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'Don't cross a man's feet': Hmong parent-daughter communication about sexual health

Laurie L. Meschke and Kim Dettmer

Department of Child and Adolescent Development, San Francisco State University, San Francisco, CA, USA

Refugee and Employment Services, Lutheran Social Service of Minnesota, St. Paul, MN, USA

Abstract

Parent-adolescent communication about sexual health is one strategy to encourage healthy adolescent sexual behaviour. However, this literature has largely overlooked immigrant families. Hmong youth, identified as facing extreme challenges to parent-adolescent communication, are considered. Content analysis was used to examine parent-adolescent communication about sexual health for forty-four pregnant or parenting Hmong adolescent girls. The minority of adolescents recalled an actual conversation about sexual health in their families with mothers most often identified as the source. Their stories reflect discussions about abstinence, puberty, pregnancy, and STIs – with much information being inaccurate. With culture being a recurrent theme, communication was reported to be hindered by cultural traditions, comfort level, applicability, and perceived consequences. The results identify opportunities for culturally-relevant sex education materials in the Hmong community.

Keywords

Hmong; parent-adolescent communication; sexual health

Parent-adolescent communication about sexual health has been related to healthier sexual outcomes for youth (see reviews by Meschke, Bartholomae, and Zentall 2000 and Miller, Benson, and Galbraith 1998). These discussions have differed by the person delivering the message and the content shared. Parents have reported a number of factors that hinder sexual health discussions with their adolescent. These include parents' lack of knowledge, concern that the conversation will go poorly, lack of efficacy, embarrassment, situational constraints, and fear of encouraging sexual behaviour (Guilamo-Ramos, et al., 2006; Jaccard, Dittus, and Gordon 2000; Rosenthal, Feldman, and Edwards 1998). Most research in this area has been conducted with non-immigrant communities in the United States.

Parent-adolescent communication in immigrant families may be further challenged by acculturation and enhanced generational differences associated with the migration experience (Farver, Narang, and Bhada, 2002; Lay and Safdar, 2003; Dinh, Sarason, and

Address correspondence to the first author at San Francisco State University, Child and Adolescent Development Program - CHHS, 1600 Holloway Avenue, SCI 394, San Francisco, CA 94132 or LMeschke@sfsu.edu; Fax: 415.405.0401.

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Meschke has research interests in adolescent sexual health, adolescent risk-taking behaviour, adolescent substance use, and Hmong adolescents

Dettmer is dedicated to providing direct service to insure the health and well-being of new immigrants

Sarason, 1994). Specifically, the disparity between the native and host culture, trauma suffered prior to migration, lack of prior exposure to the host nation, and language limitations can increase generational differences, which then contribute to communication challenges for adolescents and their parents in immigrant families. The Hmong serve as an extreme case in this regard as these families have typically experienced all of these risk factors. Thus Hmong immigrant families in the United States are especially vulnerable to limited parent-adolescent communication – especially about sensitive topics such as sexual health. Based on interviews with pregnant and/or parenting Hmong adolescent girls, this study examines if Hmong parents are involved in sexual health discussions with their daughters, the content of such discussions, and perceived conversation barriers.

Background

Parent-adolescent communication about sexual health

Social cognitive theory espouses that adolescents who internalize their parents' values are less likely to adopt values that are inconsistent with these, including those of peers (Bandura 1989). Communication is one avenue by which adolescents can realize their parents' values (Bussey and Bandura 1999). In turn, enhancing parent-adolescent communication is cited as an important strategy in promoting adolescent sexual health (U.S. Surgeon General 2001).

Research indicates parents' conversations with adolescents about sexuality can reduce sexual risk behaviour for these youth. Healthier outcomes include engagement in later and less frequent sexual activity, the use of contraceptives and/or condoms, and fewer sexual partners (Fox and Inazu 1980; Jaccard, Dittus and Gordon 1996; Karofsky et al. 2000; Leland and Barth 1993; Miller, Forehand and Kotchik 1999). Various communities have indicated that adolescent sexual health is promoted by parent-adolescent discussions about sexuality including African-American (McDermott Sales, et al., 2008), Asian (Cha, Kim, and Patrick 2008), and Caucasian families (Somers and Paulson 2000).

