

Intergenerational Dialogue About Sexual Health and HIV Prevention Among
African American Women in Rural Mississippi

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ABSTRACT

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The purpose of the study was to explore perceptions of intergenerational dialogue (IGD) among African American women and to investigate whether IGDs about sexual health and HIV prevention could be an effective cultural medium to discuss and communicate HIV prevention strategies. The motivation was to find a culturally appropriate process that would contribute to preventing HIV infections among present and future generations of African American women. This study explored the extent to which African American women in rural Scott County, Mississippi considered IGD as having the potential to decrease the transmission of HIV. This is important because of the ongoing mortality and morbidity of African American women due to HIV.

The study sample included 30 African American women aged 18 to 80 who were recruited within the town of Forest, in Scott County, Mississippi (MS). In-depth, semi-structured interviews were audio recorded and transcribed into text for this qualitative study. The data analysis was conducted using conventional content analysis.

Research results indicate that IGD is occurring. However, dialogues about sexual health and HIV prevention occur less frequently than dialogues in which more general topics are discussed. My findings also show that key features of an IGD are influenced by the nature and

quality of the relationship among the individuals engaged in the dialogue. How the IGD participants relate to each other controls what is talked about in terms of sexual health and HIV prevention. Finally, my research results illustrate that topics related to sexual health and HIV prevention are often raised in the context of discussions on risk of pregnancy, risk for contracting sexually transmitted infections, and the consequences of other personal choices.

Dedication

This work is dedicated to several important family members in my life: Carlyon Knowles (Aunt Sue), who provided the support to make the field work possible; to the memory of Dr. Lois Price Spratlen, who encouraged and believed in me so that I could start and finish the work necessary to obtain my doctoral degree; to the late Annie Louise Robinson and William Robinson Sr. (my parents); and to Willie Ford and Rosetta Strong Patrick (my grandmothers). I have life because of them. This dissertation is also in memory of Dr. Gloria Robinson Lewis, a sister who has been a shining example of how to stay connected with family.

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Chapter 1

Purpose, Significance, and Aims of the Study

Overview

The components of this chapter are the introduction, the primary purpose, significance, aim, and research design. This is the order in which they are presented. The chapter concludes with an overview of how the dissertation is organized.

Introduction

Human Immunodeficiency Virus (HIV) affects over 1.1 million people in the United States. An estimated 50,000 people are newly infected each year (American Foundation for AIDS Research [amFAR], 2014). Over the past 30 years, improving medical knowledge and treatments have increased the longevity of HIV-positive people in the United States. However, this success in treatment has not been equally distributed. African American women are still over-represented in the number of new infections reported annually, and the death rate of African American women is also elevated when compared to women in other groups affected by HIV.

To better meet the health needs of African American women living with HIV, local community agencies and health professionals need better treatment information as well as special programs to enhance the effectiveness of health services. Addressing the needs of African American women to prevent HIV infections is also an urgent health care issue (Office of Women's Health, 2012). One direction that research should take is to develop more culturally relevant, community-based approaches to delivering health services. The present study explored the potential for intergenerational dialogue to support sexual health and HIV prevention among multifamily networks in rural Scott County, Mississippi.

Purpose Statement

The purpose of the study was to explore perceptions of intergenerational dialogue (IGD) among African American women and to investigate whether IGDs about sexual health and HIV prevention could be an effective cultural medium to communicate and HIV prevention strategies. Intergenerational dialogue among African Americans has traditionally been seen as a cultural strength and a useful tool for transmitting cultural values between generations (Hillard, 1998; Hudson-Weems, 1993; Martin & Mitchell, 1978). Although African American families can be found all over the United States, many have roots in southern states (Wilkerson, 2010). In my own life, the multigenerational family network has been an ongoing source of support and wisdom, and therefore I wanted to determine whether the family network could be used to broach the topic of HIV prevention to African American women generally. Thus, this study explored perceptions about the impact of IGD on knowledge of sexual health and HIV prevention among African American women over the age of 18 living in a rural community in the southern United States. The information gained from the study can be used to make recommendations for enhancing the use of IGD in HIV prevention generally. This study also sought to meet a CDC call for research that partners with vulnerable populations to integrate HIV intervention programs with local community services in hard-to-reach communities (Office of National AIDS Policy, 2010).

Significance of the Study

Health Problem. African Americans are the ethnic group most affected by HIV (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014). African American women have 8 times the AIDS rate of White women (Kaiser Family Foundation, 2014) yet in 2010 AA women represented 13% of female population, while White women

represented 64% of the female population (US Department of Health and Human Services, Health Resources and Services Administration, & Maternal and Child Health Bureau, 2013). Most HIV research has been conducted in urban areas in the U.S., and the greatest part of the research has focused on men who have sex with men (Anderson et al., 2006). Research addressing the specific needs of rural African American women is limited, particularly for women living in the southern regions of the U.S. Batchelor, Mbajah, Shaull, Nur, and Brown (2010) reported that regionally, in the U.S., the Northeast and the South have a disproportionate burden of new AIDS cases among African American women.

HIV/AIDS research through the Centers for Disease Control and Prevention (CDC) has identified several factors that contribute to HIV becoming an epidemic in the African American community (Center for Disease Control and Prevention, 2009a, 2009b; National Center for HIV/AIDS & Division of HIV/AIDS Prevention, 2011). Contributing factors identified by previous researchers include poverty and limited access to high-quality medical care. Rose and colleagues (2008) documented that the presence of other sexually transmitted infections increases women's risk of HIV infection. In other words, as rates of other sexually transmitted infection transmission increase, there is an associated increase in the vulnerability of women to acquiring HIV (Rose et al., 2008). The CDC (2014) also reports that African Americans face a higher risk of exposure to HIV with each sexual encounter, since the prevalence of HIV is greater in the African American community compared to other ethnic and racial groups. Taken together, these factors increase the vulnerability of African American women at risk of infection (Center for Disease Control and Prevention, 2009a; Logan, Cole, & Leukefeld, 2002; National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014).

In 1999, the CDC established the Diffusion of Effective Behavioral Interventions (DEBIs) in response to the need to create culturally appropriate, community-based HIV interventions for different genders and ethnicities. DEBI in turn helped spur the creation of a branch of research known as High-Impact HIV Prevention (HIP) in 2011. The purpose of the program was to collect evidence on HIV/AIDS interventions that were shown to decrease sexually risky behaviors among specific groups (women and racial and ethnic minorities, for example) who were at higher risk for infection. However, although the evidence showed many research-based intervention programs had been developed, the programs were not getting to the local communities they were designed to serve, particularly communities of color (Wingood, Camp, Dunkie, Cooper, & DiClemente, 2009). Researchers have documented a critical need to disseminate research results for HIV prevention interventions targeted at African American women (Jemmott, Brown, & Dodds, 1998; Office of Minority Health & Health Disparities (OMHD), 2007; Wingood et al., 2009). Given that intergenerational dialogues in the African American community are part of a long tradition of transmitting cultural values, beliefs, and family stories (Boyd-Franklin, 2003; Hill, 1993; Hillard, 1998), I decided to explore whether a dialogue process among African American women of different generations—a process with which I was familiar from my own background—could be used to disseminate knowledge of HIV prevention techniques. This study is important because, as stated above, more research is needed to serve the needs of African American women at risk for HIV (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014).

Prevalence and Incidence of HIV in the United States. The HIV prevalence rate is the estimated number of individuals living with HIV per 100,000. There are over 1.1 million people living with HIV/AIDS in the U.S., and it is estimated that one fifth of that number (or 220,000

people) don't know they have HIV (American Foundation for AIDS Research [amFAR], 2014). HIV incidence refers to the total number of new HIV infections in a population within a specific time range. The CDC estimates that 50,000 new HIV infections occur each year in the United States. Men who have sex with men account for the majority of these new diagnoses (Centers for Disease Control and Prevention, 2013; Kaiser Family Foundation, 2014).

Prevalence and Incidence of HIV among Women in the U.S. HIV/AIDS prevalence rates are monitored by the National Centers for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The 2012 CDC HIV Surveillance Annual Report documents that one in four people living with HIV in the United States is a woman. According to the Kaiser Foundation's March 2014 HIV Among Women Report, women made up 20% (9,500) of the estimated 47,500 new HIV infections in the United States in 2010 (Kaiser Family Foundation, 2014). Of those new infections, the transmission route for new HIV infections contracted through heterosexual contact represented 84% (7,980) (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014).

African American and Latina women are disproportionately affected by HIV compared to other ethnic groups and or races. In 2010, The CDC documents that 60% of all women living with HIV were Black, 19% were Latina, and 18% were White. When we compare these figures to the relative percentages represented by these racial groups in the general population, the disproportionality becomes apparent. Disparity is also evident in the relative rates of infection for the different groups. For example, the HIV infection rate reported for African American women in 2010 was 20 times higher than the rate for White women, while the rate of infection for Latina women was 4 times higher than the rate for White women.

It is important to note that the incidence of HIV infection does vary from year to year. For example, a noticeable decline in new infections among African American women was reported in 2010. When the 2009 and 2010 HIV surveillance data for new infections are compared, we see that the CDC reported a 21% decrease (from 7,700 to 6,100) in new infections overall. However, African American women still accounted for the majority of new HIV infections (Centers for Disease Control and Prevention, 2013, 2014; National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014).

Prevalence of HIV in the South. The HIV and AIDS epidemic affects populations across the country, yet some states and regions of the country have significantly higher prevalence rates than others. In 2012, the highest rates of new AIDS diagnoses were reported in the Northeast (14.2/100,000), followed by the South (13.0/100,000), the West (8.8/1000, 000), and the Midwest (6.3/100,000) (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2012). In the research literature, several factors have been identified that contribute to some southern states having higher HIV prevalence. For example, Reif, Whetten, et al. (2014) identified overall poor health and high poverty rates as contributing to a generally higher prevalence of HIV in the South. The specific areas that were identified by Reif and colleagues were Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and eastern Texas. In 2010, one third of individuals diagnosed with HIV resided within those nine states (Reif, Safely, Wilson, & Whetten 2014).

Prevalence of HIV in Mississippi. In 2011, Mississippi ranked seventh nationally in HIV case rates, with a rate of 20.7 cases per 100,000 individuals (Mississippi State Department of Health, 2013a). Approximately 10,000 persons were reported living with HIV in 2012 in MS. The recent published data from the Mississippi Department of Health show that 556 new

infections were reported in 2013, and that 25-44 year olds accounted for 49% of the newly reported HIV infections. Although African Americans represent only 38% of Mississippi's population, they accounted for 76% of all the new HIV cases in 2012 (Mississippi State Department of Health, 2013a). In 2013, 22% of the number of newly reported HIV infection in Mississippi were female ($n=119$ cases out of 556) and 89% of those cases were AA women ($n=97$) (Mississippi State Department of Health, 2013a). The primary mode of exposure for African American women is reported to be heterosexual contact (Mississippi State Department of Health, 2013a).

Cultural Relevance of HIV Prevention for African American Women. Investigators of prior research studies have recommended that more research is needed to design culturally relevant HIV prevention programs for African American women (Essien, Meshack, Peters, Ogunbade, & Osemene, 2005; Wyatt, 2009; Wyatt, Williams, Henderson, & Sumner, 2009). The basic premise for this recommendation is that when programs are not relevant to the community, individuals do not use them and/or they do not work. Fortunately, government has taken these recommendations to heart, and funding for research-supported grants is now often targeted for specific ethnic and racial populations (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention Division of HIV Prevention, 2014; Rawlings & Hopson, 2009).

Research has also documented a particular need for HIV prevention programs to be culturally relevant for African American women in the following five areas: understanding the socioeconomic dynamics of HIV transmission (Adimora, 2007; Cargill & Fenton, 2009), developing negotiation skills related to condom use (Center for Disease Control and Prevention National Center for HIV STD and TB Prevention, 2006), understanding the disparities in delivery of quality HIV care (Centers for Disease Control and Prevention, 2013; Hodder et al., 2010)

theory-guided HIV interventions (St. Lawrence, 2001) and infusing “culture-bound strategies with historical roots” with HIV intervention programming (Wyatt, 2009).

Wyatt (2009) suggests that future HIV researchers rethink and reframe “culture-bound protective strategies” (p. 194) that were developed by African Americans during the slavery era and are still employed by many today. These strategies include (a) indirect communication, (b) dual identity adaptability, and (c) suspicion of outsiders. Wyatt further suggests that understanding the impact of certain behaviors within their culture will allow African American men and women to evaluate these behaviors more objectively and curtail those behaviors that are not in the interest of the group. Wyatt and colleagues do not suggest that African Americans are a homogenous group; rather, they argue that members share some common cultural roots. The article goes on to suggest that African Americans can expand existing culture-bound self-protective strategies that work to prevent HIV, or even develop new ones.

This research study sought to understand how an existing IGD could help African American women manage sensitive conversations related to sexual health and HIV. The research may be advanced with this study, first through helping others gain a greater understanding of how intergenerational dialogues work. Second, based on the results, I will suggest next steps and make recommendations for what can be included in the dialogues, with the ultimate goal of reducing and preventing HIV infections among African American women.

In summary, there are currently few published studies on how rural southern populations perceive and discuss HIV and how they provide solutions to lessen the impact of HIV infections through intergenerational dialogue (Kogan et al., 2012; Pequegnat & Szapocznik, 2000). Such studies as exist are limited in their scope. They generally do not target African American women, for example, even though these women are disproportionately affected by HIV. Thus, HIV

prevention programs that are culturally relevant for African American women are needed. This study sought to expand our understanding about both the process and content of IGD, specifically as it relates to sexual health and HIV prevention. The study also contributes knowledge about how these conversations are occurring, what is talked about, and what is perceived as being effective at preventing HIV infection. This research can also serve as a pilot study for re-examining the cultural-bound protective strategy aspects of IGD generally.

Research Aim

A major premise of the research study was that IGDs among African American women about sexual health and HIV prevention have the potential to increase understanding and change behaviors around sexual health and specific prevention practices for HIV abatement. African Americans have a historical legacy of strong family ties, a group identity, and extensive kinship networks guided by spiritual and cultural values (Waites, 2009). Thus, this study was designed to explore how those strengths could impact sexual health and HIV. The research aims consist of one primary aim and three research questions:

Aim 1: Explore participants' perceptions of whether IGDs are occurring and what they see as their key features.

Question 1. What do African American women see as the actual or potential overall benefits and limitations of IGDs in terms of changing behavior?

Question 2. In what ways might it be helpful to use IGDs for addressing sexual health and HIV prevention?

Question 3. If IGDs are perceived as being potentially helpful, what topics are included or excluded?

Research Design

In this research study, I wanted to hear women's stories in their own words, and to learn more about the sexual health and HIV prevention practices of rural communities. I also wanted

to understand the experiences of both young and older African American women. I wanted to know: Could a cultural communication style such as IGD be framed as a preventive approach?

