HHS Public Access

Author manuscript

J Adolesc Res. Author manuscript; available in PMC 2021 May 27.

Published in final edited form as:

J Adolesc Res. 2019 September 1; 34(5): 528–562. doi:10.1177/0743558418757464.

"It's Almost Like Gay Sex Doesn't Exist:" Parent-Child Sex Communication According to Gay, Bisexual, and Queer Adolescent Sons

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Abstract

Sex communication interventions facilitate positive sexual health outcomes with heterosexual adolescents. The same has yet to be established for male youth with same-sex attractions, behaviors, and identities. Our study describes the experiences of gay, bisexual and queer-identifying adolescent males with parent-child sex communication. We conducted 30 in-depth semi-structured interviews with a diverse group of 15 to 20 year-old gay, bisexual, and queer (GBQ) males. Interview transcripts were coded and themes were identified using thematic and content analysis. Narratives revealed that sex communication with parents occurs rarely, is heteronormative in content prior to adolescent males' disclosure as GBQ, and after disclosure is reactionary and based on stereotypes that associate this population with negative health outcomes. Parents were rated poorly as sex educators by adolescent males and the findings are mixed regarding perception of parents' knowledge about GBQ-specific information. Parents and healthcare providers were identified as preferred sources of sex information by GBQ adolescent males. Sex communication with parents throughout adolescence that excludes GBQ males' same-sex concerns is a missed opportunity for targeted sexual risk reduction. There are multiple ways healthcare providers can assist parents to plan age-appropriate, sexuality-inclusive, home-based discussions about sex for this group.

Keywords

adolescence; qualitative; sexual orientation; young men who have sex with men; sex communication; parenting; HIV; LGBTQ youth; safer sex

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Introduction

Parents can play a critical role as HIV prevention educators in the lives of their adolescents (Perrino, Gonzalez-Soldevilla, Pantin, & Szapocznik, 2000), including non-heterosexual adolescent males. With male-to-male HIV sexual transmission accounting for 92% of new HIV infections among all adolescent males between ages 13 to 24 (Centers for Disease Control and Prevention, 2017), prevention efforts must consider the role of parents as HIV risk reduction agents (Mustanski & Hunter, 2012). In a study involving HIV-infected young gay adults, the mean age of sexual debut was 14.5 years and the mean age of HIV diagnosis was 19.9 years (Outlaw et al., 2011). It appears that for this group, adolescence is an especially crucial phase that predisposes them to engaging in high-risk sexual behavior, given the overwhelming lack of resources that supports their emergent same-sex attractions, behaviors, and identities (Du Bois, Emerson, & Mustanski, 2011; Elia & Eliason, 2010; Harper & Riplinger, 2013). Further, specific subgroups of non-heterosexual males are disproportionately impacted by HIV infection. For example, African American and Latino adolescent males contend with both systemic and nuanced cultural barriers (e.g., machismo, stigma, racism) that impedes their access and utilization of health promotion services (see Quinn & Dickson-Gomez, 2016; Smallwood, Spencer, Ingram, Thrasher & Thompson-Robinson, 2017). With lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals disclosing their sexual orientation at younger ages than previous cohorts of LGBTQ people (Calzo, Antonucci, Mays & Cochran, 2011; Martin & D'Augelli, 2009) and early self-identification as LGBTQ being associated with greater morbidity (Remafedi, 2008; D'Augelli & Herschberger, 1993), the role of parents as HIV risk reduction agents is especially important for this population. Parent-child sex communication, the bi-directional discussions between parents and their children about sex and sexuality-related topics, is a critically important component of the overarching health aim to lower the rates of new HIV infections among this population.

Adolescence as a Sexual Minority Youth

Adolescence represents one of the critical transitions in the life span and is characterized by a high rate of growth and change. Physical, sexual, and psycho-emotional maturation lead to experiences that move the adolescent toward social and economic independence, the development of identity, and the acquisition of skills needed to carry out adult relationships and roles (Morgan, 2014). This critical window of development can be further challenged by the development of a non-heterosexual sexual identity (Harrison, 2003; Jamil, Harper, & Fernandez, 2009). Gay youth who become aware of their same-sex attractions and disclose their orientation earlier have been found to be more likely than gay youth who reach these sexual identity milestones at a later age to experience forced sex and gay-related harassment during adolescence and HIV infection during adulthood (Friedman, Marshal, Stall, Cheung & Wright, 2008). Even though the transition from adolescence to young adulthood is marked by increased independence from parents, their support remains a strong correlate of positive health outcomes for non-heterosexual youth (Needham & Austin, 2010). In particular, more positive attitudes by parents toward same-gender sexual expression has been linked to decreased unprotected sexual activity for non-heterosexual youth between the ages of 14 and 21 (Rosario, Hunter, Maguen, Gwadz & Smith, 2001). Furthermore, despite some

families' negative reactions to a child coming out as non-heterosexual (D'Augelli, Grossman & Starks, 2008), many parents express concern about their children's well-being (Conley, 2011), fear that they will contract HIV (LaSala, 2007), and want them to develop into healthy and productive adults (Bouris, Guilamo-Ramos, Pickard, Shiu, et.al., 2010). For these parents, understanding sexuality-sensitive, parent-child sex communication can help them meet their child's needs (Flores & Barroso, 2017).

Sex Communication for Young MSM

The sex-related concerns of LGBTQ adolescents are often not addressed at home (Estes, 2017; D'Augelli, Grossman & Starks, 2008; Institute of Medicine, 2011). Further, sex education in schools generally does not focus on issues pertinent to risk factors for this vulnerable group of adolescents (Currin, Hubach, Durham, Kavanaugh, et al, 2017; Pingel, Thomas, Harmell, & Bauermeister, 2013). Thus, research to understand the sexual education experiences of this group is essential to pave the way for the development of interventions that will guide parents, teachers, and healthcare providers in educating GBQ adolescents about their sexual health.

Forty years of research on parent-child sex communication, henceforth sex communication, with heterosexual youth has produced effective interventions. Sex communication between parents and heterosexual adolescents enables teens to resist pressure to have sex (Kapungu, Baptiste, Holmbeck, McBride 2010), use condoms more frequently (Widman, Choukas-Bradley, Helms, & Golin, 2013), initiate conversations about HIV status prior to sex (Crosby, Hanson, & Rager, 2009), and access sexual health services (Hall, Moreau & Trussell, 2012). Of late, sex communication research has been extended to include the concerns of other adolescent populations including those in the autism spectrum (Holmes & Himle, 2014) and those with chronic illnesses (Ballan, 2012). However, effective sex communication interventions have yet to be established for parents with non-heterosexual adolescent children (Sutton, Lasswell, Lanier, & Miller, 2014).