The specific content of the parents' messages is relevant to its impact on subsequent adolescent sexual behaviour. Parents' vocal disapproval of teen sex has been related to later onset of first sexual experience, fewer sex partners, less frequent sexual activity, and decreased teen pregnancy (Jaccard, et al. 1996; McNeely, et al. 2002; Miller, et al. 1999; Resnick, et al. 1997). More comprehensive messages from mothers about sexual health (i.e., addressing issues such as contraception and sexually transmitted infections (STIs)) also decrease the likelihood of adolescent sexual risk behaviour (Dutra, Miller, and Forehand 1999).

Fathers can influence adolescent sexual health (Dittus, Jaccard, and Gordon 1997), but mothers are most often cited as the purveyor of sexual health information (Graber, Nichols, and Brooks-Gunn, 2010; Hutchinson and Montgomery 2007; Hutchinson and Cooney 1998; McKee, O'Sullivan, and Weber 2006). In general, same gender parent-child dyads are more comfortable discussing sexual health issues than opposite sex dyads (Kirkman, Rosenthal, and Feldman, 2005; Fisher 1993).

Although parents express that communication about sexuality is important (Rosenthal, et al. 1998), the occurrence of parent-adolescent sexual health conversations is rather rare (Rosenthal and Feldman 1999; Young Pistella and Bonati 1999) with less intimate topics (e.g., postponing sexual activity) discussed more readily than the more intimate (e.g., sexually transmitted infections or condom use; McDermott Sales et al. 2008; Hutchinson and Cooney 1998). In addition to topic matter, parents have viewed discussions of sexual health as irrelevant to their children and sometimes fear that such conversations might

enhance their youth's curiosity about the topic or convey parental approval of sexual behaviour (Miller, Benson and Gordon 1998; Orgocka 2004).

Mothers in particular tend to underestimate the sexual behaviour of their adolescents (Jaccard, Dittus and Gordon 1998). Parents also believe they lack the knowledge necessary for such discussions and that these conversations will not be effective, will go poorly, or lead to embarrassment (Guilamo-Ramos, et al., 2006; Jaccard, et al. 2000; Rosenthal, et al. 1998).

Parent-adolescent communication in immigrant families

In immigrant families, the parent-adolescent relationship faces unique challenges that may further diminish the frequency and comprehensiveness of sexual health conversations (Farver, et al. 2002; Lay and Safdar 2003; Dinh, Sarason, and Sarason 1994). The typical parent-adolescent generation gap can be exacerbated by parent-adolescent differences in acculturation.

Acculturation is changes in beliefs, values, and behaviour that occur when members of a cultural minority have repeated contact with a new environment (Farver, et al., 2002; Sam and Oppedal, 2002). With regular teacher and student contact in school, youth in immigrant families typically adopt aspects of the host country's culture more completely and faster than their parents. This generational difference in tempo of acculturation results in an acculturation disparity. Greater levels of parent-adolescent acculturation disparity are associated with increased parent-adolescent conflict and negative communication (e.g., Buki, Ma, Strom, and Strom 2003; Dinh and Nguyen 2006; Qin 2006; Tardif and Geva 2006).

Some immigrant families face greater acculturation disparities than others. Such is the case of the Hmong, whose involuntary migration due to war, lack of previous exposure to American culture, language differences, little or no education and skilled labour experience, and various cultural factors enhance the cultural and generational disparity of Hmong parents and adolescents. Examining parent-adolescent sexual health discussions in the Hmong community will help determine if the communicator, content, and barriers associated with parent-adolescent sexual health discussions are in keeping with those of previous findings on non-immigrant adolescents and their families. Exploring an extreme case should provide a strong contribution to the development of strategies to promote adolescent sexual health for the Hmong and less challenged communities.