This study was inspired and guided at least partly by my own experience as an African American female. I spent a lot of time with my paternal grandmother during my elementary and high school years in rural Mississippi. My extended family would often get together, and the adults—including my grandmother, aunts, and uncles—would share their life stories with each other and with younger family members. Many of those stories influenced my life and the lives of my siblings and cousins. In those gatherings, family members had a way of talking to me such that I could get the message in the stories they told. Those experiences were still vivid in my memory as I was deciding on a topic for my dissertation topic, and that is why I chose to revisit and explore the idea of using intergenerational engagement and dialogue to understand the impact of HIV on African American women. Following from my personal experience, I also chose to do the research in my home town of Forest, Mississippi, and for my design, I chose a qualitative approach with face to face interviews with African American women, some of whom I knew personally or knew through mutual acquaintances. I believe that this research design will be particularly valuable, because it offers evidence from an insider's perspective on the intergenerational dynamics that occur among a network of mothers, daughters, aunts, grandmothers, sisters, cousins, and friends.

Dissertation Overview

The dissertation is organized in five chapters. Chapter 1 provides the introduction and also includes the background and purpose of the study, along with the problems being addressed, significance and research aim. Chapter 2 includes a discussion of relevant literature. Methods of

conducting the research are covered in Chapter 3. Data analysis and results are presented in Chapter 4. Chapter 5 covers the discussion, relationship of the results to prior research, the study limitations, recommendations for future research and conclusions.

Chapter 2

Review of Relevant Literature

Overview

The AIDS epidemic presents researchers, public health officials, nurses, and mental health professionals with many challenges. The health consequences of HIV infection combined with fear, stigma and widespread avoidance of testing make the prevalence of the disease even greater among high-risk groups. As previously stated, African Americans are exceptionally vulnerable to the disease.

My literature search covered a broad scope of sources from many disciplines. The databases and online sources searched included PubMed, Medline, Sociology Abstracts, Cochrane Library, Web of Science and Google Scholar. I subsequently examined electronic and printed indexes of many academic journals. From these sources I was able to locate a large number of empirical studies that focused on African American women as subjects. The journals reviewed were devoted to one or more of the following: (a) gerontology, (b) public health, (c) communication, (d) family studies, (e) childhood development, and (f) Black Studies. I included both domestic (U.S.) and international sources in my review. After making a broad list of articles, I narrowed my focus to intergenerational relationships and HIV prevention. The public health journals provided the largest number of studies in this area.

The key words for the literature search included “intergenerational dialogue,” “women,” “African American,” “HIV prevention,” and “sexual health.” The scope of the review was then narrowed to find articles that were relevant to the research aim and questions in any of four targeted areas: (a) the history of IGD (b) the use of IGD in disease prevention, (c) the importance of cultural relevancy to the research process, and (d) specific topics about sexual health and HIV prevention between generations in relevant bio-behavioral studies.

A Brief History of Intergenerational Research Literature

The concept that young people and older people can work together to solve social problems has been established over time (Marphatia, 2003). Ames and Youatt (1994) documented that a nationwide intergenerational dialogue had already emerged by the 1960s. At that time there were three perceived social crises that gave rise to IGD: (a) increasing concern over the rising percentage of older people in the population, (b) a decrease in educational resources for all ages, and (c) the effects of age segregation on the young and the old. In the early 1970s, educators became more interested in understanding and bridging the so-called generation gap, particularly in the United States. This was part of a social trend that coincided with the Civil Rights and Vietnam War eras. It has continued to the present day.

A common assumption is that there is value in bridging older and younger generations (United, 2007; (Larkin, Friedlander, Newman, & Goff, 2004; Thomas, 2007). At the same time, bridging the generations presents a major challenge. There are different approaches and disciplines involved in this subject area, for example, “child development, education, gerontology, social work, psychology, sociology, family studies and social policy,” among others (Larkin & Newman, 1997, p. 8). It is difficult to find one ideal intergenerational approach for bringing younger (Thomas, 2007) and older generations together . However, an intergenerational

educational approach is certainly one strategy for making connections. Broadly defined, an intergenerational educational approach includes younger and older generations working together on a mutually shared interest (DeMarco, Kendricks, Dolmo, Looby, & Rinne, 2009; Marphatia, 2003).

In reviewing the literature, I found no standardized research format for using intergenerational dialogue. However, several key concepts for facilitating intergenerational dialogue were identified, and these included respect, caring, cooperation, and understanding (Finke, 2006; Gambone, 1998, 2001; Marphatia, 2003). Each concept can serve as a guide to facilitate the process in a different way. For example, using the concept of respect can show honor and esteem. “Respect means to hold in high regard; to show consideration for; to be courteous; to avoid intruding upon or interfering with” (Gambone, 2001, p. 22). Mutual respect is important, because in an open dialogue, the unique experiences of each generation must be valued. The participants in dialogues must show each other respect and create an environment of understanding (Marphatia, 2003). Two requirements for have full participation in dialogue are that the individual participants become stakeholders by helping in the development of the dialogues and (b) that the participants have buy-in and ownership of the process.

Gambone (2008), a gerontologist, argues that the goals of intergenerational dialogues are to decrease the isolation among generations, to problem solve, and to share resources in an effort to meet the needs of multiple generations. Gambone’s method of facilitating IGD involves members of different generational groups working in teams to solve an issue they share in common. A typical list of living generation groups for the U.S. might include the following: Silent Generation (born between about 1925-1945), the Baby Boomers (1946-1964), Generation X (1965-1979), and Generation Y or the Millennials (1980-2000) (“Generation List,” 2009);

"Generations Chart" 2008). (Note: for convenience, I have used these same generation labels in my data analysis for this study.)

In Gambone's method, the ground rules of the dialogue are introduced at the beginning of the process, and the team is given a specific problem to discuss, along with a scenario (that is, a context) in which to consider the problem. The idea is that the problem will become easier to resolve when it is viewed from different generational perspectives. Possible solutions to the problem are formulated; the group can then determine which of these ideas and options to apply to the problem. The dialogues occur over a two-day event. The outcomes are generally positive. Gambone's format for conducting IGD has been used in a variety of settings such as churches, corporations, and community-based organizations. The topics covered have included prevention of child abuse, family and community violence, disaster relief, and even homeland security (Gambone, 2008).

In the disciplines of social work and nursing, Gibson (2005) and DeMarco & Norris (2004) report using an intergenerational educational approach to illustrate negative effects of HIV. DeMarco and Norris (2004) developed an intergenerational film project that featured four HIV-positive older African American women who shared their experiences and insights. An example of a typical message the women wanted convey to teens was: "There is no room for apathy when it comes to prevention of HIV" (p. 66). DeMarco and Norris (2004) also found that the outcomes produced culturally relevant information and activities that crossed generational groups and gender. As a whole, the literature showed that the outcomes of IGD are affected by group structure, the individuals involved, the expected results, and purpose (DeMarco et al., 2009; Gambone, 1998, 2001).

Intergenerational Dialogue about Sexual Health and HIV Prevention in Four Research Studies

A few studies examined how African American mothers and daughters and grandparents engage each other in dialogue about sexual topics and HIV prevention (DiClemente et al. (2001), Cornelius, LeGrand, and Jemmott (2008); Hutchinson, Jemmott, Sweet Jemmott, Braverman, and Fong (2003) and Darbes, Crepaz, Lyles, Kennedy, and Rutherford (2008)). DiClemente et al. (2001) conducted a study to address communication about sex-related topics, sexual practices with partners, and the ability to negotiate safe sex. In that study, a sample of 522 African American females from 14-18 years old was chosen. A mixed method of structured interviews and survey questions was used to collect data. No information was provided on the validity of the survey instrument. The findings of the study showed that youth who communicated less often with parents reported lower contraceptive use, less communication with partners about sex, and diminished ability to negotiate safe sex practices than those who communicated more often or more effectively with their parents. The findings confirmed that parents are vital in promoting open and honest communication about sex between maturing adolescents and their sexual partners.

Hutchinson et al. (2003) further illustrated the role communication between mothers and daughters plays in influencing risk-taking behaviors. The authors examined sexual behavior by young women relative to the quality of discussions between the women and their mothers. The mother-daughter discussion topics included sex, birth control, sexually transmitted diseases, AIDS, and condoms. The sample included 219 urban adolescent females from 12-19 years old. The study design was a randomized control trial with three intervention arms: (a) an information-based HIV risk reduction arm, (b) a skill-based HIV risk reduction arm, and (c) a general health

promotion intervention arm. The general health promotion intervention group was the control group. Data was collected by questionnaire at baseline and at 3-month follow up intervals for 12 months. The authors reported that they conducted the data analysis using the control group because they did not want to confound the effects on the control group with the results of the intervention. The results indicated that: 72.5% of respondents had discussed sex, 78.2% had discussed birth control, 69.7% had discussed STDs, 77.7% had discussed AIDS, and 73.3% had discussed condom use. Higher levels of mother-daughter communication about sexual risk correlated with reductions in the frequency of intercourse and reductions in the frequency of *unprotected* intercourse. These findings showed the protective influence of sexual risk communication between mother and daughters.

Cornelius and colleagues (2008) conducted an exploratory study on the conversations about sexuality that take place between adolescents and grandparents, as well as their respective attitudes and feelings about those interactions. The sample was 40 African American grandparent and grandchild pairs. The results in that study showed that the topics discussed typically included “sexual intercourse, birth control, condoms, and HIV/AIDS prevention” (p. 337). Grandparents’ attitudes suggested that they were open to discussing sexuality and HIV prevention but that they were unsure about when and how to start those discussions. Grandchildren did not often initiate conversations with their grandparents about these topics, primarily because they felt embarrassed.

Darbes et al. (2008) studied conversations among a group of African Americans over the age of 18. The study examined what steps the subjects felt they could take to change their behavior to decrease their risk for HIV infection. The researchers focused on assessing interventions to reduce transmission of HIV among heterosexual African Americans. Their meta-

analytic review of 38 randomized control trial studies found that interventions targeting heterosexual African Americans were effective at reducing high-risk behavior, specifically unprotected sex. Darbes and colleagues (2008) identified the following interventions as being effective at reducing transmission of HIV: (a) using peers to communicate and model appropriate methods of prevention, (b) demonstrating skills for correct use of condoms, (c) modeling skills for negotiating safer sex, and (d) providing opportunities to practice the skills learned. This study is important because it connects the act of talking about behavior change (both among peers and among different age groups) to specific skills that can be used to change behavior. The results identified the types of individuals who were most accepted as conversation partners and identified how specific skills discussed were associated with decreasing the transmission of HIV.

While discussing sexual matters with family members might be uncomfortable for some African American women, research suggests that developing dialogue-based interventions to improve communication skills and to encourage appropriate use of condoms is beneficial. Because my focus was on the content of these dialogues, I was able to build my own research on the foundation of studies that had already established the benefit of IGD.

Given that HIV infection rates among African American women have increased compared to other women, and given that some African American women have used IGD as a technique to decrease the risk of HIV infection, I felt that exploring this dialogue would assist in developing interventions. My dissertation addresses intergenerational exchanges among a small community of African American women in a rural setting. I chose this particular community because I am familiar with it and have established bonds of trust that allowed the participants to speak freely with me.

Chapter 3

Methods

Overview

This chapter describes the research methods used in my study. It is divided into six sections. They include a description of the research setting, sample selection, recruitment strategy, interview process, data collection process, and analysis procedures.

Description of the Research Setting

The research setting for this study was the city of Forest, in Scott County, MS. Three types of information about the research site are discussed in this section. First, the demographics of both the city of Forest and the state of MS are summarized. Second, the overall health conditions in the county and state are described. Third, information about HIV infections in the county and state is presented.

Mississippi is considered to be largely rural, with approximately 51% of the state's population residing in rural areas (Mississippi State Department of Health, 2010). In 2010, the population of Forest, MS was 5,725, of which 48.5% was African American, 31.3% White, 23.7% Hispanic and 0.8% Native American¹ (U.S. Census Bureau, 2014a) . In comparison, the state population totaled 2,991,207, with African Americans representing 37.4%, Whites 59.8%, Hispanic 2.8%, and Native Americans 0.6%. Women represent 50.7% of the population in Forest MS and a similar 51.4% of the population statewide. (U.S. Census Bureau, 2014a, 2014b).

¹ The population of Forest MS. in 2010 with the percentage of ethnic diversity was documented according to the U.S. Census Bureau: State and County Quick Facts. The percentage of populations estimates by ethnicity did total over 100%

I chose the research setting of Forest, because I was familiar with the area and with several of the multigenerational family networks there. Having a history and family connections in the area, I was able to gain the trust and acceptance of the women who participated in the study. For example, I was well aware of the extent to which church and community leaders would be of help in getting members of the community participate in the study. I wanted to understand in great detail how the family network could be used to talk about preventing the transmission of HIV, and my history in this community allowed me to do that; it gave me access to these discussions that no outsider could hope to have.

Moreover, Scott County, the rural county in which the city of Forest is located, is an ideal place for addressing general health of the community to include HIV prevention. Mississippi has 82 counties, and the MS State Health Department ranks them from 1 to 82 in terms of health, with a ranking of 1 for the county with the best overall health status. In the latest survey, Scott County received a ranking of 62 (placing it in the lowest one third of Mississippi's counties). The state health department uses two main measures to evaluate the health of a county: health outcome ranking and health factors rating. Both of these measures have subcategories. Health outcome subcategories are morbidity and mortality. For Scott County, the health outcomes ranking was 62nd out of 82 counties, while the health factor rating is 65th out of 82 counties (Robert Wood Johnson Foundation, 2013; University of Wisconsin Population Health Institute, 2010). Four types of health factors are assessed: behavioral, clinical, social and economic, and environmental (University of Wisconsin Population Health Institute, 2010). With regard to the health factors, Scott County has the following individual ratings: (a) health behavior: 74, (b) clinical care: 76, (c) social economic factors: 35, and (d) physical environment: 14. Scott

County's morbidity rating is 56, and its mortality rating is 46. The health factors indicating a greater need for improvement are: health behavior, clinical care, morbidity, and mortality.

Addressing the specific concern of HIV infections, there were 556 reported cases of HIV infections in 2013 for the state of Mississippi (Mississippi State Department of Health, 2013a). The number of reported cases that were female ($n = 115$ or 21%) in 2013 and 84% of those cases were AA women ($n=97$)(Mississippi State Department of Health, 2013c). The total number of Mississippi residents living with HIV in the year of 2013 was 10, 473. However, the reported newly diagnosed cases of HIV and number of residents living with HIV vary widely from county to county. In Scott County, for the year 2013, the number of residents living with HIV was 86 compared to 50 reported cases in neighboring Newton County. In one of the larger counties Rankin, the numbers of reported cases were 567 in 2013. Addressing the number of newly diagnosed cases of HIV infections, there were 6 reported cases in Scott County in 2013 and the estimated rate of infection per 100,000 in the population were 11 cases. The numbers of newly reported cases of HIV in Scott County that were AA female were not available in the cited reference.

“The National rate for HIV infection was 15.8 per 100,000 compared to MS, at 20.7 per 100,000 population in 2011 (Centers for Disease Control and Prevention, 2012, p. 1). In 2013, the state of Mississippi had the 10th highest rate of HIV infection in the nation (Mississippi State Department of Health, 2013b). According to the Centers for Disease Control and Prevention, African Americans represented 74.2% of newly diagnosed HIV cases nationwide, and in the state of Mississippi, African Americans represented 76% of newly diagnosed cases (Mississippi State Department of Health, 2013b). African Americans are thus over-represented both at the state and national levels for new HIV diagnoses. The research site is relevant because it is a rural

community where African Americans residents represent over 40% of the population. Clearly, in Scott County and in the state of Mississippi as a whole there is a need for HIV prevention and a need to improve the health of the local community.