There are conflicting and surprising results from the small number of research studies that have been published on understanding how sex communication unfolds for LGBTQ youth and their parents. An observational study of diverse parent-child dyads from the east coast established an association between higher levels of unsafe sexual activity and higher levels of disagreement between parents and gay and bisexual adolescent males (LaSala, Siebert, Fedor, & Revere, 2016). Conversely, from a survey of young men of color who have sex with men from the Midwest, a positive association was found between maternal communication about sex with males with routine HIV testing (Bouris, Hill, Fisher, Erickson, & Schneider, 2015). Still another study from a multi-city sample found an association between higher frequency of sex communication between parents and gay adolescent males and increased levels of unprotected anal intercourse (Thoma & Huebner, 2014). These cross-sectional studies are exploratory in nature and cannot make statements about causality. From qualitative studies, parental discomfort when it comes to HIV-related communication with gay and bisexual adolescent males from the northeast US has been noted (LaSala, 2014), along with limited availability of inclusive health information specific to young men who have sex with men (YMSM) and their parents (Rose, Friedman, Annang,

Spencer, & Lindley, 2014). While informative, these initial qualitative studies are limited in their generalizability given their small sample sizes, purposive and convenience sampling strategies, and the potential impact of participants coming from accepting neighborhoods or supportive families. This current study extends the knowledge base by focusing on gay, bisexual, and queer adolescent males' experiences with sex communication, identifying their thoughts on parents' approaches to these conversations and their efficacy as sex educators, and the inclusivity of these talks. To this end, a descriptive qualitative approach was best suited to understand the complexity of sex communication between heterosexual parents and GBQ adolescent males and identify how GBQ adolescent males interpret and makes sense of these interactions.

Theoretical Framework

Prior to understanding the associations between variables central to parent-child sex communication for LGBTQ youth, an in-depth exploration of their experiences and perspectives helps to establish concepts of concern. Using tenets of the Bioecological Theory of Human Development (Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2006), we explored the perspectives of GBQ-identifying adolescent males on verbal discussions with parents about sex-related topics. Bronfenbrenner's Bioecological Theory provides, in general, an encompassing approach to the study of an individual's behavior, and, in particular, a comprehensive lens to identify the factors that give rise to sexual health outcomes. The bi-directional effects of ecological systems (family, peer networks, schools) on a non-heterosexual male's pivotal life events and identity have been well-documented (Alderson, 2003; Elizur & Mintzer, 2001). Similar to previous studies using this framework that have examined bullying (Hong & Garbarino, 2012) and suicidality (Morrison & L'Heureux, 2001) among LGBTQ individuals, bioecological factors become indispensable when considering risks and protective factors that impact this populations' health outcomes. With its simultaneous focus on the individual and their environmental context, Bronfenbrenner's holistic theoretical lens has risen in prominence in the study of risky sexual behavior among adolescents (Chen, Thompson, & Morrison-Beedy, 2010).

The core of the Bioecological Theory are *proximal processes* that are "particular forms of interaction between organism and environment…that operate over time and are posited as the primary mechanisms producing human development" (Bronfenbrenner & Morris, 2006, p.795). For example, these proximal processes include an adult playing with a baby or parents and children discussing sex throughout adolescence. Through *proximal processes* individuals and their environment act on and shape each other, enabling individuals to situate themselves in the world and their roles in responding to the prevailing order while simultaneously fitting into the existing one (Tudge, Mokrova, Hatfield, & Karnik, 2009).

Bronfenbrenner's theory further emphasizes two essential ideas. The first proposition stipulates that human development occurs through reciprocal interactions that progressively gain complexity between the evolving organism and the persons, objects and symbols in their immediate surroundings. He stressed that for these proximal processes to be effective, interactions should occur regularly for extended periods. The second proposition is that the nested systems relate to and interact reciprocally with the individual, each other, and with

time. Bronfenbrenner stated that these proximal interactions vary in form, power, content, and direction to impact development. Further, development is a function of individual characteristics, the immediate and remote environments where interactions occur, the developmental outcomes of interest, the unfolding social contexts through the life course and the historical epoch in which the person was born (Bronfenbrenner & Morris, 2006). Hence, no singular system can be understood in isolation from the others (Gavazzi, 2011) and events that occur in one system can influence what happens in another system (Raingruber, 2014).

In this study, *sex communication* in the home is conceptualized as a proximal process between parents and gay, bisexual, and queer (GBQ) adolescent males for the exchange of information about sex throughout childhood and early adulthood. Further, *sex* is an encompassing term that includes the mechanics of intercourse in its many forms, and topics related to attraction, reproduction, safety, sexual orientation, and gender identity. Our aim was to describe the nature of sex communication from GBQ adolescent males' recollections and gather their perceptions of parents' knowledge of LGBTQ sexuality topics. We also assessed parents' efficacy as sex educators and identified this youth samples' preferred sources of sex information within the ecological system they and their families navigate.

Methods

Design, Setting, and Participants

A qualitative interpretive approach was used to explore perceptions of sex communication with cisgender males who self-identify as gay, bisexual, or queer youth due to the high burden of HIV and STI infection within this population. Semi-structured interviews were conducted to allow the participants to describe their experiences. During the interviews, participants were asked to share their recollections about the time their parents initially addressed sex with them. A semi-structured interview guide, formulated according to tenets of Bronfenbrenner's Bioecological Theory, was used for data collection (Table 1). The preliminary questions focused on proximal processes typically salient during sex communication as identified in extant sex communication literature from presumably heterosexual youth samples. Given that the majority of sex communication studies do not report their youth samples' sexual orientation and are framed largely as heteronormative discourses (Flores & Barroso, 2017), the questions asked of participants in this study explicitly investigated how prevailing ecological constructs throughout the macrosystem affected these discussions in their specific family's microsystem. Subsequent questions were based on ecological factors noted as integral to sex communication. Probes were used to elicit further details about their reactions to the sex communication process. Two sets of interview questions explored what participants thought about how their parents' knowledge (or lack of knowledge) of their sexual orientation might have impacted sex communication. Those adolescents who had disclosed their sexual orientation were asked whether discussions about sex contained inclusive information if the talk occurred after disclosure, and whether they perceived their being "out" as affecting the frequency, content, and parental rating as a sex educator. An evolving and naturalistic approach was used across

interviews with subsequent participants such that novel issues described by earlier participants were explored with later participants.

Participant inclusion criteria were English-speaking GBQ males between 15 and 20 years of age who could recall at least one conversation with their parents about sex. Youth who could not recall any discussions about sex were ineligible to participate. The recruitment sites included secondary school Gay-Straight Alliances, university LGBTQ student centers, LGBTQ non-profit organizations, and community events for LGBTQ individuals such as Pride Festival, in North Carolina. A purposeful sampling technique was used to identify eligible participants at the recruitment sites. Similar to previous qualitative studies about parent-child sex communication, we aimed to recruit around 25 participants to achieve data saturation, or the point at which response patterns became repetitive, when themes were thick and well-described, and little more could be gained by further data collection (Marshall & Rossman, 2011). Potential participants were recruited through flyers posted at the recruitment sites. After the first participants completed their interviews, snowball sampling was used by asking them to refer any of their friends who met the eligibility criteria and who they thought were interested in participating in this research. Copies of the approved flyer were provided for them to share with their friends or acquaintances. Forty-eight potential participants were approached for interviews and data collection was capped with the 30th participant when data saturation was achieved. Interviews were conducted from August, 2015 to March, 2016.

