sex	GP 2.00	1.15	−1.14	.254
	GC 2.30	1.18		
Too young to talk about sex	GP 1.85	0.95	1.22	.223
	GC 1.60	0.87		
Talking about sex would encourage sex	GP 1.57	0.68	−4.16	.010**
	GC 2.55	1.32		
Cannot talk about sex because knows about	GP 1.87	1.02	−0.78	.437
	GC 2.05	0.99		
Cannot talk about sex because will not listen	GP 2.07	1.19	0.74	.464
	GC 1.90	0.93		
Do not need to talk because already knows	GP 1.82	0.93	−0.73	.471
	GC 1.97	0.92		
Do not have enough knowledge to talk	GP 1.92	0.86	−0.23	.821
	GC 1.95	1.09		
Do not talk about sex in the family	GP 1.50	0.75	−8.41	.010**
	GC 3.47	1.28		
Sex is too dirty to talk about	GP 2.52	1.52	3.87	.010**
	GC 1.40	1.03		

Note: GP = grandparent; GC = grandchild.

** $p = .01$.

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Table 2

Sexuality Attitude Scores

Attitude Items	***M***	***SD***	***t***	***p***
Talk about sexual abstinence will be	GP 3.00	1.39	2.01	.048 *
less likely to get AIDS or STD	GC 2.35	1.49		
Talk about sexual abstinence	GP 2.97	1.29	2.53	.010 **
less likely to get pregnant	GC 2.25	1.28		
Talk about sexual abstinence I will feel closer	GP 2.87	1.26	2.74	.008 *
	GC 2.12	1.18		
Talk about sexual abstinence I will not listen	GP 2.02	0.66	0.00	1.000
	GC 2.02	1.10		
Talk about sexual abstinence	GP 1.70	0.56	−2.04	.044 *
I will be embarrassed	GC 2.15	1.27		

Note: GP = grandparent; GC = grandchild.

* *p* .05.

** *p* .01.

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Table 3

Sexuality Feeling Scores

Scale No. of items	***M***	***SD***	***t***	***p***
Sexual abstinence 4	GP 4.70	0.55	3.90	.010**
	GC 4.00	1.01		
HIV/STD prevention 6	GP 4.60	0.81	3.10	.002**
	GC 3.90	0.89		
Teen pregnancy 4	GP 4.40	1.00	7.30	.010**
	GC 2.60	1.39		

Note: GP = grandparent; GC = grandchild.

** *p* .01.