Sample

This section includes a description of the sample, inclusion criteria for eligible participants and the number of participants recruited. Demographic information such as age, education, county of residence, and employment characteristics are also discussed. Inclusion criteria for the study included that subjects were: (a) self-identified as African American women, (b) self-identified as age 18 or older, and (c) self-identified as currently or previously sexually active. Exclusion criteria were women self-identified as under the age of 18, or with no history of sexual activity or unwilling/unable to complete the informed consent. The target number of 30 subjects was chosen based on what is reported in research literature as being a desirable number of participants needed to reach saturation in qualitative studies. Charmaz (2006) suggests a range of 10-20 participants for qualitative studies. Since the higher end of Charmaz's range was 20, a target number of 30 participants was an over-estimation of participants needed to reach saturation of data. Thus, the target sample number was reached. A convenience sample of 30 African American women (mean age = 48, median age=49, SD= 15) were interviewed. All of the participants spoke English. All of the participants had engaged in one or more intergenerational dialogues within the past year. For the purpose of this study, IGD means a conversation between the participant and another female family member in the range of 20 years younger or 20 years older than the participant. Each participant reported that they did not have any problems talking about sexual health and HIV prevention with the primary investigator.

The women lived in Scott County ($n= 28$) or one of the two neighboring counties, Newton County ($n=1$) and Rankin County ($n=1$). The two participants who resided in Newton and Rankin Counties at the time of the research study worked in Scott County and had a history of residing in Scott County. The 28 women who lived in Scott County at the time of the study reported having resided there for an average of 41 years. In terms of education, nearly half (14) reported completing 2 or more years of college (MS or MA degree, $n= 6$; BA, $n= 6$; AA degree, $n= 2$). Nine of the women had taken some college classes, and two of them had completed high school. The education level of the women in the study is higher than average when compared to the demographics of Scott County as a whole. According to U.S. census summary data, 75% of the Scott County residents have completed a high school education, and 9.6% have completed a bachelor's degree or higher (U.S. Census Bureau, 2013). Regarding employment status of the women in the study, 46% were employed and 30% were retired.

Recruitment Strategy

IRB approval was obtained from the institutional review board at the University of Washington in Seattle. Recruitment for the study occurred between January 8, 2013 and February 14, 2013 in Forest, MS. The initial phase of recruiting began with key informants who were familiar with the area and able to identify participants according to established eligibility study criteria. (See Appendices B (Letters of Cooperation) C, and D.) Introductory letters were mailed to potential participants. (See Appendix E.) Each potential participant was informed about the voluntary consent process and was given the opportunity to ask questions throughout the research process. Purposive and snowball sample techniques were used for recruiting participants. Purposive sampling was chosen as a technique in this study because of the specific phenomenon of interest. The purposive sampling process involved selecting participants who had

been involved in intergenerational conversations with someone 20 years younger or older than they were. The snowball sampling technique involved sharing with participants the lead researcher's contact information so that other potential participants could learn about the study by word of mouth. Local churches and community organizations were contacted and informed about the study as well, and an information flyer about the study was created and used as recruitment tool. (See Appendices F and G.)

Pilot Interview

The process of conducting a pilot interview helped me produce a better interview guide for the research study. Prior to starting fieldwork with actual interviews in Forest, MS, I conducted a pilot interview session in Seattle, Washington. Two women were included in the pilot session. Both had previous experience with IGD. One of them had had conversations with her own adult children and grandchildren. The second woman did not have children of her own, but she had helped raise her nieces and nephews and she had had conversations with them. She also counseled youth in her mental health-related profession. I completed the pilot session 3 months prior to submitting my research study proposal to the University of Washington institutional review board. After reviewing some of the insights I gained in the pilot interview with a veteran researcher, I made several changes based on her recommendations, and this improved the interview protocol. For example, I shortened my working definition of IGD, and the improved language helped me ask questions more clearly. Changes in the guide also allowed me to practice pausing and being patient while anticipating responses in face-to-face interviews. Kvale and Brinkmann (2009), state that when researchers are developing protocols, a researcher will collect more accurate data when the questions asked can be communicated to participants in such a way that they can use their experiences to answer the research questions Therefore, the

final interview guide was designed and tested to be an appropriate tool for data collection (Kvale & Brinkmann, 2009). The interview guide developed for this study was effective because it used open-ended questions and dialogue (Rubin & Rubin, 2005) that encouraged participants to answer each of the research questions with in-depth, high-quality information (see Appendices H and I).

Interview Process

The interview guide was used to ensure the flow and content of the interview. Each participant was interviewed separately in a confidential place of her choice. In addition, each participant was offered the option of using a pseudonym for the interview. All participants signed a consent form prior to starting the interviews and had the opportunity to stop the interview at any time. Participants were also allowed to ask questions during the interview (see Appendix H). Going over these safeguards helped me to build rapport with participants and to create an environment in which they could feel comfortable disclosing information about their intergenerational dialogues (Kvale & Brinkmann, 2009).

The initial strategy for collecting the interviews was to audio-record interviews; time allotted was 60-90 minutes per interview. A total of 29 interviews were audio-recorded, and one was handwritten because the participant was more comfortable doing the interview without the recording. At the end of each interview, participants were offered a \$25.00 gift card as an appreciation for their time and participation in the research study. The recorded interviews were secured on the primary researcher's computer with a locked password. The recorded interviews were later transcribed to text and thank you letters were sent to all participants at the end of the data collection process (see Appendix J).

Semi-structured interview questions were used to address the study aims, and descriptive data on the study sample were collected to establish social context factors associated with the everyday lives of the participants (Miles & Huberman, 1994). For example, demographic data such as age, ethnicity, education, employment status, county of residence, and health insurance status were recorded for each participant. The responses from the semi-structured interviews and demographic data were assessed simultaneously for fit and relevance throughout the study process (Charmaz, 2006; Miles & Huberman, 1994). These were important steps in maintaining systematic consistency in the research.

Interview Content

The main goal of the interview process was to explore participants' perceptions of whether IGDs related to sexual behavior were occurring, and if so, what were the key features of those dialogues. Other related research questions were also asked. For instance, some of the questions were: What do African American women see as the actual or potential benefits and limitations of intergenerational dialogue in terms of changing behavior? In what ways might it be helpful to develop and use IGD for addressing sexual health and HIV prevention? If IGD is perceived as being potentially helpful, what topics were included or excluded in those dialogues?

To fully understand the perceptions of IGD, I asked each participant to share an example of a dialogue she had had with someone between 20 years older or 20 years younger than herself, if she could remember one. If a dialogue had occurred, I asked the participant to describe it for me and to share examples of what made the dialogue go well (or poorly) and how the conversation may have contributed to improving sexual health, HIV prevention, and so on. I asked who the participants in the conversation were (mother? grandmother? aunt?) and whether there were any topics not covered or deliberately avoided. Finally, I asked: In what ways do you

think IGD could be improved to help change behavior that puts African American women at risk for contracting HIV? In closing the interview I asked each participant how she felt about sharing her experiences and perceptions of sexual health and preventing HIV.

Confidentiality of Research Data

Confidentiality of the data was safeguarded by keeping the study materials in a secure location during the field work. This included using a password-protected computer and handheld audio recorder. In addition, each participant chose a pseudonym to anonymize her identity. The interviews were conducted in locations that were convenient and safe for the participants, such as in the home, at a local Black community library, or at the city library. Each participant was aware of her option to discontinue participating in the study at any time. This was explained during the consent phase.

Data Analysis

This section describes the specific research tools used to prepare and summarize the data. These tools systematized the analysis process and show how the research conclusions were made. Conventional qualitative content analysis as described by Hsieh and Shanon (2005) was used to analyze the transcribed interviews. Conventional content analysis is applied when a researcher wants to describe a specific phenomenon, in this case intergenerational dialogues about sexual health and HIV prevention. This type of analysis is particularly useful when existing research about the phenomenon is limited, as it was in this case. As a research method, content analysis is also commonly used for analyzing qualitative data (Twycross & Shields, 2008). Researchers who do qualitative work suggest that, depending on the goals of the research, the process of conducting content analysis can either use a standardized format or a flexible one. In other words, although the researchers might be using the same analysis process, they do have

options for implementing that process. Zhang and Wildemuth (2009) document that the process can be divided into eight steps:

- Step 1. Prepare data
- Step 2. Define unit of analysis
- Step 3. Develop categories and a coding scheme
- Step 4. Test your coding scheme on a sample of the text
- Step 5. Code all the text
- Step 6. Assess your coding consistency
- Step 7. Draw conclusion for the coded data
- Step 8. Report your methods and findings

Each of the steps is discussed below. Appendix I illustrates how the steps were customized to the actual work involved in this research study. Although Zhang and Wildemuth (2009) describe eight steps in sequence, my experience using this method was not linear.

Step 1. Preparing data refers to selecting what data will be analyzed based on the purpose of the study. Data analysis began with the first interview and research notes taken during data collection. Keeping the aims and the research questions in mind, I listened to each audio-recorded interview (and reviewed the written transcript) to discern the significance of what participants were saying as they responded to the interview questions. I also listened for areas in the conversation that needed more exploration or explanation in order to prepare for the next interview. I also took written notes on the participants' responses throughout the field work.

Step 2. Defining the unit of analysis went hand in hand with my reading of the written text. Thus, the unit of analysis was the written text. During this phase, I used the aim and research questions to guide the categorization of the text by themes. I assigned a code to text if the idea being expressed was relevant to either the aim or research question (Zhang & Wildemuth, 2009) and a code could be assigned to either a phrase, a sentence, or a paragraph. For example, if the idea in the text addressed a benefit to engaging in, then a specific code

("Benefit of IGD") was assigned to the phrase, sentence, or paragraph, depending upon the duration participant's reply. A paragraph was defined as someone providing at least three sentences of information.

Step 3. Developing categories and a coding scheme involved creating codes from three sources: (a) data, (b) previous relevant literature, and (c) theories (Hsieh & Shanon, 2005; Zhang & Wildemuth, 2009). In this study the coding was informed by previous literature and developed from the data. The examination of text initially involved reading through all 30 transcribed interview texts line by line. After thoroughly reading all the transcriptions, I developed a preliminary blueprint for codes by manually coding and highlighting references to perceptions of talking about HIV and sexual health issues. An initial set of codes was identified and discussed with a second coder. The second coder independently and randomly assessed 20% of the transcripts ($n=6$) using the initial set of codes (Graneheim & Lundman, 2004). Both coders then met in person to review and reconcile any differences in the coding (Miles & Huberman, 1994). As the primary researcher, I used a software program (ATLAS.ti, ver. 6.0) to do qualitative data analysis and to complete the process of coding all the transcripts.

Step 4. Testing the coding scheme was based on sampling from the text. This refers to an iterative process that started with the early stages of developing the codes to be applied to the text. The codes were assessed for relevancy and clarity up to the point of reporting of the results. Steps 3-6 involved intense assessments of the data as patterns were identified.

Step 5. Coding all the text meant that I applied my tested and reliable coding scheme to all the interview transcripts. A line-by-line review of the data produced 460 in-vivo codes. (In-vivo coding uses the actual text from the transcripts to label the data, and those labels becomes codes (Friese, 2012). After consulting with a member of the dissertation committee and

reviewing the transcripts over 3 weeks, I was able to condense the number of codes to 58 codes, grouped into 7 clusters (Hsieh & Shanon, 2005).(Hsieh & Shanon, 2005).(Hsieh & Shanon, 2005). For a sample list of final codes, refer to Appendix M. The seven major clusters of codes were (a) Generational Groups, (b) IGD Who, (c) Sexual Health IGD, (d) HIV IGD, (e) Sexual Health Topics, (f) HIV topics, and (g) response to the researcher. The definition of each cluster of codes will be explained as it is presented in the findings.

Step 6. Assessing coding for consistency required taking the time to review and determine how well my coding system represents the data. This was also a time to check for errors in the labeling. At this time I looked for adjustments that might have occurred in the back-and-forth exchange that happens when a researcher is emerged in the data. This was the time to understand why adjustments were made. It was important to be transparent about the reasons for changes. ATLAS.ti software (Version 6.0) was used to organize the documents and set up a computerized coding process for the text. In order to keep the ideas identified from the content analysis as closely related to the experience of the participants as possible, in vivo coding and an open coding process (Friese, 2012; Saldana, 2009) were used in the management of the data. Although I worked independently with the software to manage and analyze the data, I consulted with two members of the dissertation committee familiar with content analysis as I worked through the analysis.

Step 7. Drawing conclusions from the coded data refers to making sense of the themes or categories identified. At this stage a researcher answers the question of what insights can be found from the data. Thus, the next phase of the analysis for this study involved organizing the relevant themes and categories into relationships that were meaningful to the study aims (Hsieh & Shanon, 2005). To accomplish this, I ran queries of the code data in order to begin answering

the research aim of the study and to further the analysis. ATLAS.ti software allows the user to retrieve all quotations based on a specific code or a combination of codes (Friese, 2012), so, for example, I could query the data for all quotations and memos associated with the code label “Barriers_IGD.” After the query was run, I printed out the results and performed mind mapping (Buzan & Buzan, 1993) to identify patterns in the clusters. Mind mapping the query results allowed me to visualize the different dimensions associated with the clustered data (Richards & Morse, 2007). In addition, I was able to visualize the possible relationships among the themes and identify the co-occurrence of themes within the data (Krippendorff, 2013). In the report findings, each theme is identified with the number of participants associated with that theme. For instance, 17 participants are associated with the theme “Sexual Health IGD,” indicating that 17 out of the 30 participants reported engaging in sexual health dialogues.

As questions arose during the data analysis phase, I consulted with members of the dissertation committee about the work. Their advice aided me in identifying the most significant patterns from the transcribed interviews.

Step 8. Reporting methods and findings requires putting all of the steps together into a written summary and text. This is represented by Chapter 4 of the dissertation. The research procedures are illustrated. The process for evaluating the quality of the content analysis research is discussed by describing the trustworthiness of the research (Zhang & Wildemuth, 2009). The elements of trustworthiness are credibility, transferability, and dependability.

Trustworthiness. Trustworthiness, as described by Hsieh and Shannon (2005), consists of three content areas: credibility, dependability, and confirmability. **Credibility.** To establish credibility, a researcher must ask the question: Does the research work collected represent what it was designed to study? To answer this question, Lincoln and Guba (1985) proposed that the

researcher do a set of activities. These include (a) spending an extended amount of time in the field, (b) observing persistently, (c) triangulating, (d) doing negative case analysis, (e) checking interpretations against raw data, (e) debriefing peers, and (f) doing member checking. The subset of Lincoln and Guba's suggested activities that were relevant to this study were checking members, doing peer debriefing, checking interpretations against raw data, and, where indicated, doing a negative case analysis.