Procedures

The interviewer, a young gay adult trained in qualitative interviewing through formal course work and didactic simulations, conducted the interviews. The interview guide was pilot tested, which helped refine the study procedures and approach of the interviewer. Questions and probes elicited details about participants' experiences, including their thoughts, feelings, and reactions about the sex communication process. The audio-recorded interviews were conducted in a location of the participants' choice, including in a secure office at university LGBTQ student centers or in a designated space at the authors' primary institution. Most of the interviews were 60 to 90 minutes each.

All participants provided written consent before data collection commenced. In order to allow the participation of GBQ adolescent males under 18 years of age who have not yet disclosed their sexual orientation to their parents, a waiver of parental consent was granted by the Duke University IRB. To protect their privacy and to keep data confidential, participants were addressed by their chosen pseudonyms. A trained graduate student served as an observer during each interview. These interview observers sat mostly beyond participants' fields of vision to minimize distractions and not impede rapport building. Additional details about the study protocol is detailed elsewhere (Flores, McKinney, Arscott & Barroso, 2017).

Data Analysis

We conducted qualitative content analysis (Graneheim & Lundman, 2004; Sandelowski, 2010) of the interview transcripts using a text-based software program (NVivo 11) to aid in

organization. Transcripts were read multiple times, allowing us to become familiar with each participant's experience (Sandelowski, 1995). Next, data were aggregated into first level codes that shared a central meaning (Barroso, 2010). Based on frequency and mutuality of descriptions, we reorganized and realigned the codes to develop an ongoing thematic and conceptual structure throughout the second cycle of coding (Saldana, 2015). From this constant reorganization of the data, the resulting codes were arranged into categories. Themes were generated to link the underlying meanings of the categories (Graneheim & Lundman, 2004) and were formulated based on similarity of core concepts and marked differences between categories.

To be consistent with the theoretical framework, codes and themes generated were situated within Bronfenbrenner's Bioecological framework (Bronfenbrenner & Morris, 2006) with a focus on the proximal processes between parent and child during sex communication. Since the interview questions were patterned from existing literature that heavily sampled heterosexual adolescents, emergent themes from this study of GBQ males were analyzed relative to perceptions regarding sex communication in the home by that group and in comparison to what is known in the literature. Thus, the findings are organized according to child-, parent-, and dyadic factors that are, first, similar to their heterosexual peers and, second, those that are unique to these dyads that affect the reciprocal exchanges during sex communication.

Lincoln and Guba's (1985) four criteria for trustworthiness were used to ensure scientific rigor in this study. First, credibility or accuracy was achieved through triangulation and peer debriefing. In this study, data from transcripts were analyzed with theoretical memos and reflexive journal entries to come up with new insights and to arrive at a more complete description of the phenomenon. Peer debriefing involved exposing the primary author's assumptions and beliefs to members of the research team to ensure that assumptions were honest, and that emerging hypotheses were based on data and not biases. Second, transferability or the potential to extrapolate the findings to other contexts (Polit & Beck, 2012), will be determined by the future readers of the research. To assure that this will happen, thick descriptions of the data are included in this manuscript to sufficiently inform readers. By providing rich depictions of the data, readers can then render informed judgments as to the interchangeability of the findings from the original context to their own. Third, dependability pertains to the ability to track the changes in qualitative data over time and through changing conditions. An audit trail was kept about how emerging data were gathered and how decisions were made during data collection and analysis. A codebook was maintained and helps explain the processes that led to the formation of codes and themes. Finally, confirmability deals with the objectivity of the data where conclusions drawn are from the participants' contributions and not from a researcher's biased accounting of the data. Maintaining the audit trail mentioned earlier, plus frequent member checks with two or more people about the veracity of the data, were ways we ensured confirmability. Finally, by maintaining awareness of the primary author/interviewer's concurrent insider and outsider positions, we were cognizant of the need to balance having a shared viewpoint with the target population and the demand for objectivity (LaSala, 2009). Emphasizing participant confidentiality was an additional way we minimized any potential halo effect participants

may succumb to for fear of being judged harshly by a member of his community (LaSala, 2009).

Results

Demographic Summary

Table 2 describes demographic characteristics of the sample (n=30). Participants in this sample were on average 18.5 years of age (5 < 18 years), with 19 participants (63.3%) in college, 23 (76.7%) who self-identified as gay, and 26 (86.7%) having disclosed their sexual orientation to parents. Most participants remembered first being attracted to another male and self-identifying as GBQ at the mean ages of 10.5 (SD 3.5) and 14.7 years (SD 2.2), respectively. In this sample, the mean age of first disclosure as GBQ to another person was 15.4 years (SD 2.6).

Nature of Sex Communication

GBQ adolescent males had infrequent discussions with parents about sex and sexuality– and only mostly after they came out. These conversations were generally not inclusive in content and mostly reinforced heteronormative information. At a time when GBQ youth were beginning to actively search for information about their unique attractions, behaviors and identities, they did not receive it in the home through sex communication. Table 3 details the key findings regarding frequency and inclusivity of sex talks and their perceptions of parents' knowledge about LGBTQ topics.

Infrequent Conversations

Participants recruited had to recall at least one instance of discussing sex with parents to be in the study. We purposefully did not provide any definition of sex when we asked about their recollections and instead allowed them to respond based on their conceptualizations of what topics fell under 'sex talks.' We found that majority in our sample did not have regular discussions with their parents about sex. Three distinct patterns emerged in terms of sex communication frequency: (a) rare (n=21 participants); (b) occasional (n=6 participants); and (c) often (n=3 participants). Participants who reported rare sex talks experienced a limited number of discussions ("once or twice"), which were timed mostly around puberty. Participants believe these talks occurred because parents observed adolescent males undergoing physical changes or they were at an age when they were deemed ready for sex communication. A.W. (16 years old, White) recalled:

> My Dad sat me down in the playroom and said, 'You're old enough now son. It's time for you to know the facts about life…and here it goes.' And he basically told me that a penis goes into a vagina, and then miraculously babies come out. No details, no alternative forms of sex, just straight up intercourse and that's it. I was just like, 'OK thanks.'

For the participants who reported occasional talks *("between three to five times"*), they recalled discussions occurring at younger ages compared to those in the rare group and they remembered specific topics and later follow-up conversations. These discussions were mostly initiated by curious adolescent males during early childhood and focused on

mechanisms of human reproduction, including anatomical differences between males and females. G.O., (19 years old, White) remembers:

> I said, 'Hey, I'm reading this encyclopedia and it said that this is where children come from. Is this the case?' I mean I was just sort of saying 'Is this really what happens? Like 'This sounds kind of weird.' And she said, 'Yeah. No, that's true. This is what happens.'