The Hmong community and sexual health

A review of Hmong history and culture will provide a backdrop to the challenges facing Hmong parent-adolescent sexual health discussions. Special attention will be given to the previously listed risk factors – involuntary migration due to war, lack of previous exposure to American culture, language differences, and little or no education and skilled labor experience – that expand the generational gap and acculturation disparities in these families. Hmong cultural factors may further hinder the likelihood of parent-adolescent sexual health discussions.

Prior to the Vietnam War, the majority of Hmong lived in Laos as an isolated agrarian society. The absence of a written Hmong language until 1956 increased their isolation, resulting in little or no exposure to American culture. Following the Vietnam War the Hmong, supporters of the American forces, were forced to flee Laos to refugee camps in Thailand (Rice 2000).

The majority of the Hmong has resettled in the United States (Rice 2000) – now the home of an estimated 185,000 Hmong (Reeves and Bennett 2004). Twenty-five years after the first Hmong migration wave, 2000 U.S. Census data revealed that 35.3% of Hmong ages 18–64 did not speak English well compared to 21.9% of the general U.S. population. Nearly half of the Hmong age 25 or older (45.3%) had completed no school in contrast to only 1.4% of the overall population. Over a third of Hmong had incomes below the poverty level, with two-thirds of Hmong children under the age of 18 living in poverty (Hmong National Development (HND) and Hmong Cultural and Resource Center (HCRC) 2004).

Traditional knowledge and cultural norms of the Hmong also influence the content and frequency of parent-adolescent sexual health communication. The Hmong born in Laos have little knowledge regarding the anatomical and physiological functions of the human body, and their language lacks words for direct translation of Western disease processes (Benson 1987; Cheon-Kessig, Camerilli, McElmurry, and Ohlson 1988 as in Johnson 2002). This may create challenges in discussing reproductive body parts, their function, and topics such as sexually transmitted infections (STIs).

Past research of the Hmong community has also identified proscriptions against the open discussion of sex and sexuality (Robinson, Freske, Scheltema, and Heu 1999). Hmong women's unwillingness to discuss family planning and pregnancy in the presence of men has been associated with this taboo (Nyce and Hollinshead 1984). However, these behaviours are equally likely to be the result of Hmong disinterest in family planning and an understanding that pregnancy is women's domain. It is considered impolite to speak directly about sex, and that doing so will embarrass both speaker and listener (Spring, 2001; Spring and Lochungvu 2003).

Despite the historical and cultural challenges, a 2002 survey of 192 Hmong parents of adolescents revealed that most (89%) agreed that it was "important for Hmong teens to know about sexual health (e.g., like sleeping with a boy/girl, pregnancy prevention, and sexually transmitted infections)." Three-quarters of these parents also agreed that "Hmong parents have a responsibility to educate their teens about sexual health" (Meschke 2003).

Research questions

Very little is known about sexual health communications in the Hmong community, with but one earlier study that focused on the reproductive health of older Hmong mothers ($M_{age} = 30$ years; Spring 2001). This is the first known study to focus on Hmong adolescents, specifically pregnant or parenting adolescent girls. These interview data are part of a larger needs assessment of Hmong adolescent pregnancy in Ramsey County, Minnesota that also included 11 years of birth record data, numerous focus groups with various contingents of the Hmong community, and surveys of Hmong adolescents and parents. Using these secondary interview data, this study examines the sexual health information that Hmong parents share with pregnant and/or parenting adolescents and the barriers to such conversations.

Methods

Procedure

This study included 44 young Hmong pregnant or parenting adolescent females who were recruited in Ramsey County, Minnesota, the residence of the largest concentration of Hmong in the U.S. (HND and HCRC, 2004). Recruitment was done through word of mouth, flyers, and advertisements in two local Hmong newspapers. All adolescents interviewed met the following criteria: (1) Hmong ethnicity; (2) age 20 or younger; and (3) actual or anticipated birth before age 20. Prior to the interview the participants were given a copy of

the interview guide; this was organized to address a wide variety of topics associated with adolescent pregnancy. The complete interview began with basic demographic information and then moved to topics such as school and work, family, friends, Hmong culture, and gender roles. Given the breadth of the questions and time limitations, follow up questions were limited in number. The youth were told to respond only if comfortable doing so and each received a \$50 honorarium for their time.