Credibility also refers to the stability of the codes assigned to the text. In practice, a credible coding scheme would be one where codes assigned to the text by any one coder could easily be applied to the text by any other coder. This is important because the coding process influences the findings developed from the data analysis. In this study a high degree of credibility was established between myself as the primary investigator (PI) and the second coder. The second coder used a coding list and randomly selected 20% (n=6) of the transcripts using the same coding list. In the areas where we had differences on the coding of the text, we reached agreement through discussion. The unified code list was then used to apply to the rest of the transcripts. The other 80% of the coding was managed by myself, the author. Thereafter, whenever a code label or code category needed adjusting or relabeling that decision was made by me. The research process was very transparent and was evaluated according to the research aim. I consulted frequently with members of the dissertation committee throughout the process, from the proposal stage through final approval of the research study.

Transferability. This refers to the extent to which the researcher's hypothesis can be applied to another context. This design of this study did not include a prior hypothesis that is associated with quantitative research designs. This study is a qualitative study with African American women in rural Scott County, Mississippi who were connected with multigenerational

networks. As the PI, I acknowledge that limitation of the study, and thus do not claim transferability to settings that do not share similar characteristics.

Dependability. Dependability refers to how the PI is able to account for unintended changes that occur during the research process. Dependability also refers to consistency in the researcher's ability to implement the approved research plan. My plan for addressing unforeseen changes that occurred in the field was to stay in contact the IRB staff at the University of Washington to ensure that I continued to observe all policies set by the University. Some changes did occur in the field. For example, in the initial plan, participants were to be given a token of appreciation for volunteering their time in the form of a \$25.00 phone card. However, once I arrived at the research site, I discovered that there was no single phone card that would work with the many different mobile phone plans in the area. The IRB staff was notified of this and they approved a change from a phone card to a gift card of the same value. I then informed the participants of the change. Thus, an unforeseen change that occurred during the data analysis and was managed by my being in contact with the chair of the dissertation committee and supervisory committee members.

Confirmability. Confirmability refers to the degree to which the study findings can be verified by others. Hsieh and Shanon (2005) suggest that confirmability is determined by the internal consistency among the data, findings, interpretations, and recommendations. confirmability can be established by an audit of the research process and findings. For this dissertation, a formal audit of the research process was not conducted; however, a thorough review of the research process and data analysis for the dissertation, as described by Lincoln and Guba (1985), was done by the Chair of my committee and supported by the supervisory committee. The transparency of the entire research process and documents for review were

available for confirmability checking. In addition, the findings were similar to prior research studies and can be confirmed from the literature.

Summary

The role of the methods in this dissertation was to show what I, as the primary investigator, actually did in the field and in managing and analyzing the data. The methods also introduced the choice of literature and resources that were used to guide the data analysis. My goal as PI was to maintain transparency throughout the research process. Before I collected any data, the institutional review board at the University of Washington approved the implementation of research study. The areas addressed in the methods included a description of the sample, the setting, the interview guide, the data collection, and the data analysis. The evaluation of the trustworthiness of the process included an assessment of the credibility, dependability, transferability, and confirmability of the research. The next chapter contains a report of the research findings.

Chapter 4

Findings

Overview

This chapter presents the major findings from the data analysis to answer the research aim and research questions using conventional content analysis (Hsieh & Shanon, 2005). First, the research assumptions are stated. The research study aim and questions are then presented, followed by the findings.

Research Aim

The purpose of the study was to explore perceptions of intergenerational dialogue among African American women and to investigate whether IGDs about sexual health and HIV prevention could be an effective cultural medium in which to discuss, and thereby prevent, HIV infections. The study aim and associated questions were:

Research Aim: Explore participants' perceptions of whether IGD is occurring and what they see as its key features.

Research Question 1. What do African American women see as the actual or potential overall benefits and limitations of IGD in terms of changing behavior?

Research Question 2. In what ways might it be helpful to use IGD for addressing sexual health and HIV prevention?

Research Question 3. If IGD is perceived as being potentially helpful, what topics are included or excluded?

The findings are reported related to the study aim and research questions. The presentation of the findings begins with demographics of the study sample and continues with the perception of IGD, sexual health IGD, and HIV IGD. Next, the benefits, limitations and

topics identified from the analysis are presented. The chapter concludes with a summary of the results.

Findings

Sample Demographics. A description of the sample demographics is presented in Table 1. Generational groups of participants are identified along with categories by age, education, number of children, and county of residence. Four generational groups were represented in the sample: the Silent Generation (born 1925-1945, $n=1$); Baby Boomers (born 1946-1964, $n=16$); Generation X (born 1965-1979, $n=6$); and Generation Y or the Millennials (born 1980-2000, $n=6$). (See "Generations Chart," 2008.) The age of the participants ranged from 18-80 years with a mean age of 49 ($SD=17$). The education level of the participants varied, as shown in Table 1. Twenty-eight of the thirty women had children. The average number of children was 2, with a range of 0-5 ($SD=1.5$). Most of the women ($n=28$) had been residents of Scott County for a period ranging from 5 years to 65 years, with a median residency of 6.5 years ($SD=4$). The other two participants resided in Newton and Rankin counties; however, they worked in Scott County, participated in some community activities there, and otherwise met the eligibility criteria for the study. (Please see Table 1 for information about the education and county of residence of the sample.)

Table 1

Sample Demographics

Education and County of Residence		
Education	Count	% of Sample (<i>n</i> =30)
9 th to 12 th grade, no diploma	5	16.7%
High School graduate	2	6.7%
Some College	9	30.0%
Associate of Arts Degree	2	6.7%
Bachelor's Degree	6	20.0%
Masters of Science/or Arts	6	20.0%

County of Residence	Count	% of Sample (<i>n</i> =30)
Scott	28	93.3%
Newton	1	3.3%
Rankin	1	3.3%

Aim 1: Perceptions of IGD Occurrence and Key Features

Perceptions of IGD. The perception of IGD focused on descriptions of self-reported conversations. In this section, three key findings in this category are addressed. First, individuals who engaged in IGD are identified as a finding. Second, selections of reported IGDs are presented. Third, the frequency of IGD occurrence is shown. Each category of IGD is discussed, from broad-ranging, non-specific IGDs to IGDs focused on sexual health and HIV.

The number of women participating in the study was 30. Participants identified who they had dialogues with when engaging in non-specific IGD and this is reflected in Table 2. Participants had IGD most frequently with their mothers ($n = 12$, 40% of participants), followed by aunts ($n = 11$, 36% of participants), and daughters ($n = 5$, 33 % or participants). However, some women identified that they had IGD with more than one person. The participants reported having a total of 50 encounters of IGD.

Table 2

Breakdown of IGD by Dialogue Partner

IGD with whom?	#of IGDs with Person of this Relationship	% of Sample (n=30)
Mother	12	40%
Aunt	11	36%
Daughter	10	33%
Grandmother	5	17%
Father	3	10%
Son	3	10%
Friend	2	6%
Cousin	2	6%
Neighbor	1	3%
Coworker	1	3%
Total IGDs =	50	

In this research study, only women were interviewed. As shown in Table 2, some of the women reported having IGDs with their fathers or their sons. I noted this because it indicates that participants had IGD with both females and males. However, as the table shows, most IGD occurred with women. As stated above, all of the participants had engaged in IGD of some kind, and each participant stated they had had conversations with someone who was within a range of 20 years younger to 20 years older than themselves. The generational differences were best illustrated by one participant, who described a typical gathering of women:

I think, you know, the neighborhood women always tried to keep the young girls informed, and that was their way of, when they ended up sitting around, they would generate a conversation. I can't say how it just actually started. And they would get a topic, and then everybody would start giving their opinion about things. The neighborhood women all sat on Ms. Bertha's porch and you'd hear from all of them and their experiences. Sometimes they used humor to talk about how fast they were, as young

women, and how not to be taken advantage of ... Your mother might be there, your grandmother. –Generation Baby Boomer, 62-year-old mother.

In general, in this type of gathering, women shared life lessons with each other. Humor was an important part of sharing the story. In the statement above, the participant acknowledged the occurrence of IGD across generations.

In another example, a mother shared a general conversation that she had with her mother and daughter. Here she is giving her perspective on how things have changed over time:

Ummm, we, my mom and me, were talking to my daughter, my 18 year old, about sex and different things that, the type of diseases that were around when she was growing up and things that, ummm, new diseases that come along as I was growing up. And what's coming along now she's growing up. –, Generation X, 37-year-old mother.

In this case, three generations of women were involved in the dialogue. During the interviews, the women were asked to estimate the frequency of IGD they'd had with someone up to 20 years older and then with someone up to 20 years younger, as shown in Table 3 and Table 4. The frequency of IGD was indicated on a measure of weekly, monthly, bimonthly, quarterly, yearly or none at all.

Table 3

Frequency of IGD With Someone 20 Years Older

Interval	Frequency	Percent(<i>n</i> =30)
Weekly	12	40.0
Monthly	6	20.0
Bimonthly	3	10.0
Quarterly	3	10.0
Yearly	4	13.3
None	2	6.7
Total	30	100.0

Table 4

Frequency of IGD With Someone 20 Years Younger

Interval	Frequency	Percent(<i>n</i> =30)
Weekly	18	60.0
Monthly	3	10.0
Bimonthly	1	3.3
Quarterly	4	13.3
Yearly	2	6.7
None	2	6.7
Total	30	100.0

As seen in the participants' statements and Tables 2, 3 and 4, IGD does occur, and study participants are aware that it does take place. The responses to the survey questions assessing frequency of IGD show that for some participants (*n*=2) IGD did not occur at all.

Perceptions of Sexual Health IGD. I queried data for the code "Sex_IGD_WHO" to identify who engaged in IGD about sexual health. Over half of the participants *n*=17 (56%) reported that they had engaged in sexual health dialogue with older or younger relatives. The top two relatives identified by participants as engaging in sexual health IGD were daughter (*n*=4, or 6% of the sample) and cousin (*n*=3, 10%).

Table 5

Sexual Health IGD by Relationship

IGD with whom?	#of IGDs	% of Sample ($n=30$)
Daughter	4	6%
Cousin	3	10%
Mother	2	6%
Sister	2	6%
Friend	2	6%
Peer	1	3%
Grandmother	1	3%
Aunt	1	3%
Parent	1	3%
Total	17	56%

The next three most frequent groups of dialogue, by relationship, were dialogue with mother, sister, and friend. Each category had a representation of $n=2$ (6%). This was important, because it shows there was a slight shift in who participants reported having sexual health-related IGD with, as opposed to who they had non-specific IGD with. The extended network of individuals available to be resources for the conversation included daughters, cousins, mothers, sisters, and friends.

The frequency of IGD about sexual health was indicated on an interval of weekly, monthly, bimonthly, quarterly, yearly or none at all. The reported frequency of sexual health dialogue occurring is illustrated in Table 6. The most frequently reported interval of sexual health IGD was yearly ($n=11$). The least frequent was none ($n=1$).

Table 6

Frequency of Sexual Health IGD

Interval	Frequency	Percent(<i>n</i> =30)
Weekly	4	13.3
Monthly	5	16.7
Bimonthly	2	6.7
Quarterly	7	23.3
Yearly	11	36.7
None	1	3.3
Total	30	100.0

Sample Demographics. I did an ATLAS.ti query of the data using the code label "HIV_IGD_Who" to identify which participants engaged in HIV conversations. The results are illustrated in Table 7.

Table 7

HIV-related IGD

IGD with whom?	Number of Participants	% of Sample (<i>n</i> =30)
Aunt	3	10%
Friend	3	10%
Daughter	2	6%
Boyfriend	1	3%
Parent	1	3%
Cousin	1	3%
Son	1	3%
Neighbor	1	3%
Total	13	43%

The query reported that 13 people (43% of the sample) had shared experiences of having IGD specifically about HIV. The top two categories of participants, by relationship, who identified as engaging in HIV IGD with others were aunt (*n*=3, 10%) followed by friend (*n*= 3,

10%). HIV-related IGD that occurred with a boyfriend, mother, daughter, parent, cousin, son, or neighbor was reported by a least one participant each. Those interactions each represented 3% of the total number of interactions among the group of 30 participants in the sample. However in this subset 13 participants reported having HIV-related IGDs.

The frequency of HIV-related IGD was reported as weekly, monthly, bimonthly, quarterly, yearly or not at all (see Table 8). The most frequent HIV dialogues occurred on a monthly basis ($n=4$, or 13.3% of the sample). The frequency of HIV-related IGD occurring quarterly or bimonthly was 4 (13%) and yearly was 6 (20%). The number of participants reporting that HIV dialogues did not occur at all was 3 (10%).

Table 8

Frequency of HIV-related IGD

Interval	Frequency	Percent($n=30$)
Weekly	5	16.7
Monthly	8	26.7
Bimonthly	4	13.3
Quarterly	4	13.3
Yearly	6	20.0
None	3	10.0
Total	30	100.0

Further analysis of the data identified components of IGD that worked well. Those components were defined as the key features of a successful IGD.

Key Features of IGD. I ran a query of the data coded “related to how IGD is going well.” This code was applied to text describing what worked with intergenerational conversation. Over half the participants ($n=18$, or 60% of the sample) reported aspects of IGD that went well and made them feel that the IGD as a whole was a success.

Two main key features were identified from the query. The first feature was the closeness of the relationships that individuals had with others. The second feature was the design of dialogues. Each of these key features will be explained below in more detail.

Closeness of the relationship. The closeness of the relationship related to the bond that was shared among individuals. The bond described by participants ($n=9$, or 50% of the 18 who spoke about key features) was variable depending on the person. The relationship that the participant had with the person whom they talked to was very important, because it influenced what the participant would talk about and how seriously she would take the information that was shared in the dialogues. This is best illustrated by a quote from one of the mothers:

It all depends on who I talk to. If I know you, then I would initiate any conversation. If I don't know you, then we just get together and talk and find out what you're like, and I guess they do the same for me. But once I form that relationship to where we can just talk about anything, then we just talk about anything. But at first it all depends on the person, how well I know the person. –Participant 6, Baby Boomer generation, 60-year-old mother.

Three important dimensions of the relationship that were consistently mentioned by participants were trust ($n=3$), ability to listen ($n=3$), and the closeness of the relationship ($n=3$). Trust dealt with how the information in the dialogue would be managed and how the person would be treated in the conversation. Trust was described by one mother this way:

For one, you can open up to [the person you're talking to] and tell them about some of your personal experiences, and ummm, maybe they'll come out and start to talk to you and trust you more and open up to you. You know, [you can be] be free to go ahead with the conversation and I think it'll flow better. Long as you know that, you know, you're

open and honest. It comes across to them. –Generation Baby Boomer, 52-year-old mother.

Thus, if the conversation partner was perceived to be trustworthy, then conversation would go forward and a way would be created to share experiences, gain insight, and evaluate the content of the dialogue.

Ability to listen was related to allowing each person to share information and to be heard by every other person in the conversation. Ability to listen was a central component throughout the process of having IGD that was identified in all three types of dialogues. Listening involved paying attention and being open to what was being discussed. From the younger generation's view, listening also meant that the older generation would restrain from imposing its view of a situation onto the younger generation. This was important because it was a basis for sharing information and building rapport. One participant explained what can occur when the ability to listen is out of balance:

I think things that might keep us from having the conversations [between] generations are like sometimes the young people might not wanna listen to the older people. They might not wanna hear it. And sometimes the older people might think they just know everything and all this kind of stuff, and try to force it on a young person, by saying just sit down and listen and let me tell you this. And the young person would kinda reject it a little bit because the situation might not be comfortable either. –Generation Millennial, 19-year-old mother.