Finally, the participants who recalled sex talks occurring often ("more than five times") experienced routine discussions with parents. These conversations were initiated by either the parent or the son, on a wide range of topics, and discussed sex like any topic of conversation. These participants described close relationships with parents, with the discussions initiated pre-adolescence. According to them, the onset of puberty signaled a change in topics, with parents focused on the introduction of bodily changes that come with adolescence followed by discussions about safe sex. M.S. (18 years old, White) recalled that growing up:

> We would watch a lot of art films on our projector at home and there would be sex scenes. My mom would be like, 'Oh that's not really realistic…' She specifically told me not to watch porn because she said it would give me unrealistic ideas of what sex looked like.

From the entire sample, it should be noted that five of the participants remembered discussions about sex after parents learned of adolescent males' sexual orientation. According to them, parents initiated sex communication either after inadvertently discovering their sons' sexual orientation or were informed by sons of same-sex attractions. The frequency of conversations about sex and sexuality after disclosure varied as well from one-time talks to occasional check-ins by parents.

Non-inclusivity of Topics Covered

Adolescent males reported the sex talk they received as overwhelmingly heteronormative in content prior to disclosing their own sexual orientation. More than half of the sample (n=17) did not hear about same-sex attractions and other sexual orientations during routine sex communication prior to disclosure as GBQ. Of those who did hear about sexual orientation from their parents (n=8) before coming out as GBQ, many remember negative comments made about LGBTQ people which they attributed their parents' generation. Sex communication was mostly non-inclusive of other sexual orientations and emphasized the heteronormative aspect of topics being discussed. For example, C.W. (17 years old, African American), who reported being effeminate all his life, recalled:

> My teacher strongly encouraged all parents to talk to kids about sex because we were 'gonna have a Sex Ed class. So my mom sat me down and she was like, 'Okay son, here's how it's gonna be. You are a guy, you're supposed to date girls and when you get married that's when you can have sex and sex makes babies.' I was like, 'Okay,' and then deep down inside I knew that two guys couldn't make a baby.

The few adolescent males who reported positive discussions (n=5) regarding sexual orientation during early childhood were all son-initiated inquiries. Participants who reported

initiating these conversations with parents did so knowing that they would not face negative parental reactions due to prior family discussions that conveyed general acceptance of non-heterosexual individuals. For example, after asking his father what would happen to him if he turned out to be gay, T.H. (19 year old, Asian) recalled his father saying to his then 8-year old son, “It would be a little bit more difficult, but we’d love you and we’d work through it.”

Almost half of the participants described an increase in discussions when parents learned of adolescent males’ sexual orientation. These discussions caused adolescent males to be irritated because parents focused on safe sex practices and their concerns about the threat of HIV and STIs. Several adolescents who reported a spike in sex talks after disclosure of sexual orientation recalled that parents were suddenly worried about their sex lives and even asked about their previous and present dating behaviors, including current sexual activity. C.D. (19 years old, Latino) explained how after years of not hearing anything about sex, his mother became overly concerned after he disclosed that he was attracted to guys:

> All she kept saying was, ‘Charles, make sure that if you do have sex or something, wear protection. Be safe. I don’t care that you’re gay but I wanna make sure that you’re safe and that you’re practicing safe sex.’ And I would say, ‘You can stop now!’

Finally, five other participants described a total lack of discussion on topics specific to sexual orientation or same-sex attraction following disclosure. According to them, their parents either ignored the new piece of information presented or could not muster the energy to verbalize any concerns or thoughts they might have about adolescent males’ sexual orientation. J.F. (18 years old, White) described how he wished sex communication was more inclusive:

> In my case, from the conversation, it’s almost like gay sex doesn’t exist, you know? So it’s like when you feel same sex attraction, but you still have no idea what gay sex is, you just kind of have this sudden conflict. I just think overall it would be much better - especially those who are still in the closet to their parents and even their peers - just to know that they are being recognized and that they exist. Even if they are not ready to tell their parents, it’s still good [for them] to know that gay sex exists. I mean just from having that conversation you already know that the parent is like someone who almost inevitably respects their sexuality and that already is a huge step.

From these recollections, parents did not respond to sons’ disclosure as non-heterosexual and extended parental silence even on a topic that squarely affected their home. According to the sample, opportunities to talk about GBQ-specific topics were not utilized by parents. From a health promotion perspective, this chance for a teachable moment was missed and left participants feeling ignored.

Parents’ Variable Knowledge of GBQ Sexuality Issues

From the sample’s perspectives, parents were viewed as having varying levels of knowledge about GBQ-specific topics. Following the narratives, participants’ perceptions of parents’ knowledge of GBQ topics coalesced around three groupings. The first group (n=12) felt that

their parents did not possess GBQ-specific information before or after adolescent males' disclosure. Many of the participants noted how parents not having any LGBTQ friends, lack of skills to look for appropriate materials regarding adolescent males' sexual orientation, or being heterosexual were the main reasons for them perceiving parents as not having GBQ-specific knowledge. When asked how their heterosexual parents should respond to GBQ adolescent males' questions about same-sex attraction, T.H. (19 years old, Asian) suggested:

> I'd connect them (GBQ adolescent males) to resources that can actually talk about issues from a perspective of someone who is gay. Because parents don't have the experience of being gay, it's just really hard for them to have that conversation.

A few of the parents in this group were parents who were still having difficulty accepting their adolescent males' sexual orientation. A few parents also had previously made clear their disapproval of LGBTQ individuals. After T.R. (19 years old, Latino) was discovered in middle school downloading sexually explicit materials from the internet, his mother could only verbalize puzzlement about why he would do such a thing:

> She said she didn't know why I was doing that. She didn't understand why I had pictures of naked guys. And I just told her I didn't know, I just really didn't know. And then she talked about when she was a little girl, she didn't do that.

A few participants in this group reported educating their parents themselves about what being GBQ entailed. They reported feeling responsible for informing their parents about the health issues they face as a population. D.J. (20 years old, Caucasian) remembered:

> If I had asked, they would have just been like, 'I don't know. Ask a gay person.' They really wouldn't have had an answer for me…I didn't think my parents knew much. I'm always teaching my parents gay things.

A second group of participants (n=11) assumed that their parents definitely had ample knowledge of GBQ sexuality. The participants pointed out that parents started with a solid base of heterosexual-focused knowledge about sexual health. These parents then extended that knowledge base to include GBQ sexuality issues after the adolescent males' same-sex attractions or behavior was known. After disclosure, participants recalled that their parents actively sought out information and educated themselves. C.D. (19 years old, Latino) recalled how his mother extended her knowledge about GBQ information through a cable TV program about gay men:

> My mom would come in and she would sit there and be like, 'What are you watching….?' I would be like, 'Oooh, I don't know if you wanna watch this Mom…' She would be like, 'Is this porn?' 'Nooo, this is Netflix,' and she would be like, 'If this is what you're watching…then I'm going to watch it too.' So she just sat there and watched it and she's asking me all these questions! Afterwards she asked if we were going to watch the next episode and I was like, 'No! I think we are good for today!' She's definitely more accepting than at first since she sat there and watched 'Queer as Folk' with me.