The interviewers included three Hmong females in their early twenties and two Caucasian females who were approaching middle age. All interviewers participated in the formulation of the interview questions and received three hours of interview data collection training; this was facilitated by the first author (one of the Caucasian interviewers). All interviews were conducted in one or two sittings (depending on the respondent's availability and the duration of the interview). The estimated length of the interviews based on the transcripts was about 90 minutes. The interviews occurred in a private office at a local Hmong social service provider. All semi-structured interviews were completed between April and September 2002.

The interviews were audio taped. Of the 44 interviews 35 (80%) were conducted in English. Nine (20%) were conducted in Hmong. The English interviews were literally transcribed for analyses, including laughter, false starts, and the like. The Hmong interviews were translated into English by a person bilingual in Hmong and English. Following transcription, the principle investigator then stripped all identifying information from the transcripts. Aliases were then assigned to each of the cases to promote confidentiality in reporting the results.

Content analysis

A graduate assistant reviewed and summarized all transcribed interviews by topic area designated by the interview guide. The first author validated the summary via line by line analysis, marking all quotes associated with sexual health communication for inclusion. Open coding (Strauss and Corbin 1990) was then enlisted to identify the topics of interest. This process resulted in the three primary topics – who shared sexual health information, the type of sexual health information shared, and barriers to sexual health discussions. The selected quotes then were examined and sorted with these topics in mind. Categories soon evolved within each of the topic areas (Morse and Richards 2002). These categories became the reporting structure for the results, and reflect all responses associated with sexual health communication provided by the adolescents.

Characteristics of respondents—The interviewees were between the ages of 14 and 20 years ($M = 17.55$; $SD = 1.62$). Thirty-three respondents (75%) were married; twenty percent were married in the Hmong tradition and over half (54%) were married under Minnesota law. Thirteen (30%) youth were currently pregnant. Thirty-five (80%) had at least one child, with one adolescent being the mother of four children. Most respondents (86%) were enrolled in school and nearly a quarter (23%) was employed.

Over half (52%) lived with their husband and his parents – a customary arrangement for the Hmong. Just over a quarter (27%) lived with their biological parents. Eight women (18%) lived independently with their husbands and children. Given the high Hmong birthrate (e.g., 55% of the U.S. Hmong population is under the age of 18; Reeves and Bennett, 2004) and their strong commitment to extended families (McInnis, 1991), it is not uncommon to find more than ten persons in a Hmong household. One-third of the adolescents lived with ten or more people, and two respondents resided in households of twenty persons.

Results

Who is talking?

Only a third of the respondents recalled that sexual health was discussed in their parents' home. Half of these youth reported that their mother was the sole informant. Plia, married at age 15, shared, "...my father ...won't talk to me about it because in the Hmong culture; from what I know the father is not the one that should be talking to you about it – it should be your mother."

Most of the others indicated that both mothers and fathers shared sexual health information. Nineteen year old Kia, mother of two children, remembered a consistent message from both parents.

My mom always kept saying, 'Don't have sex. Do not have sex no matter where it is, don't have sex until you're married cause you are gonna regret. You want to give it in or just to be loved.' And so my dad encouraged the same thing. He said the same thing and safety about sex and what can go wrong. He kept telling us, 'I just don't want you guys to come home someday and your tummy blown up big and so you're pregnant.'

Content of sexual health discussions

The content of the discussion varied for the 15 teens who recalled conversations about sexual health with their parent(s). Most received sexual information about only one topic; the others remembered discussing two or more topics with their parents. Topics included: abstinence, puberty, pregnancy, and STIs.

Abstinence—The topic of abstinence was usually linked to teen pregnancy prevention. Seventeen year-old Joua, married at 15, shared, "My parents say, 'Don't have sex too young because when you come home with a big belly, we don't want you in our house anymore. You're a disgrace.'"

Phoa (married at the age of 13) shared that her mom had a more comprehensive message, although language challenges seemed to reduce the potency of the message.