Another participant describes how, by listening quietly within a group context, she could relax and calmly decide what advice to keep and what to discard:

The fact that generally they said it takes a whole neighborhood, a whole village to raise a child, I guess it worked well, because you didn't have anything to distract you so you sat there and you listened. And you sifted out the good, you know, and deleted the bad, that you didn't wanna be part of. –Generation Baby Boomer, 65-year-old mother.

Design of the dialogue. This sections describes how the organization of IGD can influence its effectiveness. Eleven (or 61%) of the 18 participants who talked about what worked well, described elements that influenced the dialogue positively. Five participants (27%) said it was the tone and delivery of the messages, three (16%) said it was demonstration of caring and three (16%) said it was the mindfulness of timing and subject matter. Each of these elements will be described below in order. Representative quotes will be included to illustrate the concepts from the point of view of the participants.

The tone and delivery of the messages involved how either person in the dialogue expressed their thoughts in a tone and form in which the receiver would listen to the message. This was best illustrated by one of the mothers when she described what worked well with having an IGD. “I think it’s just being calm and not judgmental, and not chastising.” – Generation Y, 33-year-old mother.

Demonstration of caring was associated with ability to listen and to convey understanding, and being open to whatever might come up in the conversation, as well as being aware of what is going on in the conversation. One mother described this as follows: “Being a good listener, not putting people down, and coming at people in a way that you know you could be candid with them.” –Generation Baby Boomer, 67-year-old mother.

Being mindful of timing and subject matter meant taking into consideration the age of the other conversation partner and ensuring that the explanations of sexually related topics were

appropriate for the age of the listener. The idea of talking to young girls at an early age was mentioned repeatedly in the interview sessions, and participants felt that when talking with a middle-school-aged female it was important to explain how the body works with language and models appropriate for that age. The language and models used for 10-year-old girl would obviously be very different from those used with a young adult, for example. Beyond that, explanations should be relevant to each listener's experience and level of understanding, participants said.

Research Question 1-What do African American women see as the actual or potential overall benefits and limitations of IGD in terms of changing behavior?

One of the assumptions for this study was that IGD occurred among African American women and that they have the potential to change behavior regarding sexual health and HIV prevention. To explore this assumption and to answer the research question, I first reviewed the data for the benefits of IGD, sexual health IGD, and HIV IGD in terms of changing behavior. Then I explored the limitations of each.

To answer the research question, I ran a query of codes associated with benefits of IGD and then analyzed the texts. The main code queried was: IGD_Benefit. Under the main code were five subcodes: (a) it takes a village to raise a child, (b) about life, (c) advice giving (d) almost anything, and (e) IGD topic. The results indicated that about two thirds of the participants ($n=21$ of 30 participants, or 70%) articulated that there was a benefit to IGD in terms of changing behavior. The group that felt there was a benefit went to identify three areas that could influence behavior change. First was establishing rapport as a foundation and then sharing information. This was reported by 12 (or 57%) of the 21 participants who articulated a benefit. Second was making life choices ($n= 5$ out of 21 or 24%). Third was experiencing consequences ($n= 4$ out of

21, or 19%). An example of a consequence would be a sexually transmitted infection or unintended pregnancy. Each of the above areas is described in more detail below.

Establishing Rapport and Sharing Information. Among the participants in the study, an initial basis for starting IGD was knowing the other person or people in the conversation. As one participant stated “people should have somebody that they feel comfortable talking to, somebody who’s gonna tell them something right.” –Generation Y, 29-year-old mother.

Sharing information across generations refers to passing on specific information from one generation to the next; for example, a mother passing on a family story to a daughter. The daughter then passes that family story on to her daughter. A good example of sharing information across generations was best illustrated by one mother when she responded to the interview question: *How do you think having conversations from generation to generation can help the women in the community better protect themselves?*

Because our forefathers, like my grandmama and, my mama, her mama, generation.

What I tell them, it pass on. Because we have to keep each other in check. If she say, “Me and Mama say it’s so much out there,” I say, “Mama it is.” I mean it’s so much going on now. My mama don’t even know about a lot of things. What’s going on about women being with women and men being with men—how can they do it? And she’ll ask me. “Well how can they do that?” I say, “Well mama it’s women just have sex, and they having oral sex.” I had to explain it to her, and she understood. But she say, “Well tell your daughter.” I tell my daughter and she say, “You tell your son,” and I say, “Yeah I tell them all about being safe, because it’s not hiding now.” –Generation Baby Boomer, 51-year-old mother.

This illustrates a value in having family members communicate what was identified as

important to pass on from one generation to the next. The reference of sharing information went back several generations (“my mama, her mama, generation.”) The process of asking a question, as exemplified by the mother talking to her daughter, led to a series of actions. First, the mother gained greater understanding about a topic she was not familiar with in her generation: women having sex with women and men having sex with men. Then the mother instructed her daughter to inform *her* daughter and the daughter was then instructed to inform her son. Thus, one benefit of IGD in terms of changing behavior is in the transmission of values from the older generation to the younger generation by word of mouth.

Making Life Choices. This referred to the phase of decision making in which you make choices on your own—choices that could be different than the choices your parents might want you to make. One mother described this process:

With my children, the road is always, “OK, Mama, I hear you.” And then my children seems to go on the path that I’m telling them to go on, and they seem to get what the consequences are going to be if they take a different action than what I tell them to do. And however, children are going to be children, and they’re gonna do their own experiences. But the foundation’s been laid. –Generation Baby Boomer, 47-year-old mother.

This response from the participant illustrates that a mother can give advice to her children; however, they may or may not follow that advice. Yet at the same time it was understood that choosing one’s own path is a part of learning and managing decision making (Covey, 2004; Covey & England, 2011). In the quote above, the mother says she had made clear her expectations for which path her children should follow, but at the same time, she understood that her children were not bound to follow it.

Experiencing Consequences. Experiencing consequences refers to facing the outcomes that naturally follows from one's own life choices:

You know they need to know the consequences you know. Whatever they... 'cause when you make a choice, you do have a consequence and you know that choice is, you know, you have to suffer the consequences. So they need to know what's gonna happen to them when they make that choice. –Generation Baby Boomer, 62-year-old grandmother.

Intergenerational dialogue provides a sense of direction and a sense of connection to family (Hill, 1993; Wyatt, 1997). The opportunity to influence behavior can start with a dialogue depending on the situation. In this study some women recognized that children may choose to take a different path than the one they were advised to take and that there could be consequences associated with that.

Benefits of Sexual Health IGD. Nine out of thirty participants (30%) spoke about the benefits of sexual health IGD and changing behavior. There are two main ideas identified from this section as being important to the participants. The first idea was being proactive toward changing behaviors, which was voiced by six out of nine (or 67%) participants who spoke about sexual health. Being proactive had three sub-elements: (a) educating girls at an early age, (b) understanding priorities, and (c) demonstrating self-care. The second main idea was learning from others' experiences, which was voiced by three out of the nine (33%) participants who spoke about sexual health. Participants voiced that women could and did learn from sharing their experiences, especially given the increased amount of information about women's health now as compared to 40 years ago. Each main idea will be described in more detail below.

Proactive Responses. Proactive actions ($n=6$) for changing behavior around sexual responsibility were focused on talking to girls at a younger age due to the fact that girls' bodies

are reaching sexual maturity earlier now. Thus, younger girls would benefit from knowing how and why their bodies are changing. The typical “age to start talking about sexual health” given by participants was when a girl was around 10 years old:

I would say 10, and then to be honest, really when[ever] they start they cycle. Sometimes they don't start they cycle [but] still be trying something. But really, after they done started they cycle. But now the way stuff is so rapid now, I would say 10. –Generation X, 35-year-old mother.

Another proactive step mothers took was to ask others for help in sharing knowledge with their daughters:

I have had some friends and they had kids that was sorta out there in the street. And I would, I sorta asked one lady, “Do you talk to your children about AIDS or HIV or use protection and stuff like that? Do you talk to your kids about it?” And this one lady said no, and I asked her why. And she said it's just something that she don't feel comfortable talking to her child about. And two days later, she came knocking on my door, and she said, “I brought you somebody to talk to.” And she just left. And I knew what she wanted. –Generation Baby Boomer, 58-year-old mother.

What this participant discovered was that her friend was not comfortable talking about sex or HIV with her daughter, but after she raised the issue of IGD, the friend was motivated to bring her daughter to the participant, who was comfortable talking about sex with the girl.

Learning from others' experiences. The wording of the theme “learning from others' experiences” ($n=3$) came from the in vivo coding of the text and referred to lessons about life that could be learned by younger generations from older ones. For example, a daughter could learn from listening to her mother, aunt, or grandmother talk about their own experiences. The

daughter could learn about being sexually responsible, about planning a pregnancy, or about using updated methods to prevent pregnancy until she was ready to have children. She could also learn about how to protect herself from sexually transmitted infections. In other words, she could learn from the stories and experiences of other women to chart her own path. This was summarized by one mother, who said:

Sometimes those conversations were helpful because it shows you other people's experiences and it gives you another way of learning, when you can learn from others' experiences. –Generation Baby Boomer, 67-year-old mother.

Another mother articulated a similar concept when she stated:

Let them know this is how we come up, or our age. We come up this way and now you have a better chance of, than what we had, of preventing. You don't have to go through what we went through, you don't have to go through that now, cause it's ways to prevent a lot of different things.–Generation Baby Boomer, 48-year-old mother of three children.

Benefits of HIV IGD. The query “HIV_IGD” returned 11 responses out of 30 participants (or 37%). The results of this query showed three main behavior-changing benefits resulting from HIV-related IGD: “formulating strategies for prevention” ($n=5$ out of 11), “acting in self-preservation” ($n=4$ out of 11), and “asking more questions” ($n=2$ out of 11). The following paragraphs provide more detail about each identified benefit.

Strategies for prevention. The four strategies for prevention identified were: (a) use condoms, (b) don't sleep around with everybody, (c) be well-informed about HIV, and (d) get tested and know your HIV status. Being well-informed means knowing your risk and what risk others may be putting you in. Knowing your HIV status was best illustrated by one of the daughters when she said:

Well I think that a diagnosis of HIV would be the most extreme for them to just stop talking about it [HIV] and for them to take action against it. So try different things like get tested every so often and know where you stand. –Generation Y, 19-year-old daughter.

Acting on self-preservation. “Wondering if you are safe” was a subtheme of this theme. Wondering if you are safe ($n=4$) referred to a participant hearing about someone who was HIV positive and then wanting to know whom that person could have passed the virus to. This uncertainty created a need for people to know if they or someone they knew was at risk.

Asking more questions. Asking more questions ($n=2$) meant gaining more information about a specific case of HIV: how it was transmitted, how it was detected, were there any symptoms of an infection, and was it detected from a routine medical exam? It could also refer to knowing where you stood with a partner and what their sexual history was. For example: Could you be putting yourself at risk with this partner? How can you take action against being at risk? This is best illustrated by one of the mothers when she stated:

First, don't be afraid to ask questions, cause, um, you get involved with people and you never know you know what kind of lifestyle they live, so I think that's the first thing.

Don't be afraid to ask the question, Have you been tested? –and all that kind of stuff. – Generation X, 39-year-old mother.

Although the interaction that occurs with non-specific IGD, sexual health IGD and HIV IGD has some identified benefits, there are limitations to having the dialogues as well. The limitations for each IGD are discussed below.

Limitations of IGD. Intergenerational Dialogues ($n=10$ out of 30, or 33%). Three main ideas identified as barriers to IGD are (a) decreased communication, ($n=4$ out of 10, or 40%), (b)

attitudes ($n=5$ out of 10, or 50%), and (c) fear, ($n= 3$ out of 10, or 30%). Decreased communication refers to the change in family communication patterns over time. For example, whereas a generation ago family members sat down at the dinner table together and shared information, they now tend to eat by themselves or eat on the go. One participant described the decreasing opportunities for family sharing as follows:

Well, there's one thing, the younger generation tend to not, people do not sit around and have conversations any more. They do not eat at the table together, the opportunity is just not there anymore. And when they realize it, it's too late, and they've already gotten involved in [other] things. –Generation Baby Boomer, 65-year-old mother.

This same participant later explained the situation by saying that “parents are working more and children have more activities now than they ever had.” One mother stated that people are communicating *differently* now than in the past. For example, many people—especially young people—prefer to text others family members now, rather than having face-to-face conversations:

Because you tend, when you text, you can say things on this text that you probably won't normally say to a person in their face. I think that's what it is. Now I can text you and say some things that I probably normally wouldn't say to your face. But I can get away with it with texting. –Generation Baby Boomer, 48-year-old mother.

Other factors noted by the participants have changed how families communicate and when they gather together to talk. The effects of working parents, busy children, cell phones and texting were expressed by several participants; however, new communication technologies could increase sharing of information, depending on the technology, the situation, and the individuals.

The second barrier, attitude, refers to the perception that the younger generation has a stubborn or angry posture. Adolescents may think they are grown and don't need advice, for example. Or they may resent the restrictions that they perceive adults are imposing upon them.

The third barrier associated with IGDs is fear. The two components of fear were a sense of being isolated and feeling uncertain of what the consequences from the dialogue might be.

Limitations of Sexual Health IGD. Sexual Health IGD involved 11 out of 30 participants, or 36%. A core idea was identified by 10 out of these 11 (90%), which is that sexual health-related conversations were being avoided. A large majority of participants who described limitations in this area articulated that talking about sex was uncomfortable for some mothers and daughters. The specific reasons for the discomfort were not identified.

Limitations of HIV IGD. The two main barriers identified by the 12 participants out of 30 (40%) who spoke to this were lack of information and fear of isolation. An illustration of lack of information was captured when one participant responded to the interview question, *What do you think needs to be done to get more people to participate in the conversations to even know how big of an issue it (HIV) is?:*

You got to get the word out. You got to get the knowledge to them you know. I don't know whether we need to have more, have community meetings with our children and you know, I don't know if the church need to take a part in it. We just need to find some way to get the information to them, 'cause I think the lack of information might be some of the problems in the Black community. –Generation Baby Boomer, 51-year-old mother.

An aspect of the fear of isolation is best illustrated by one participant who described why she did not talk to others about what she was experiencing:

I held onto the stigma that, gosh this is my daughter, you know. This is my daughter. I don't want people to know. If they don't know, I don't want them to know. I don't want them to shun me. Because when my son started dating, the lady hated him, his mother-in-law hated him. "I heard that your sister had AIDS," [she said] and just you know, I went through that, and I said, "God, no. She *didn't* say that!" So I guess that's why. I just don't wanna get just down personal with it 'cause you just don't, you don't want people to know. It hurts enough to have to deal with the fact that you this is happening. Ah, that just, I thought I would just die right then and there. So it just hurts. But like I said, I could accept the fact that somebody else was talking to me about their child, but I was just never able to say "Well, hey! I'm going through the same thing." –Baby Boomer Generation, 60-year-old mother.

This comment captured the reality of what a mother can experience with caring for her children, and why she might not choose to share her story with others. She was able to state that it hurts to be shunned by others in the community.