Finally, a third group (n=7) was uncertain about the extent of parents' knowledge. Because sex communication was almost non-existent for them, they reported not being able to

accurately assess parents' familiarity with GBQ issues. For example, A.J. (19 years old, African American) was under the impression that:

> I think that they [parents] do know about how certain STDs are transferred and stuff like that but … I guess for me in particular, I don't know because they don't really talk about that. I feel like the knowledge might be within them but they may not disclose it to me because they don't think I'm going to be involved with that [sex].

The variability of parents' knowledge as perceived by GBQ sons suggests opportunities for providing basic sexuality education and building upon parents' existing knowledge base. Across the three groupings, participants reported that a majority of parents can benefit from learning more about LGBTQ-specific health topics. Parents who are asked about GBQ-specific information instruct their children to look up resources that can better answer those questions. Participants further allude to communication strategies parents might find helpful when attempting to convey existing heterosexual-based information when tailoring discussions for their sons' unique same-sex interests.

Poor Parental Ratings as Sex Educators

Across the board, parents were rated poorly as sex educators. Study participants were asked to rate their parents as sex educators from zero ("worst sex educators") to ten ("best sex educators"); Table 4 provides a summary of the parental ratings reported by the sample. For most of the participants, they tended to rate both parents poorly as sex educators. Some parents scored zero for not broaching any sex talks at all, while some were remembered as not being proactive in bringing up issues of benefit to GBQ adolescent males. Fueling poor ratings even further was the heteronormative content of the talks.

Of the participants who wanted to give different scores for each parent, more mothers were rated as better sex educators than fathers because they were more open to these discussions, were easy to talk with, and seemed to have more information to share than fathers. Mothers received credit for broaching the talks when compared to fathers, who were mostly silent. Throughout the interviews, participants tended to rate higher those parents who initiated sex communication. Several participants noted that parents did the best they could and identified multiple barriers parents faced when initiating inclusive sex communication. Many adolescent males assumed that their heterosexual parents have never had same-sex attractions, and reported that this cannot be held against them. These parents, adolescent males said, would have received even higher scores had sex communication been more inclusive. When both parents received high ratings, they were credited for broaching the sex talks and creating opportunities where adolescent males had ample space to discover things on their own. Additionally, nonverbal acts such as provision of condoms communicated expectations about safe sex and earned parents positive ratings. Conversely, broad and generic messages from parents about "being safe" without concrete examples or detailed information on how sexual safety can be accomplished resulted in lower ratings.

Parents, Healthcare Providers, and Sex Communication

With a number of information sources at their disposal, including the internet and their peers, GBQ youth identified parents and providers as their most ideal sources of sexuality-

specific sex information. When asked which resource in the ecological system they would turn to first when they started wondering about their sexual orientation and needed information about being GBQ, parents were chosen as the preferred source for these facts. The vast majority of the participants (n=29) identified parents as their first option for sexuality information especially when they were younger. C.D. (19 years old, Latino) explained:

> I feel like you can't always trust everything that you see or that you read. But if it is coming from your parents then you have a lot more trust in your parents so that it's easier to believe. So if they talk about something like HIV, you realize that that's a reality, rather than something you read online that you go, 'Oh, that's something distant.' It's like you read online that someone was killed, you're like, 'Oh that would never happen to me.' But having a conversation with family - that's close and personal - then it's scary. If you have the conversation within the family, face-to-face, human interaction, then you're going to absorb it more rather than something online that you might forget. From screen it's just different.

The regular interface between parents, GBQ adolescent males, and healthcare providers created opportunities for discussions about sexuality-related issues, which led participants to identify healthcare providers as second-most preferred sources after their own parents. Participants recalled that routine wellness visits where joint conversations about hygiene and its associations with illness and wellness with parents and providers paved the way for future talks about preventive health and STDs. A.V. (15 years old, Caucasian) recalled asking his mother what hepatitis was while waiting to get vaccinated:

> I asked her and she said, 'Oh well, hepatitis is a disease.' I said, 'Okay.' And then she was like, 'Oh and there are these things called STDs.' 'Okay, well what's an STD?' And she said, 'Well, when two people have sex and one of them is sick and then their sickness is in their genitals, then the other person gets that same disease.' And I was like, 'Okay, well that makes sense.'

When they were inside the examination room, A.V.'s mother brought up the conversation they just had. The healthcare provider reinforced the discussion and gave additional details about vaccinations. A.V. even recalled being shown pictures of bacteria and viruses to illustrate the need for preventive health.

Healthcare providers were viewed as credible sources of information on LGBTQ health issues and were also mentioned as a resource parents could turn to after adolescent males' disclosure. Adolescent males suggested that joint appointments with family practitioners were useful for obtaining reliable information and learning about sexual orientation together with parents. When providers advocated for their privacy by asking parents to step out of the examination room, adolescent males' trust in the healthcare system was supported. The inability of healthcare personnel to keep confidential information from parents was mentioned as a factor that could deter future discussions about sexual health between GBQ individuals and the healthcare system. D.J. (20 years old, Caucasian) recalled how a confidentiality breach left a lasting negative impression that will impact his future engagement with medical providers:

> I came home from college and went to the doctor ‘cause I have been sick. It was just me and him in the room and he said, ‘We don’t really know what’s going on with you. Would you have a reason to be immune-suppressed?’ and I’m like, ‘No.’ And I said, ‘Well, I’m gay,’ and he was like, ‘We should test you for HIV.’ So he did and then he told my mom on the phone that he had tested me for HIV. I was over 18…That was just inappropriate when my mom was talking about that, I was not really happy about it. And also very angry at the doctor for violating HIPAA, she (Mom) said, ‘We don’t want you to have HIV…’ or something like that. ‘Of course you don’t want your son to have HIV. You don’t want any of them to have HIV!’

The identification of parents and providers as GBQ adolescent males’ preferred sources of sexuality information suggests that they can be best leveraged for primary HIV and STI prevention. When presented with the opportunity to pick a resource from the ecological system that GBQ adolescent males would most ideally like to hear from, the reciprocal relationships they had with parents and providers were identified as crucial. Parents and providers were preferred over their peers, teachers, clergy and the online resources they easily have at their disposal.