She was just basically talking about, mostly about condoms and she was just like, 'If a guy tries to pressure you to do it and you don't feel like it, I would say no. Stay abstinence' ... I was laughing to my mom cause my mom didn't know how to say it.

Puberty: Even though puberty might be considered a less intimate topic for sexual health discussions, its occurrence was quite rare. If recalled, very little detail was shared. A typical example is Mee, a young mother of one child who remembered: "My dad talked a lot about it [sexuality]. ... He talked about the whole puberty and growing up and having sex thing and we shouldn't do it before we're adults and stuff like that."

Pregnancy—The most popular message about pregnancy is simply "don't get pregnant." Dawb, married at the age of 14 shared, "My mom says she's been telling me about it [sexuality] but I've never heard anything, except if you get pregnant don't come home."

The information shared about pregnancy was rife with cultural euphemisms. The teens viewed such information as inappropriate or inaccurate. Nineteen-year-old Mai Chia (married at 14) recalled a message about conception as not understandable.

...Hmong use metaphors to talk about things like that [sexuality]. For example, 'Don't cross a man's feet.' They keep saying that, but you don't know what they mean or don't get it. You just think you shouldn't cross even your brother's feet. Parents don't tell the truth so you don't understand what they're implying. They tell you, but they don't get to the point. You're just a child so you end up thinking you shouldn't cross any man's feet or something bad will happen."¹

Chia, married at age 18 in the Hmong tradition, felt patronized by her parents' message. "... see that's what I'm saying where they [parents] treat you as children. They talked to you as like their children, and they don't say penis, they just say hot dog, or they find some different word for penis."

The process of conception was also described inaccurately but in keeping with traditional Hmong beliefs (see Spring, 2001). The grandmother of Shoua (a mother of one) advised her about conception and menstruation. "My grandma told me to not get near the guys when you're having your menstrual or else you could get pregnant."

In a similar vein, Zoua who married at 13 disclosed her confusion and embarrassment about the information she received from her mom.

The first time when I had my period, my mom would always talk to me and tell me I can't go out because I was 12 and I had it. She would lie to me that if I held a guy's hand I would get pregnant. I used to be afraid of that. I said that to my husband and my husband was laughing at me because he said my mom is lying to me, and I felt stupid cause I told him what my mom said and how he was a guy too.

Contraception information was also less than accurate for some of the young mothers.

Sexually transmitted infections [STIs]: Oftentimes STI information was conveyed as a fear appeal to promote adolescent sexual abstinence. Ah, a fifteen-year-old mother, shared

She [Mom] said, 'Don't have sex.' She tried to scare me you know. 'If you have sex, you know you're gonna get AIDS and you're gonna get bugs on your hair and you're gonna get these little pimples, herpes on your vagina and you're gonna get sick and you're gonna die.'

Comparable to puberty, very little detail about STIs was shared. Mee, mother of one, shared a typical experience of the interviewees. "She [Mom] said that you can get a lot of diseases from having sex and stuff." Other than AIDS and herpes, the youth recalled no mention of a specific STI in conversations with their parents.

Why the silence? Culture, comfort, applicability, and consequences

Most respondents (64%) did not have sexual health issues discussed in their homes. The aversion to discussing sexual health was attributed to culture, comfort level, applicability or fear that the information might promote adolescent sexual activity.

Culture—Discussions about sexuality were identified as taboo in the Hmong culture most frequently by the older adolescents. They viewed their parents' lack of discussion as normal. Chong (married at age 16) said, "Hmong people don't talk about sex. I think it's more of an

¹The meaning behind this phrase was further discussed at the 2003 Hmong National Development Conference. This phrase may have been initiated in the Thai refugee camps. Here bathroom facilities were scarce and men often urinated on the ground. Women were cautioned not to step over a man's urine, as wet urine would be a sign that a man's penis was recently exposed in that vicinity. Thus avoiding exposure would help reduce pregnancy risk. The evolution of the phrasing from *urine* to *feet* is likely to have occurred after migration to the U.S.

embarrassment; it's not for them natural." Eighteen year old Ka shared, "I don't think any Hmong home discusses sexuality. It's just taboo for parents to speak of the topic." Vue (age 14) said, "It really wasn't talked about because Hmong people don't really talk about those things. Because they know that you should be good and not know that much about sex."