Research Question 2: In what ways might it be helpful to use IGD for addressing sexual health and HIV prevention?

The answers to this research question were identified by looking at participants' comments in the sexual health and HIV prevention-specific dialogues. The participants ($n = 29$ out of 30, or 96%) articulated in the interviews that it is helpful to develop and use IGD for addressing sexual health and HIV prevention, because the interactions provide a forum for "learning to protect yourself" ($n=18$ out of 29, or 62%) and "truth telling about HIV" ($n=11$ out of 29, or 38%). "Learning to protect yourself" refers to protecting oneself from sexually

transmitted infections (STIs or STDs) generally. One mother described what was helpful about sharing experiences about STIs with younger women:

All we can do is just talk and tell one another. A lot of us have already had an STD that's gonna be with us the rest of our lives because of the fact that when we started we didn't really know about STDs and this and that. We just didn't know at our age way back then. So some of us have developed STD. And we'll talk about that and how it affects our lives and you know, that helps me to be able to talk to other girls or young ladies. I don't want you to go through anything like that. You know, learn to protect yourself. Generation Baby Boomer, 60-year-old grandmother.

Most women in the study (96%) voiced they wanted to help other women avoid contracting sexually transmitted diseases. If their experiences could help others, they would share what they knew. They would share because they wanted other women to know how STIs can affect women's lives.

The theme "truth telling about HIV" refers to talking about HIV as a manageable illness, a health condition that can be medically treated. Three ideas were identified by participants ($n=11$ out of 29 participants) regarding telling the truth about what it really means to be HIV-positive. First, HIV is not a curable disease. Second, HIV can affect both a mother and her children, and third, it's important to feel comfortable talking about HIV and its management.

Research Question 3: If IGD is perceived as being potentially helpful, what topics are included or excluded?

The answer to this research question was identified from a query of the data for topics that are included in IGD, sexual health IGD, and HIV IGD.

Topics to Include in Non-specific IGD. The topics identified in IGD had a wide range depending on who was involved in the conversations. For instance, half of the participants talked about family stories ($n=15$ out of 30), and among these, some simply stated they could talk about anything with their family ($n=14$ out of 30, or 47%). One participant illustrates her experience of talking about family stories:

Topics could be about family stories and what [family members] did when they were growing up. And they try to pass it on to us, some of their beliefs in how they grew up. Self-discipline and stuff. And it came from my mother. Of course I didn't know my grandmother; she died before I was born. But they talked about the family home and how much fun they had. It was five kids in their family. Generation Baby Boomer, 60-year-old mother.

Another mother describes how the topics could vary, depending on the characteristics of the people involved in the conversations:

I think when you have friends you learn who you can talk to about what. I think everybody has *their* person [that you think], Well I know I can talk to [her] about family relationships. I know I can talk to Jamie about money or finances; I know I can talk to Shelia about clothing or weight or body types—things of that nature. You know which one of your friends you can talk to about what. —Generation Y, 29-year-old mother.

These excerpts are a small reflection of the range of topics that women in the study identified with regard to IGD. The topics could be about a variety of life experiences; the scope of the dialogue could be diverse.

Topics to Include in Sexual Health IGD. Half of the participant ($n=15$ out of 30) identified topics that would be useful to include in sexual health IGDs. The topics most often

articulated by the participants who spoke to this issue were (a) protective behavior ($n=8$), (b) pregnancy ($n=7$) and (c) “rules of engagement” ($n=4$).

Protective behavior meant taking actions to care for one’s own sexual health. In this area, participants talked about getting annual exams ($n=4$), practicing safe sex or abstaining from sex ($n=5$), and asking a potential partner about sexual history ($n=3$). One participant illustrated the idea of protective behavior when she described her strategy for taking care of herself:

I mean [get a checkup] annually. Every year. Every year you need to do it. And if there’s something strange going on or something—your body changing or anything like that—go get yourself checked, and see what’s going on.” –Generation X, 39-year-old mother.

The concern for preventing pregnancy was commonly discussed during the interviews. This subject was represented by 10 out of 30 participants [33%]. Two important messages were identified. One was that the older generation needs to prepare young girls by educating them about the change that will occur in their bodies. At the same time, girls should be told about how to prevent pregnancy; they should be given straightforward advice about birth control. One mother shared this perspective of what to include in that discussion:

Telling them about their reproductive system and how everything works, you tell them, about protection that you have to [use in order to] keep from becoming, you know, pregnant or from catching diseases, STDs, something like that. –Generation Baby Boomer, 52-year-old mother.

Another mother had this to say:

Actually, back when I was growing up and my mom talked to me about sex, it was more like “Don’t get pregnant!” You know, the kinda [talk about] preventing pregnancy. “If you’re gonna have sex, just use protection.” –Generation Y, 33-year-old mother.

This participant shared an experience that showed her mother stressed avoiding pregnancy to her when she was a teenager. Overall, these topics were important to include because the content provides a template to talk about sexual health to their daughters.

“Rules of engagement” refers to having criteria for determining who would make a good conversation partner. One mother said it best when she expressed the value of knowing yourself and what you prefer before becoming sexually involved:

Find out who you are first. Love yourself. And then, in loving yourself, you can look for those same qualities in relationships with another person. [Ask:] How am I treating myself? Is the person going to treat me how I would treat myself? And then you start looking at the pros and cons in what would I like in another person, how I would like for them to treat me. –Generation Baby Boomer, 47-year-old mother.

The mother states the benefit of knowing who you are. She talks about knowing what you value and what you expect from yourself, so that when you choose an intimate partner you can better assess whether they have the basic qualities and values that are important to you.

Topics to Include in HIV IGD. I ran three queries on the data to determine the best topics to include in HIV IGD. Those queries searched for the terms “HIV_IGD_Behavior at risk,” “HIV_Topic_Consequences,” and “HIV_IGD_Prevention.” A total of 13 out of 30 total participants (or 43%) suggested topics to include in HIV intergenerational dialogues, which fell into two categories. Prevention was identified by 12 out of 13 participants (or 92%) who had HIV-related IGD and behavioral risk was identified by 6 of the 13 participants (or 46%). An explanation for why those topics were included is discussed next.

Prevention. For this study, prevention means methods for preventing the transmission of HIV. It also includes participants' attitudes toward prevention. One participant articulated the reason for including prevention this way:

As a part of prevention, testing needs to be done to make sure that you know what your own status is, that you do not feel shamed. People should go to their doctors or go to the clinic, be tested, get medical treatment, look at prevention. Then next, make sure that whatever your diagnosis is that you follow up. You just don't say to yourself, ok, you know... follow up and be able to do what you need to do. –Generation Y, 33-year-old mother.

The participant encouraged other women to get the support they need. Her statement reinforced the importance of knowing your HIV status, getting tested, and following up with your doctors. She also reinforced getting medical treatment if you test positive.

Behavioral risk. For this study, behavioral risk refers to a series of actions or behaviors in which a person is exposed to HIV. One of the issues identified in the data was that women take risks based on how they perceive their *level* of risk. In the interviews, this was sometimes described as a mentality of “it will not happen to me” ($n=4$ out of 13 women who had HIV-related IGD). This behavioral risk is best illustrated by one mother when she stated, “I can say I think most of the youth today are aware that [HIV] is prevalent, but what they don't realize is that it could happen to them.” –Generation Baby Boomer, 65 year old mother. According to this woman and other participants, risk-taking behavior was typical of younger women, who do not take precautions against HIV because they think they will not be affected.

Topics to Exclude from IGD. No topics to exclude from non-specific IGD were sought. Topics to include or exclude were considered only for those dialogues focusing on sexual health or HIV.

Topics to Exclude from Sexual Health IGD. The general sentiment of what to exclude from sexual health conversations was explicit details associated with the act of sex. This sentiment was voiced by 4 out of 30 total participants. Participants said that they could talk about being sexually healthy without going into the details of their own sexual experiences. One participant summed it up by saying: “If the question is about your sexual content, and uh, just not get too deep with their personal involvement, enter the talk around it.” –Generation X, 47-year-old mother.

Topics to Exclude from HIV-related IGD. The data analysis of the coded text identified 11 out of 30 participants who gave a response about what to exclude in HIV IGD. No exclusions were identified and it was positively asserted that everything related to HIV should be discussed. One mother expressed this well when she said: “Nothing should ever be avoided because there may be something somebody doesn’t know. Anytime you can state facts or back it up with something written, then that too can help a person become [aware] on another level.” – Generation Baby Boomer, 60-year-old grandmother.

Conclusion

There several conclusions to be drawn from the findings. First, it was primarily relatives (mother, daughter, grandmother, aunt) who participated in the IGDs described in this study. All study participants were female, and 40% of IGDs were participants talking to their mothers, while 36% were participants talking with their aunts, and 33% were participants talking with their daughters. Key features associated with IGD involved how participants talked about

relationships, for example, the closeness of the bonds of the parties in the conversation and the “design” of the dialogues. Limitations that could deter IGD were identified as (a) decreased opportunities to talk in modern life, (b) uncooperative attitudes on the part of the younger women (for example, being stubborn and not listening), and (c) fear about of the outcome of the dialogue. In spite of the limitations, there were several features of the relationships that worked to form a basis for a positive exchange of information in the dialogues. Thus, the topics that could be discussed in IGD were unlimited.

In reviewing the nature of non-specific vs. sexual health-related IGD, a slight shift in who was engaged in the dialogues was noted. Mothers, aunts, and daughters had the highest rate of interaction in non-specific IGD, as compared to daughters, cousins and mothers having the highest rate in sexual health IGD.

The benefits of IGD relative to behavior change included the opportunity for the women to be proactive and to learn from others’ experiences. There was a limitation associated with sexual health IGD, however, which was that certain conversational topics were likely to be avoided; thus, the sexual health conversations were occurring less frequently than general topic conversations. Although participants recognized that sexual health conversations were happening less often, they were still able to identify topics that *should* be included in such conversations when they did occur. These topics included rules for engaging in sexual activity, protective behavior for self-care, and preventing pregnancy.

Fewer participants reported having HIV-related IGD as compared with either non-specific or sexual health-related IGD. The barriers for engaging in HIV dialogue included fear and lack of knowledge about HIV. Benefits of participating in HIV IGD included having opportunities to learn about HIV and to explore options for prevention, reflect on personal risk,

and seek out medical advice. The main reason given by participants for engaging in HIV IGD was to help others so they would not become infected. Broadly speaking, participants who expressed an opinion on what topics should be included felt that behavioral risks and prevention were the key ones. There were no topics identified as needing to be excluded from the dialogues.

IGDs are occurring among African American women in the different generational groups that were represented in the study sample. Discussion among mothers, aunts, and daughters are the more common interactions for IGD in the sample. The data analysis found a slight shift to daughters, cousins and then mothers in sexual health discussion. With HIV dialogues there was a noticeable shift to aunts and friends as individuals chosen to talk to most often. As I've noted, the key features of IGD develop from the types and qualities of the bonds among the individuals included in the discussion. These bonds influence the degree of exchange that occurs. A common barrier in both sexual health and HIV IGD was people being afraid of the negative reactions that could happen as a result of information sharing. Participants felt that after they revealed their behavior or HIV status in a discussion, that might be judged or criticized, and they could then be isolated from their network of family and friends. However, although barriers exist, the participants felt that these were outweighed by the benefits of changing behavior through IGD, and that IGD could be proactive, preventive and persuasive.

Chapter 5

Discussion Overview

This chapter discusses the study purpose, aim and research questions in light of the research findings. The discussion will illustrate how this work contributes to the existing literature about intergenerational dialogue and HIV prevention. This chapter also includes implications and limitations of the research study. Recommendations for action and further research are then presented. The chapter concludes with a dissertation summary.

Research Aim and Questions

The purpose of the study was to explore perceptions of intergenerational dialogues (IGDs) among African American women and to investigate whether IGDs about sexual health and HIV prevention could be an effective cultural medium to discuss HIV prevention. This is critically important because new incidences of HIV infections are occurring across multiple generations of the African American population (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention, 2014). A large body of research is available on communication between adolescents and mothers around sexual topics in general (DiClemente et al., 2001; R. J. DiClemente & Wingood, 1995; Jemmott, 2000; Jemmott, Jemmott, Hines, & Fong, 2001; Jemmott et al., 2014; Pluhar, DiIorio, & McCarty, 2008; Sales et al., 2008; Wingood & DiClemente, 1992). However, not much is known about how IDGs occur when the topic is specifically about sexual health and HIV prevention, or when African American women over the age of 18 are involved in the discussion. Still less published research is available about IGDs of this kind that take place in rural areas, where extended families may play a greater role in transferring knowledge and sexual mores from one generation to the next (Kogan et al., 2012).

HIV infections are the fourth leading cause of death for African American women age 35-44, and the fifth leading cause of death for African American women 25-34 (Centers of Disease Control and Prevention, 2013). Given the persistent incidence of HIV infection, HIV mortality among African American women, and the fact that there is limited research on IGD in rural African American communities, this study was undertaken to explore perceptions about the nature of IGDs concerning sexual health and HIV prevention among African American women 18-80 years of age living in a rural community in the southern United States. The research aim and research questions are provided below. A discussion of the research aim and each research question is subsequently presented. The research aim and questions are:

Research Aim: Explore participants' perceptions of whether IGDs are occurring and what they see as their key features.

Question 1. What do African American women see as the actual or potential benefits and limitations of IGDs in terms of changing behavior?

Question 2. In what ways might it be helpful to use IGDs for addressing sexual health and HIV prevention?

Question 3. If IGDs are perceived as being potentially helpful, what topics are included or excluded?

Discussion of the Research Findings

Research Aim: Perceptions of IGDs and Key Features

The research study aim was reflected in the fact that women in the study did feel that IGDs were occurring and provided multiple examples of IGDs to support that. Prior research has also indicated that IDGs do occur specifically between African American mothers and daughters (J. B. Cornelius, S. LeGrand, & L. Jemmott, 2008). Although there are some similarities between prior studies and the current study, this study expands on the previous research and adds new interpretations of the data. For example Hutchinson and Montgomery (2007b) noted that IGD

between mothers and daughters about sex had a positive effect on the daughters' sexual behavior. Similar to that study, the current study found that mothers and daughters had IGD about sex, pregnancy, and sexually transmitted infections. However, the current study also found that extended family members, such as aunts and grandmothers, were also resources for sexual health conversations. This study found that when grandmothers and granddaughters had conversations about sex, specific details about sexual health related to self-care and avoiding unwanted pregnancy emerged. However, when aunts and nieces engaged in IDGs, sexual health and HIV prevention details were shared.

Based on the experiences shared by the participants, key features of IGD were identified. The two most commonly referred to features that were necessary for a useful IGD were: (a) a close relationship, in which trust was a key factor and the participants could feel safe and (b) a comfortable and relaxed relationship, in which the participants felt safe to talk about sensitive subjects. Those two features were also a foundation for understanding how IGDs about sensitive subjects worked both for the person delivering the message about sexual health, and the person receiving it.