Discussion

The nascent research on inclusive sex communication has established that the sexual education needs of LGBTQ youth are not being addressed sufficiently at home (LaSala, et al., 2016; Rose & Friedman, 2012; Kubicek, et al, 2010; Estes, 2017). The interest in non-heteronormative parent-child sex communication is timely given that more American youth are identifying as LGBT (Gallup, 2017) and are disclosing their sexual orientation (“coming out”) at earlier ages (D’Augelli, et al, 2008; Bauermeister, et al, 2010; Ryan, Huebner, Diaz & Sanchez, 2009; Ryan, Russell, Huebner, Diaz & Sanchez, 2010), which affords more time for parents to positively influence their children’s health. Our findings indicate that sex communication is a largely heteronormative proximal process and a missed opportunity for targeted sexual risk reduction. Parents were rated poorly as sex educators and perceived to lack sexuality-specific information pertinent for GBQ adolescent males. Our findings and recommendations can help practitioners and researchers to address barriers to inclusive sex communication and plan age-appropriate, home-based HIV/STI prevention interventions focused on the informational needs of both GBQ adolescents and their parents.

From the data, sex communication for GBQ adolescent males and their parents have similarities to reports based on presumably heterosexual samples. Our results also mirror findings from the few studies with LGBTQ samples. For example, sex communication, whether heteronormative or inclusive, does not occur frequently between most parents and GBQ children, and mothers receive higher ratings than fathers (Flores & Barroso, 2017). When sex communication occurs, the discussions are premised on assumed heterosexuality (Martin, 2009; Goldfarb, et al., 2015).

Specific to our sample, parents who attempted inclusive sex communication with GBQ adolescent males received higher ratings than those who did not go beyond providing

heteronormative information. This implies a premium adolescent males place on parental efforts to discuss with them topics that are unique to their emerging attractions, behaviors, and identities. Also, for this population, non-verbal acts such as provisions of condoms reinforced expectations about safe sex and also earned parents higher ratings as sex educators. These recollections of non-verbal acts they offered when asked about explicit discussions indicates the significance of parental actions beyond the typical warnings they have come to expect about risky sexual behaviors.

When framed within Bronfenbrenner's propositions that human development is fueled by sustained interactions that occur reciprocally between parent-child dyads over time, inclusive sex communication appears to be a process that is not supported in most family systems with GBQ adolescent children. Reports of rare or occasional sex talks that are heteronormative in nature point to the lack of sustained, sexuality-sensitive, parent-guided sexual education for GBQ youth throughout adolescence. Our findings about adolescent males' perceptions that parents have inadequate GBQ-specific knowledge is reflected in the poor ratings they received as sex educators. Taken together, inclusive sex communication is a missed chance for parents to contribute to this population's sexual education. Moreover, the nearly 5-year difference between our sample's mean ages of first attraction to someone of the same sex and self-disclosure as GBQ can be seen as five years of missed opportunities for parents and providers to furnish GBQ youth with targeted information pertinent to their emerging attractions, behaviors, and identities. Given that younger age of disclosure as GBQ is associated with higher morbidity (Remafedi, 2008; D'Augelli & Herschberger, 1993), increasing parents' information about their GBQ adolescent males' sexual education needs, and their capacity to be purveyors of reliable sexual health information, warrants prioritization.

First noted by Voisin and colleagues (2013), we also found that GBQ youth view parents as their preferred source of information during the early years of adolescence. However, once initial thoughts about their same-sex attractions began to form, they simultaneously received external messages from the non-inclusive sex talks that made them choose not to be forthright with parents about these issues. With the exception of a few adolescent males, most of our participants perceived their initial feelings as taboo topics that they must either ignore or keep to themselves and must not broach with parents. Whereas heterosexual school-age children are encouraged to take part in scripts that socialize them to future roles in the ecological system, children who are beginning to recognize their same-sex attractions learn to be quiet about their feelings. At the pre-sexual stage, this population is socialized into silence.

Thoma and Huebner (2014) have suggested that sex communication might not protect GBQ youth against risky behavior through the same mechanisms as it does for heterosexual youth. Our findings provide initial support for that notion and stress the potential counterproductive impact of reactive sex communication immediately after disclosure. When parents have initial talks about their adolescent males' sexual orientation at a time of family distress, the messages they convey may be based on fears and outdated stereotypes associated with gay men. For these families, educational interventions and referrals to family-centered services to support them during adolescent males' disclosure is therefore of prime importance

(LaSala, Siebert, Fedor, & Revere, 2016). At this critical juncture, healthcare providers have opportunities to address the parents' knowledge gap that, if left unattended, may lead to extended disruptions in family communication or permanent rifts in the parent-child proximal relationship.

With healthcare personnel identified by GBQ males as their second most preferred source of sexuality information, they can also counter the inaccurate and limited information about LGBTQ health available to this group and their parents (Rose & Friedman, 2012), and identify additional resources in the larger ecological system to address a family's needs. However, LGBTQ youth also face more difficulty engaging with healthcare professionals compared to their heterosexual peers (Martens, Di Meglio & Frappier, 2012), with their confidentiality concerns being a barrier to accessing sexual health information. Nevertheless, when providers are sensitive in their approach to GBQ youth, the inclusiveness conveys recognition of their sexual orientation. For a group that includes closeted youth who anticipate parental rejection after disclosure (Pearson & Wilkinson, 2012), inclusivity in healthcare has an affirming value. When providers protect confidentiality, this encourages GBQ youth to communicate with providers openly and has potential implications for long-standing engagement with care.

Limitations

Several study limitations should be noted. First, the nature of this exploratory study based on a largely school-based sample limits the generalizability of our findings as the perspectives of GBQ youth in non-school settings may differ considerably from our sample. Second, we are cognizant that the majority of our sample are college students who are developmentally at a different stage compared to our high school participants. Also, despite our best efforts, one-on-one interviews may have compelled some participants to report idealized versions of their childhood. Further, social desirability bias may have influenced some of our participants given that we relied on LGBTQ enclaves in North Carolina for recruitment and the study team was embedded in that community. Also, our findings do not extend to other sexual minority adolescents who are lesbian, transgender or those who reside in geographic areas that are different from where we recruited our participants. Finally, the lack of parents' own perspectives limits our view of the full sex communication picture as a proximal process. To this end, we recommend that future studies consider recruiting parents to determine the consistency of responses across families and roles. Future quantitative investigations that explore other factors that affect sex communication (e.g., parent-child closeness, comfort with sex communication, etc.) would also provide a more complete picture of this process.

However, despite these limitations, we believe that our diverse sample provides a solid starting base from which future studies can learn. We have extended the literature by identifying parents as GBQ adolescent males' preferred source of sexuality information despite the infrequent and heteronormative nature of these talks. With healthcare providers' help, parents can be better sex educators and conduits of pertinent sexual health information for their GBQ adolescents.