However, other researchers have not studied key features in the same way. For example, while trust has also been viewed as a key element in the existing research, it is defined as a characteristic of the relationship between researcher and subject, rather than the relationship between two subjects. Kogan et al. (2012) evaluated the Strong African American Families-Teen (SAAF-T) Program and found that it was an effective tool for discussing sexual health issues. Considerable trust had to be developed between the program facilitators and the adults in the study prior to approaching the topic.

Another difference noted with this study is that the bond among the individuals in the dialogue strongly influenced whether messages about sexual health and HIV were received or rejected. Although previous research such as that by Hutchinson and Montgomery (2007a) explored dialogue between mothers and daughters, key features that facilitated those conversations were not explored. The current study is thus unique in that key features of the interaction and information exchange were identified and can be used to identify implications for further interventions.

Research Question 1

A goal of the research study was to identify perceived benefits and limitations of IGDs in terms of promoting sexual health and HIV prevention. To better address the responses of the women in the study to this research question, I remind the reader of the context. The women in the study had taken conscious action to stay involved with women of other generations in the local area. For example, many of the women in the study sample had engaged in local community functions such as volunteering in school programs, working with the local food bank, and participating in church and sorority functions. This community involvement is significant, because it allowed the women to build intergenerational relationships. In this rural community context, this study identified three perceived benefits of IGDs: (a) establishing the rapport needed to share information openly, (b) discussing the implications of making life choices, and (c) discussing the consequences of those choices. Although (b) and (c) seem similar, the subtle difference is discussing implications addresses what is talked about prior to making a decision and the possible ramifications of the pending choice. Whereas, the consequences are the results of the choices and actions one makes. The dialogues described by the participants represent a process of learning the life lessons needed to address sexual health and HIV prevention.

Gambone (2001) and Gambone (2001); Springate, Atkinson, and Martin (2008) and Springate et al. (2008) have documented that as older and younger individuals interact, both gain understanding, friendship, and confidence in communicating with each other.

Although there are many clear benefits to IGDs, this study found specific limiting factors or barriers as well. The most frequent barrier to sexual health IGD, according to older generation participants, was that younger participants sometimes expressed an attitude of being “already grown” and therefore not needing any advice or input from their elders. A barrier described by some younger participants in HIV-related IGD was the fear of being rejected by family and community if their HIV status became known. A prior study by Pluhr and Kuriloff (2004) A prior study by Pluhr and Kuriloff (2004) reported that barriers to communication between mothers and daughters included participants in the discussion feeling uncomfortable during the dialogue, expressing anger (yelling), and silence. The barrier of participants feeling uncomfortable during dialogue was also reported in this study. Although this study did not involve an intervention, barriers identified in prior studies and those found in this study has implications for the importance of finding ways to avoid or reduce discomfort for future research.

An important finding this study contributes to the literature is the finding that behavior change in a rural, African American multigenerational family network was perceived to be connected to relationship-building and trust. The women in the study demonstrated how being involved in community activities and having different goals in life aided in establishing rapport between the generations. This rapport in turn supported the abilities of the conversation partners to discuss implications of life choices and consequences. A point you made very well today is that this rapport was important over time so people could address age specific or situational issues as they arose if this rapport had been established already. On the other hand, the

existence of barriers to IGD illustrated the complexity of the dialogues related to sexual health, and particularly the topic of HIV.

Research Question 2

Another goal of the study was to identify what might be helpful in using IGD for addressing sexual health and HIV prevention. A majority of the women said that starting conversations to educate young females about their developing bodies and changes that occur in their bodies over time would help promote healthy growth and development. The older-generation women in the study said that they wanted to inform their daughters and other young women so they could take action to protect themselves from unintended pregnancies and sexually transmitted infections. In this context, “taking action” meant getting annual exams, practicing safe sex or abstinence, and asking potential partners about sexual history. Prior research has also found that there is a protective nature to having dialogues about sexual risk and prevention (Izugbara, 2008; Painter, Herbst, Diallo, & White, 2014; Pequegnat & Szapocznik, 2000; Pluhar et al., 2008).

According to the older-generation participants, they wanted the younger generation of African American women to make better choices about when to engage in sexual activity and with whom. One of the important findings that this study adds to the literature is that women in this rural context believed that conversations around sexual health should be started when girls are around age 10. Most participants felt that conversations about female body development and sexual health education could occur either at school or at home, as long as the material covered in the discussion was appropriate for the age of the girls and young women receiving it. In addition to the home and school, participants identified other settings in which sexual-health IGDs could be useful. These include family events such as family reunions, planned programs at

church, and community health events. Although these gatherings are larger and less confidential, they do bring together African American women in the community and therefore may increase the likelihood of IGDs being started.

Research Question 3

The last goal of the study was to identify what specific topics within the category of sexual health and HIV prevention should be included or excluded in the discussion, if IGDs were to be perceived as being helpful. The findings demonstrated that topic content can be broadly summarized into two categories: (a) the risk of unintended pregnancy and (b) the effects of sexually transmitted infections, including HIV. For each of the categories, most participants talked about the topics being age-appropriate and indicated that information should generally not be withheld from either younger or older generation. The most important criterion for including a topic was: Is the listener able to understand and process the information?

Although the topic categories in this study were broad, similar topic areas were reported by other researchers. For instance, Dilorio, Maureen, and Hockenberry-Eaton (1999) in which the authors identified the content and comfort level of discussion about sexual issues between mothers, fathers, and their adolescent children. There were broad similarities in topics between both the Dilorio et al. (1999) study and this one. Both included menstrual cycles, the maturing body, selecting partners, preventing pregnancy, and preventing sexually transmitted infections. The Dilorio et al. (1999) study recognized that some sexually related topics were considered uncomfortable to talk about and therefore not be discussed with a mother or father. Unlike their study, however, the current study found that participants wanted to *increase* transmitted dialogue about sexually sensitive topics, particularly HIV. Participants expressed that not discussing

sexuality and the transmission of HIV was viewed as limiting young women's ability to prepare for adult sexual relationships and for assessing their risk of HIV infection.

Implications

A practical implication suggested from this research study is for African American women in multigenerational families to intentionally have sexual health IGDs and HIV-related IGDs. Mothers and/or other family members who are comfortable talking about sexual health can initiate the conversations. Aunts, mothers, and grandmothers can collaborate with each other to plan and initiate discussions with younger-generation family members, either at home or in other safe locations such as a church, a community center, or a family reunion. On the other hand IGDs can happen spontaneously. For example, they can happen while the parties are driving to an event, walking in a park, or watching TV. There are two essential conditions for an IGD to occur. First, the parties must be trusted by one another. Trust allows for candid, informative, and calm discussions to occur. Second, the discussion initiator should be focused more on listening than on talking, and she should be conscious of the need to show understanding, openness, and awareness. This posture by (as opposed to one of being judgmental) is more likely to lead to a change in thinking and thus a change in behavior on the part of the listener.

A clinical implication of this research for nurse educators and future researchers is that it may help them determine which dyads are more likely to ensure that certain topics are covered adequately. For example, when it is known that an aunt or other older adult has an effective way of reaching a person in the younger generation, that adult she could be designated the "go-to" person in the family and community for that topic of conversation.

Furthermore, based on the resources that I found while conducting this research study, there are many and varied printed and online resources that can be used to increase knowledge

and confidence for talking about sensitive sexual topics within families. There are published resources for young girls and women that provide models for talking about women's bodies, sexual health, and HIV (Office of Adolescent Health, 2014). Gaston and Porter (2001) discuss using HIV prevention to improve the lives of African American women. Natterson (2012) writes for an audience of young girls and talks about how the physical and emotional changes that young girls experience are a normal part of growing up. The Office of Adolescent Health (2013) and Healthy People 2020 (2014) have websites that provide general guidelines for talking to adolescents, parents, and older adults about HIV prevention.

There are also resources based within the African American community and targeted at that community's needs. The documentary by Paul Grant (2012) *The Gospel of Healing: The Black Church's Response to HIV/AIDS*, provides a model of a church health ministry raising awareness of HIV/AIDS and treatment in African American communities throughout the U.S. This study does not cover all the possible forms that an intergenerational dialogue may take; I would therefore advise researchers to explore more on their own, selecting the resources that work for their particular needs. I would also encourage African American women generally to be persistent and to engage in IGD frequently.

Limitations

There are several limitations to this research study. The sample consisted of African American women and thus the views and behaviors of African American men (and other races of both sexes) were not represented. The level of education attained by half of the women in the sample was higher than what is reflected in the demographics of Scott County, MS from the county census reports. Therefore, their life experiences and views may not be representative of the typical woman living in Scott County. This study used a convenience sample of women who

resided and/or worked in a single county in rural Mississippi. It is not claimed that the city of Forest or Scott County are typical of all rural counties in the South, and, as is generally true of qualitative studies like this, any generalizations must be made with caution.

Recommendations

More studies are needed to understand the bond that exists across generations of African American family networks. In addition more empirical exploration is needed in order to gain a more precise measurement of IGD occurrence and effectiveness influencing sexual health behavior. Further, in the interest of identifying more culturally relevant approaches to HIV prevention, studies comparing and contrasting the nature and role of IGD in different communities and populations (e.g., Latina or White) would be useful.

Findings from this study coupled with the above research recommendations can inform future interventions that involve IGD among African American women in multigenerational families. I believe that IGD helps African American women re-bond with each other and can regenerate the kinds of conversations that are needed to prevent HIV infection in the community. Therefore, more research should be devoted to it. More broadly, I encourage African American families and community leaders to create environments that foster safe zones of comfort and trust in which discussions on sexual health can occur. Health practitioners are encouraged to establish safe zones for talking about HIV prevention as well.

Conclusion

This research study explored the perceptions of IGDs among African American women and investigated whether these women believe IGDs about sexual health and HIV prevention can be an effective cultural medium in which to discuss and prevent HIV infections. The research

findings are similar to prior research studies indicating that African American mothers through dialogue may influence their daughters on sexual health conduct.

Based on the self-reported experiences of the participants, conditions for having intergenerational dialogues are good, and conversations between mothers and daughters about sexual health are occurring. Aunt/niece conversations about HIV are also occurring, though to a lesser extent. Sometimes the topics vary based on the familial combination of the intergenerational dyad. In this study, more conversations about sexual health generally were reported than conversations specifically about HIV.

The main barrier to dialogue was fear of a participant being disconnected from family as a result of disclosing a diagnosis or fear of family members being affected by HIV. In spite of the barriers and limitations, IGDs allow multigenerational families to talk through sensitive issues like birth control and sexually transmitted disease. IGDs create close personal bonds of trust, demonstrate caring, and can provide accurate, relevant and age-appropriate information to younger women. Further studies that illustrate African American women are comfortable talking about sensitive topics like HIV in multigenerational families will demonstrate how IGD can address HIV prevention in rural southern communities.

In this community of women, family is very important. Indeed, the fear of being ostracized from family and friends is immobilizing and keeps some women in silence. Therefore, families, church leaders, and nurses should acknowledge that the prospect of talking about HIV and risk factors is frightening for many people.

Finally, my study results demonstrate that IGD represents a way for family members of different ages and experiences to discuss sexual health. As such, IGDs have the potential to improve sexual health and prevent HIV infections. The key features of an IGD are influenced by

the nature and quality of the relationship among the individuals engaged in the dialogue. How the IGD participants relate to each other controls what is talked about and how effectively information on sexual health and HIV is passed from one generation to the next. This research supports the concept that we can discuss HIV prevention in our dialogue's or as the Centers for Diseases promote "We Can Stop HIV One Conversation At A Time" (National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention Division of HIV Prevention, 2014)

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Appendix A

Screening the Potential Participants for Recruitment: Telephone Contact

Date _____

Participant ID _____

Gayle Robinson MN, RN

Principal Investigator

Hello, this is Gayle Robinson. Thank You for giving me your phone number and taking an interest in my study. As you may already know, I am a student at School of Nursing at the University of Washington. I am pursuing my doctorate degree. I am conducting a research study to understand the potential for intergenerational dialogues to be useful for improving black women’s sexual health and preventing new HIV infections among Black women. I would like to know when, how, and what we share in our conversations about sexual health and preventing new HIV infections among Black women.

If you agree to participate in the study, I will ask you to meet with me fact to face to do an individual interview. The interview may last up to 2 hours. The interview will be audio taped. I will also take notes during the interview. I am legally and professionally obligated to protect your identity. Your name will be kept confidential in all materials that grow out of this research. You may refuse to answer any question, or stop the interview at any time.

Would you be interested in participating in the study?

If No, Say: Thank you for your time and for calling me

If yes, say: Now I will go over the eligibility criteria with you.

Inclusion Criteria	Responses	Action
Are you at least 18 years of age	Y N	If no, ineligible
Do you live in district V or VI in Mississippi This includes Scott and neighboring Counties	Y N	If no, ineligible

Exclusion criteria	Response	Action
Are you under the age of 18	Y N	If yes ineligible
Are you able to provide oral and written informed consent?	Y N	If no ineligible

If ineligible, say, I am so sorry you cannot participate in the study because (state the reason). Thank you very much for letting me talk to you about the research study.

If eligible, say, great! You are eligible. Now we can set a time and place that would work for you review the research consent forms and to do the individual interview.

Date _____ Time _____ Place _____

Appendix B

Letters of Cooperation

CONCORD
MISSIONARY BAPTIST CHURCH

Rev. Henry L. Patrick, Pastor

June 23, 2012

Ms. Gayle Robinson
3942 South Angel Place
Seattle, WA 98118

Dear Ms. Robinson:

We, the Concord Missionary Baptist Church, pastor and members would indeed support you in any way we can help. We will gladly make announcements and encourage the congregation to participate in your study.

Mrs. Delore Nelson has agreed to serve as a coordinator from the church family. Please keep in touch and let us know how you are progressing.

Yours in Christ,
Concord M. B. Church

Henry L. Patrick

Rev. Henry L. Patrick, Pastor

Mrs. Lisa Darby, Clerk
244 North First Avenue, Forest, Mississippi, 39074 (601) 469-1694

Appendix C

Letters of Cooperation

Carolyn E. Knowles
430 George Street
Forest, Mississippi 39074
601-469-1861

June 22, 2012

Ms. Gayle Robinson
3942 South Angel Place
Seattle, Washington 98118


Dear Ms. Robinson,

Congratulations on pursuing a higher degree in Nursing. In response to your request to help you with your research study, I have received positive responses from over ten mothers and daughters who are willing to participate in the sexual health and HIV prevention health issue affecting African American study.

Presently, I have a large number of contacts from my sorority circle and other organizations that I am part of.

If you have any additional concerns, please free to contact me. Best wishes for a successful course of study.

Sincerely,


Carolyn E. Knowles
cseknowles1@bellsouth.net

Appendix D

Letters of Cooperation

June 19, 2012

Ms. Gayle Robinson, MN, RN
3942 South Angel Place
Seattle, WA 98118

Dear Ms. Robinson,

It is my pleasure to write in support of your doctoral work at the University of Washington, School of Nursing. You state that the purpose of your study "is to understand whether and the extent to which intergenerational dialogues about sexual health and HIV prevention among African American women are occurring and how useful they are for responding to this health issue." I consider this to be a very important issue and am hopeful that your research can be used to educate and to prevent HIV.

In support of your research I am prepared to assist in information dissemination about the study and/or follow up with potential contacts to post information about the study. I trust you will let me know if there are other ways I might be of help.

Lastly, Gayle, I wish to again congratulate you on your decision to pursue a doctoral degree and to focus HIV prevention. I wish you all the best as you move forward.

Sincerely,


B. Anne Lovelady

Introductory Letter to Participant

Dear (Name of Participant)

Date:

My name is Gayle Robinson and I am a graduate student at University of Washington. I am pursuing my doctorate. I am studying characteristics of how intergenerational dialogues about sexual health and HIV prevention among African American women are occurring.

You are being asked to participate in this study because you are an African American woman who is at least 18 years old, a mother, daughter, aunt, or grandmother. If you agree to participate, I will schedule a time and a date when I can explain the consent forms for the study and to conduct an interview. The consent forms describe the study in greater detail. In the review of the consent you may ask any questions you may have. You may also determine if you want to participate.

The interview will last approximately 60-90 min. In it, I will ask you a series of questions about your perception of intergenerational dialogues, sexual health and HIV prevention, as well as some background questions. I am legally and professionally obligated to protect your identity. All of the responses that you give in the interview are voluntary. I will tape record the interview to ensure accuracy, and when the study is complete the tape will be destroyed. Your name will be kept confidential in all materials that grow out of this research. You may refuse to answer any question, or stop the interview at any time.

If possible, I would like to meet with you a second time, after I have listened to the taped interview or reviewed my notes. This is to make sure that I understand everything you told me during our interview. The second interview would be scheduled at a later date.

I look forward to scheduling our initial interview with you on a day and time that will work for you. Thank you very much for your help. Please do not hesitate to contact me if you have any questions.

Sincerely,

Gayle Robinson, MN, RN
Principle investigator
Box 357260
University of Washington
School of Nursing
Seattle, WA 98195
(Phone) 601-880-9129
gmwamba@uw.edu

Appendix F



Letters to Community Organizers

Dear (Name of Participant)

Date:

My Name is Gayle Robinson. I am pursuing my doctorate at the University of Washington, School of Nursing. Thank you for helping me with my study. My goal with this study is to understand the potential for how intergenerational dialogues about sexual health and HIV prevention among African American women are occurring and if they are how they are useful for this health issue.

I understand that as a _____ you have interactions with different women and families. I am wondering if you could help get the word around about my study or recommend individuals who may be interested. I want to interview African American women who are at least 18 years old, a mother, daughter, aunt, or grandmother. I would also like to get your permission to post flyers in your facility about the study.

Thank you very much for your help. Please do not hesitate to contact me if you have any questions.

Sincerely,

Gayle Robinson, MN, RN
Principal Investigator
Box357260
University of Washington
School of Nursing
Seattle, WA 98195
(Phone) 601-880-9129
gmwamba@uw.edu

Appendix G

Flyer



African American Mothers, Aunts, Daughters, & Grandmothers Needed

If you are 18 years or older and are willing to spend 60-90 min.
discussing your health and views regarding women's

- Sexual Health
- STD Prevention
- Adult Women talk about sexual health

Your views are wanted

Sexual Health is an important part of living well. There is a great need to learn more about how culture and family dynamics shape our individual perspectives and health decisions.

Please contact

Gayle Robinson MN, RN, Lead researcher, at
601-880-9129 or gmwamba@uw.edu so you can participate
in a brief research study



Department of Psychosocial
And Community Health

Appendix H.

UNIVERSITY OF WASHINGTON CONSENT FORM

Intergenerational Dialogue on Sexual Health and HIV Prevention among African American Women in Rural Mississippi

Researcher:

Gayle Robinson MN RN PhC

Doctoral Candidate

Psychosocial and Community Health

University of Washington

School of Nursing

Box 357260

206-498-7897

David Allen RN PhD

Faculty Sponsor

Director, Nursing and Health Studies

University of Washington, Bothell

School of Nursing

Box 358352

425-352-5396

Researchers' statement

We are asking you to be in a research study. This consent form is used to give you the information you will need to help you decide whether to participate in the study. Please read the form carefully. Before making your decision we want to be sure that you understand the purpose of the research and the kinds of questions that we will ask. For example, some will involve details about personal and intimate relationships. As a participant you may choose not to answer any specific question. We want to make clear any risks, benefits or other details about the research that will help you make your decision. When we have answered all your questions, you can decide whether to be in the study. This process is called "informed consent." If you decide to participate, we will give you a signed copy of this form for your records.

PURPOSE OF THE STUDY

I want to talk to you about how you have conversations with other women in different generations such as with your aunt, niece or cousin about preventing HIV and managing sexual health. The purpose is to explore how African American women use intergenerational conversations to talk about HIV prevention and sexual health. We want to understand what is included in the conversations, how the communication is used and whether it is beneficial in decision making regarding HIV prevention and sexual health.

STUDY PROCEDURES

I want to have a conversation with you in the form of a personal interview, so that I can learn from you. Because I want to learn from you I will ask you questions like: In your experience, have you had conversations related to sexual health with your aunt, niece or other family member of another generation? What was the topic of the conversations? When did they take place? Were the conversations helpful? If so, how? If not, why not? Have you had those inter-generational conversations about HIV prevention? If so, tell me an example. If not, tell me why this topic was not mentioned? Later I will ask a personal question such as your age, and type of health care insurance you have. At any time during our conversation you can tell me what you do not want to answer or that you want to stop talking about a specific topic.

Our conversation can last as long or as short as you and I wish. But I believe our talk will take about 60 min. If possible, I would like to talk with you twice. The first would be an initial interview. The second would be at a later time, after I listen to the taped interview or reviewed my notes. This is to make sure that I understand everything that you told me during our conversation. It would be a shorter conversation of about 20-30 minutes. I would like to offer you a \$25.00 phone card for the personal interview(s). Because I do not want to miss anything we talk about, I would like to tape record all of our conversation.

RISKS, STRESS, OR DISCOMFORT

Some people recall memories about their health or others that they know that cause sadness or uncomfortable feelings. You may pause or stop the interview at any time. Some people feel that talking about their health is an invasion of privacy. I will keep the conversations private. Your name will not be used at any time when I talk or write about this research study.

ALTERNATIVES TO TAKING PART IN THIS STUDY

This is not a treatment study. Your alternative to participation in this study is not to participate.

BENEFITS OF THE STUDY

You may not benefit directly from being in this study. However, your participation will help us understand how African American women have conversations about sexual health and HIV prevention across different generations. The results of the research may help us identify and find ways of improving how African American women learn about ways of improving sexual health and HIV prevention.

CONFIDENTIALITY OF RESEARCH INFORMATION

All of the information you provide will be confidential. If I record our conversation, I will keep the tape recording until a complete written record is made and then destroy it. The written record will not contain any information identifying you in the conversation or as a participant in this

project. Confidentiality will be maintained by using fictional names to the written record.

Records for this study are confidential and will be secured on my computer with a locked password. I will keep the written information for up to 5 years

OTHER INFORMATION

You are free to tell me that you do not wish to be involved in this project. You can also agree to the interview but not to have our conversation recorded by tape. I will keep all records of our meeting locked in a safe place. Do you have any questions? Would like to participate? Can I tape-record the interview?

Printed name of study staff obtaining consent Signature Date

Participant's statement

This research study has been explained to me. I have had a chance to ask questions. If I have questions later about the research, I can ask the researchers listed above. If I have questions about my rights as a research subject, I can call the University of Washington Human Subjects Division at (206) 543-0098. I volunteer to take part in this research. I will receive a signed copy of this consent form.

Please initial one of the following statements:

_____ I give my permission for the interview to be audiotaped.

_____ I do not want the interview to be tape-recorded, but the interviewer can take notes.

Printed name of participant Signature of participant Date

Copies to: Research participant
 Gayle Robinson

Appendix I

Interview Script

Thank you for agreeing to be a part of my research project. I want to interview you today for 60-90 minutes. We will need to be a quiet place and I wish to tape-record the interview. Do you still have time to participate in this project today?

(If the response is no, say). When would be a good time to meet and talk for 60-90 minutes? (If the response is yes, say). Wonderful, I want to explain what will happen next. The first part of the interview I will ask you some open questions. Reply as you would if we were talking in a conversation. Then, I will ask you more structured questions about yourself and your family. In the end, I will ask if you wish to share any concerns with me or other ideas. Do you have any questions about this interview?

Are you ready to begin? (If so, say). I am interested in talking to you about conversations that happen across generations – that is having a conversations with other adults who are about 20years older than you or younger, (Then start the interview guide).

Appendix J

Interview Guide

Research Aim	Interview Questions	Comments
<p>Aim 1: Explore perceptions of whether intergenerational dialogue is occurring and what the participants see as its key features.</p>	<p>(Start here after reading the interview script.)</p> <p>In your experience, when have you had those types of conversations between grandmothers to granddaughters or aunts and nieces for example)</p> <p>Tell me when they would occur in your life?</p> <p>Who were involved in the conversation?</p> <p>What was the topic of the conversation?</p> <p>Where the conversations helpful? If so, how? If not, why not?</p> <p>Have you had those generational conversations about sexual health?</p> <p>If so, tell me an example.</p> <p>If not, what makes that not happen?</p> <p>Have you had those generational conversations about HIV?</p> <p>If so, tell me an example.</p> <p>If not, what makes that not happen?</p> <p>Imagine or remember one of those conversations about sexual health? Who had the conversation? What was discussed? What made it work well? What did not work so well?</p> <p>Probe for more description based on prior question. If you talk to your peers, mother, aunt, or grandmother about sexual topics, how does it begin? Who initiates the conversation? Who is most influential in the discussion?</p>	

Research Aim	Interview Questions	Comments
<p>Sub Aim 1: What do African American women see as the actual or potential overall benefits and limitations of intergenerational dialogue in terms of changing behavior?</p>	<p>How might conversations across generations help women in our community better protect themselves in sexual relationships?</p> <p>What helps women move from talking to behavior change to protect themselves from HIV?</p> <p>What are barriers to these types of generation to generation conversations?</p> <p>What are the opportunities for strengthening these generational to generational conversations?</p>	
<p>Sub Aim 2: In what ways might it be helpful to develop/use intergenerational dialogue for addressing sexual health and HIV prevention?</p>	<p>Do you think talking across generations is a way to approach the topic of HIV prevention? If so, tell me more. If not, tell me why not.</p> <p>How might intergenerational dialogues be used to talk specifically about sexual health? About HIV?</p> <p>What needs to be done to get people to participate in conversations about sexual health? About HIV?</p> <p>Are there ways to help these conversations lead to behavior change?</p>	
<p>Sub Aim 3: If they see it as potentially helpful, what topics are included or excluded?</p>	<p>If you were to talk with someone from another generation, older or younger than you, about sexual health and HIV prevention, what topics are important to include about sexual health?</p> <p>If you were talking to someone from another generation, older or younger than you, about HIV what would you say?</p> <p>What topics should be avoided in conversations about sexual health if you are talking to someone younger?</p> <p>What topics should be avoided in conversations about HIV if you are talking to someone younger?</p> <p>What topics should be avoided in conversations about sexual health if you are talking to someone older?</p> <p>What topics should be avoided in conversations about HIV if you are talking to someone older?</p>	

Research Aim	Interview Questions	Comments
	<p>Are there particular factors (time, setting, individuals, and occasions) that should be paid attention to when the conversation is about sexual health?</p> <p>Are there particular factors (time, setting, individuals, and occasions) that should be paid attention to when the conversations is about HIV?</p>	
Closing the first part of the interview	<p>What was it like for you to talk with me about these topics today?</p> <p>Before Closing: is there anything else you wish to share?</p> <p>Thank you for your time today. I may need to follow-up with you to clarify some points. Is it possible for me to call you, if I need to understand something we discussed more?</p>	

Appendix K

Study ID Name: _____

Demographic information

How do you classify your sex? F: _____ M _____ Other _____

In which year were you born? _____

May I ask your current age? _____

Intergenerational Demographics

Given your age, how many people are you in contact with from a generation above you, that is 20 years older than you? _____

How many people are you in contact with from a generation below you that is 20 years younger than you? _____

How often do you engage in intergenerational conversations with persons 20 years older than you?

- _____ Weekly
- _____ Monthly
- _____ Bimonthly
- _____ Quarterly
- _____ Yearly

How often do you engage in intergenerational conversations with persons 20 years younger than you?

- _____ Weekly
- _____ Monthly
- _____ Bimonthly
- _____ Quarterly
- _____ Yearly

How often has someone older than you engaged you in a conversation about sexual health?

- _____ Weekly
- _____ Monthly
- _____ Bimonthly
- _____ Quarterly
- _____ Yearly

How often has someone younger than you engaged you in a conversation About HIV?

- Weekly
- Monthly
- Bimonthly
- Quarterly
- Yearly

What is your marital status? S _____ M _____ Sep. _____ D _____ Wid _____

How many children do you have?

What are their ages?

How many grandchildren to you have?

What are their ages?

Are there boys or girls you mother or care for that are not your own children? Yes No

How many?

What are their ages?

Ethnicity Demographics

I will say the following labels people use to identify their racial or ethnic background. I wish to know how you identify yourself. When I get to the word or words that you use, please tell me.

Black /African American _____ Mixed Race/Multicultural _____
Hispanic/Latino _____ Caucasian _____
Native American _____ Asian/Pacific Islander _____ Other _____

Educational Demographics

What is your educational level? When I get to the category that identifies you, please stop me
Less than 9th grade _____ 9th to 12th grade _____ no diploma _____ High School graduate _____
Some Collage _____ AA _____ BA _____ MS/MA _____ PhD/Ed.D/D.Div/MD _____

What do you do for a living?

How many jobs do you have?

Health Demographics

How would you rate your current health status? I will read you some choices:
Excellent_____Very Good_____Good_____Fair_____Poor

What type of medical insurance do you have?

Now, I will ask you questions you may consider personal about sex.

Do you have any concerns about your sexual health?

What are those concerns?

Do you prefer to have sex with women, men, both or neither?

Sexual Orientation Demographics

Heterosexual_____, Lesbian_____, Transgendered_____
or_____ (other)

What makes it difficult to talk about sex and sexual health for you?

What makes it difficult to talk about sex and sexual health to others?

Now, I will ask you some questions about your living situation.

Living Situation & County Demographics:

Own home_____ Rent Apt._____

Live with children or other family members (specify)_____

In which county do you live? _____

How long have you lived in this county? _____

Have you ever heard women talking openly about sexual health in (name the county) or HIV?

Income Demographics

I will show you some numbers. Please point to the income level that represents your total yearly income. Or if it's easier for you to tell me how much you earn a month, I will calculate that for a year.

Less than \$10,000____\$10,000- \$14,999____\$15,000-\$24,999____\$25,000-34,999____

\$35,000-\$49,999____\$50,000-\$74,999____\$75,000-\$99,999_____

more than \$100,000_____

Appendix L

Text for Thank You Letter

Dear Mr. or Mrs. (participant name)

I would like to thank you very much for your time and support of my dissertation research on intergenerational dialogue about sexual health and HIV prevention among African American women. Thank you very much for sharing your stories and experiences about your dialogues with your immediate and extended family.

I appreciated your time and thank you again,

Sincerely,

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Appendix M

Sample Dissertation Codes (58 codes)