Implications and Future Research

Key practice and research implications should be noted. At the family level, informational support must be offered to GBQ adolescents and their parents to increase their knowledge about general LGBTQ information and the specific ways their sexual health and wellbeing can be ensured. Parents, and fathers in particular, can also be encouraged to explore their thoughts about sex communication that is inclusive of sons' same-sex attractions. With parents relying on outdated stereotypes during reactive sex communication about gay men and HIV, focused education for them and referrals to family counseling and social support systems would be prudent. Parents can also be encouraged to provide additional resources to their GBQ sons that will reinforce the safe sex messages they want to convey. These include provision of condoms during sex talks or by signing them up for educational opportunities offered at their local LGBTQ youth-serving organizations.

Given that GBQ youth reside with and prefer parents as ideal sources of sex information, there is initial evidence to further explore devising home-based interventions that targets this population's sexual education. At the community level, healthcare providers are in a position to encourage parents to more frequently discuss sex-related issues and provide inclusive content for discussions about sex and sexuality. During routine wellness visits, healthcare providers can model inclusive behavior for parents that does not assume adolescent males' heterosexuality. For example, being affirming in word choice ("Are you dating anyone?" instead of "Do you have a girlfriend?") not only conveys a nonjudgmental practice, but also encourages access and use of healthcare at a young age and potentially impacts continued engagement with the healthcare system as they progress to adulthood. With regard to research, we recommend conducting future studies that directly solicits the input of this understudied adolescent group. Most sexuality research with sexual minority youth rely on samples ages 18 and above and fails to account for the current reality of younger LGBTQ adolescents (Macapagal, Coventry, Arbeit, Fisher & Mustanski, 2017). Seeking institutional permission to waive parental consent is an underused strategy to address this limitation (Flores, McKinney, Arscott & Barroso, 2017). Additionally, research with parent-son dyads are recommended to identify salient interpersonal factors that are unique to adolescent males who self-identify as GBQ.

Conclusion

This study extends our understanding of the larger roles parents and healthcare providers can play in facilitating positive sexual health discussions and outcomes for GBQ youth that is family-based and specific to their emerging attractions, current and future behavior, and identities. Parents are a preferred source of sex information and can play a central role in the sexual socialization of GBQ adolescent males. The growing information on how sex communication occurs between parents and LGBTQ children can ultimately assist families and healthcare providers address this population's health outcomes through inclusive sex communication. Supporting parents' capacity to address the needs of their LGBTQ children through inclusive sex communication has the potential to minimize risk behaviors before these youth leave the confines of the home.

Funding:

Dr. Flores was supported by an NIH training grant during the study period (01F31NR015013) and is currently receiving postdoctoral funding (5T32NR007100-18). The study also received supplementary funding from the Surgeon General C. Everett Koop HIV/AIDS Research Award. The funding sources had no involvement in the study design, data collection, analysis, interpretation, write-up or any decisions regarding the publication of results.

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Table 1.

Sample Interview Questions and Probes

Sample questions and probes	**Underlying Bioecological Construct and Rationale**
Please tell me about the time your parents first addressed sex with you. • What was it like having your mother/father talk about sex with you? • Do you think there are factors that affect how parent/s talk about sex with their gay/bi/queer sons? • Looking back at it, would you change/have changed anything about how your parent/s handle/handled conversations about sex with you? Tell me more.	*Proximal process* to establish the frequency and nature of talks in the *microsystem*, how sex communication may be a *driving force of development*, and the underlying *ecological barriers* to inclusive sex communication
What do you think of your parent/s knowledge about your sexuality education needs? From zero to ten, with zero being the worst and ten being the best, how would you score them as sex educators? Why?	Parental awareness of the *signs and symbols* that are pertinent to GBQ adolescent males and establish the effectiveness of the discussions to foster *sustained reciprocal relationships*
If you could choose, who would you prefer talk to you and explain about gay/bi/queer-specific sex/sexuality? • Teachers? Doctors? Nurses? Parent/s? Friends? Other family members? Your priest/pastor or a religious leader? Why?	Resources within the *ecological systems* viewed as knowledgeable and trustworthy by participants

Table 2:

Demographic Characteristics

Sample (N=30)	Categories	N	%
Sexual Orientation	Gay	23	76.7
	Bisexual	5	16.7
	Queer	2	6.7
Race/Ethnicity	Asian	4	13.3
	Black	4	13.3
	Latino	10	33.3
	Multiracial	1	3.3
	White	11	36.7
Age	15	2	6.7
	16	2	6.7
	17	1	3.3
	18	8	26.6
	19	9	30.0
	20	8	26.6
Education	High school student	5	16.7
	High school graduate	6	20.0
	College student	19	63.3
Parents' Awareness of Son's Sexual orientation	Definitely Knows	26	86.7
	Probably Knows	1	3.3
	Probably Does Not Know	2	6.7
	Definitely Does Not Know	1	3.3
		Mean	***Range***
Sexual Identity Milestones	Age First Attracted to Same Sex	10.5 years (SD 3.5)	5–17 years
	Age First Self-Identified as GBQ	14.7 years (SD 2.2)	10–18 years
	Age First Self-Disclosed as GBQ	15.4 years (SD 2.6)	6–17 years

Table 3.

Key findings and number of participants who endorsed each theme

Sex Communication	Thematic Finding	Number of Participants who Endorsed Theme
Frequency	Rare	21 (70%)
	Occasional	6 (20%)
	Frequent	3 (10%)
Inclusivity	Purely Heteronormative	17 (57%)
	Negative Towards LGBTQ	8 (26%)
	Inclusive	5 (17)
Parents' Knowledge about LGBTQ topics	Parents weren't knowledgeable	12 (40%)
	Parents had ample knowledge	11 (37%)
	Uncertain of parents' knowledge	7 (23%)

Table 4.

Parental Ratings and Rationale

Participant	Parental Rating	Rationale for Ratings
D.J. (20, White)	(No rating given)	They're fine. I haven't really turned to my parents or relied on them as sex educators so I kinda like… whatever…they're good.
I.H. (20, Asian)	5 (both)	I think they made it enough of an open space for them to say, "We know that these happen, we know that you're doing this, we know you're growing up" and therefore maybe making it comfortable for me to go on online and look it up, to watch MTV past midnight to figure out what they're doing. So yeah, I think that's kind of what I would say. For the grand scale of how much people should be doing, I think maybe a 5, very average.
T.R. (19, Latino)	3 (both)	They were really bad! (laughs)
M.W1. (20, Latino)	(No rating given)	
T.H. (19, Asian)	3–4 (both)	Maybe, in actual practical information, pretty low…like a 3. Or 4 maybe including creating an open environment… But in that proactive side, they didn't provide me [LGBT] information. I don't know whether they have [the LGBT info] themselves… They definitely weren't proactive about it.
A.J. (19, Black)	7 (both)	I would say … seven of ten. Because I think they did a lot in terms of explaining from an anatomical standpoint, hormones and stuff like that, and the social implications as well. But I feel like their lens was very much that conservative, straightforward lens and I wish they could have been more open and receptive to talking about things that weren't necessarily that kind of route.
C.D. (19, Latino)	2 (both)	Like a 2. I got nothing!
G.C. (18, Black)	7+ (Mother)	It's because she was just as real with us [although] she didn't tell us her personal experiences with sex. Plus, she gets like a 7+ because she had condoms for us. And she was supporting safe sex.
	10 (Father)	He gets a 10 because he tells us the good and the bad. He doesn't try and sugar-coat things. My dad just tells what it is, how he's experienced it. And since he's experienced a lot, he has a lot to tell me about. And although he's only experienced a lot with girls, I mean, that's one whole side of what I need told.
A.L. (15, White)	9–10 (Mother)	I think she's very good at that [sex talk]. She received some kind of training on therapy and general communication skills so it's kind of expected that she'd be good at talking about that kind of thing. Very open, very easy to talk to, has a lot of information if not everything.
	5 (Father)	I'd have to say 5 because he doesn't give any misinformation or lie about anything. My Dad just doesn't want me to have sex - he makes that clear. He doesn't lie about anything. He just doesn't want to talk about it.
D.S. (20, White)	5 (Mother)	I mean she didn't really mention gay people at all.
J.H. (19, Latino)	1 or 2 (Mother)	She's not so good.
	3 or 4 (Father)	I think for him it's because he feels awkward talking to my sister about it, but if my sister were to be a boy he'd more comfortable with it.
C.W. (17, Black)	2 (Birth Mother)	She talked too much about the bible.
	12 (Foster Mother)	Probably a 12! She went into full details. Everything! She makes sure I have condoms and everything that I need.
J.S. (18, Latino)	5 (Mother)	In the ideal world where parents actually give their kids same-sex talks about same-sex interactions, I'd give her a 5. Including same-sex issues would never happen in my family. I don't think my mom will ever, even if she considered my sexuality, she would never consider giving me a talk on gay sex.
T.R. (18, Black)	3 (Mother)	With Mom, we've hardly really ever talked about sex at all. But I would have to give a three just as a preliminary score for trying.
	<3 (Father)	I'd always score him lower than my mom because I don't think he knows anything about anything besides penises 'cause he has one. That's pretty much it.
B.B. (18, White)	5 or 6 (both)	They didn't directly teach specific stuff, but they did a good enough job. "Okay, try not to have sex before marriage. But if you do, be safe about it."
L.W. (19, Asian)	2 (both)	I'd probably give them like a 2!! (laughing) They barely talked about it. And she's a nurse!

Participant	Parental Rating	Rationale for Ratings
J.F. (18, White)	4–5 (Mother)	You know, she's never said anything about sex that would establish a damaging mentality. She hasn't really said anything problematic about it, but the fact that she hasn't brought it up is obviously not… She's not really getting herself out there as a pro-sex educator so somewhere kind of in the middle [ranking].
	2–3 (Father)	Because he's said less than Mom.
G.W. (16, White)	3 (Both)	I know she knows stuff, but it's just she doesn't talk about it. She obviously enforces "Use a condom. Use a condom. Use a condom." They just mainly say, "Make sure you're using a condom." (laughs) I mean that's basically the extent of their sex education.
R.J. (18, Latino)	−1 (Both)	Because it just barely happened.
J.D. (20, Black)	7 (Mother)	When she actually started being a bit more upfront about it, it was around the time when I kind of already had a lot of sort of information (laughs). So it didn't feel like I necessarily needed to turn to her for anything. But it's still been good for me to have her there to, like, have her in my corner to like talk to…as someone I could go to.
J.F. (20, White)	2 (Mother)	It was very shame-filled, it didn't do a whole lot. She made it a lot more difficult for me to learn in any way because there was a lot of shame connected to it. So I think that had longer term repercussions. It just took a while for me to learn about sex because of that.
	6 (Father)	I mean it was fairly normal every time we talked about it, he has this sort of, he had the sort of dad thing. He didn't really have to say a lot… It wasn't because of a lack of communication -- it was just a very clear communication. He just made clear what the rules were or whatever, but he did it in a way where I didn't feel shame about it.
B.S. (20, Asian)	4 (Mother)	Because she tries to encourage me to make good behaviors, but she doesn't exactly say what those good behaviors are. Like her saying, "Be safe going to this event." It's like reminding me to make good behavior, but she's not exactly saying what being safe entails.
	5 (Father)	Probably a five because he bought the condoms.
R.E. (20, Latino)	8 or a 9 (Mother)	Just because she doesn't know a lot about the gay sex part of it. But she does try to do her best to answer my questions so I can appreciate that.
	Negative (Father)	Like a negative rating! (laughs) Because he's never talked to me about it. Ever. He's never brought it up!
A.W. (16, White)	(No rating given)	
R.L. (19, Latino)	0 (both)	She can't even say the word. And he just doesn't have the courage to tell me about it. I mean, should I be the one to be sparking the conversation or should they be the ones to do it? That's where I'm just like, "What do I do?" Because if I ask him, I don't know what his reaction would be. I know what my mom's reaction would be – "We're not talking about that."
A.V. (15, White)	4 (Mother)	Honestly, if I was not as like sleuth-y and logical as I am, I probably would not have known a lot of the stuff that I do.
	0 (Father)	He doesn't talk about it.
M.W2. (19, Latino)	6 (Mother)	'Cause she mostly talked about the heterosexual part of it, like pregnancy, which doesn't really apply to me. I guess that's her main concern, pregnancy. She doesn't want me to bring a kid home. And I guess her second priority was HIV…I would give her a higher score if she would've talked to me about not just HIV because I had to do that on my own. It would've been nice for her to give me a little insight on other stuff and not me looking it up myself.
	0 (Father)	He doesn't talk much.
M.S. (18, White)	0 (both)	I never received anything LGBT-related.
G.O. (19, White)	>1–2 (Mother)	I feel like she has made a big deal about condoms enough times I feel like she merits something above a one or a two. There was another time my Mom told me, "I saw an article in the newspaper about HIV in our county. We have the highest rates of HIV in Florida. Maybe, you know, just think about that."
	3–4 (Father)	I'm trying to decide between a three and a four because I feel like he was so forthright with some of the sexual stuff he talked about that I appreciated that directness. He was forthright in the fact that when he told me that he had gay sex once, it was enough for me to realize, "Okay he let me into a very, very personal part of his life and was trying hard to help me even if it was some weird way. He was trying to help me. He genuinely opened himself up to me."
M.E. (18, Latino)	6–7 (Mother)	I mean she actually did try to teach me about sex. I don't think she didn't teach me about like gay sexuality because …in her idyllic perfect heterosexual, middle class, family world, "My son's not

Participant	Parental Rating	Rationale for Ratings
		gay." I think it truly never crossed her mind. She did the best she could given her experiences and her knowledge.

Some participants provided two separate ratings and rationale for each parent, others gave a single combined score for both, others refused to rate parents due to the infrequent sex talks they had, while still a few others chose to provide a rating just for mothers or fathers, but not both.