Yer (age 19) indicated that the cultural issues underlying the lack of communication were an intergenerational issue, "It's [sexual health] not something they [parents] can easily talk about to their children since it was never taught to them from their parents." However, Gao, a mother at 19, was clear that regardless of her parents' lack of conversation, she had intentions of having sexual health conversations with her daughter.

...my parents didn't think it [talking about sex] was a big deal but with my daughter I think I would rather talk to her about that [sex] because you wouldn't really know if they did or didn't [know] if you didn't really talk to them about it. I kind of want to have a bond with her other than with my mom where I didn't really have a bond with her.

Discomfort—Nearly half of teen mothers believed their parents' discomfort in discussing sexuality was the reason that they were not forthcoming or could not discuss it in a productive manner. Pa Houa, married at 15 said:

My mom would yell about it, not talk about it, but yell about it... every now and then you would hear her lecture one of us and that's the only time she would talk about it. It's just uncomfortable. It's just my mom, me. I'd rather have discussed it with somebody at school you know, because it's so different coming from her.

Mee who became a mother at age 17 recalled, "She [mom] didn't really talk about it too much, she was really uncomfortable talking about stuff like that except for making fun of us or teasing us, but it wasn't like educational or anything, not like how my father was."

Applicability—Some of the adolescents perceived that their parents thought that sexual information was not applicable to their daughters. Timing seemed relevant, as some daughters thought their parents viewed them as being too young for the information. Yia, married at age 13 shared, "...my parents didn't talk to me about sex because they felt that I was too young and that I wouldn't get married anytime soon. ... they must have felt I wasn't ready to know any of that stuff yet." Dawb, a seventeen-year-old mother of two revealed, "I think he [Dad] thought I was too young to really think about it. Probably... I wasn't thinking about sex, all I was thinking about was having fun. I wasn't thinking sex. I wasn't into that." Lis (age 16) responded, "I guess they think I'd be the last person on earth gonna be having sex, I guess."

Timing was perceived as influential for Soua, age 19. She shared that the birth of her daughter advanced sexual health discussions with her mom. "We [Mom and daughter] don't discuss what we do but she's just like, 'Are you protected? I don't want you to have another baby again. Here's some birth control pills.' Whereas before in my household my mom would never talk about that."

Consequences—Finally, a third of the daughters reported that their parents believed sexual health conversations would lead to unfortunate consequences for the youth. Sixteen-year-old Cha, a mother of one, shared, "... they [parents] don't want me to learn. They think if they talk about it, that I'm gonna go out and have sex or they think... I don't know. They don't think I need to know."

Not being romantically involved or sexually active was also cited as an attribute of a good daughter. Bao, a 19 year old mother of three said, “They [parents] don’t want you to know men very well soon. They don’t want you to run around with guys right away. They want you to be a good daughter, so they don’t tell you these things yet.”

Discussion

Previous research reports that parent-adolescent communication about sexual health promotes healthy adolescent sexuality. Parents have indicated that such discussions are often challenging due to discomfort and lack of knowledge (Guilamo-Ramos, et al., 2006; Jaccard, et al. 2000). Acculturation and past trauma of immigrant families can further estrange parents and adolescents contributing to infrequent conversations about limited sexual health topics. Historical and cultural circumstances position Hmong families to be less likely than non-immigrant families to initiate parent-adolescent sexual health discussions. This study is the first to examine Hmong parent-adolescent sexual health communication and its obstacles; thus these findings primarily are discussed in regards to their contributions to future research.

Who is talking

The majority of the respondents shared that sexual health was not discussed in their parents’ home. Indeed, these conversations occurred for only one-third of youth. This infrequency is comparable to a previous study of Asian Pacific Islanders (e.g., 22%; Chung, et al. 2007). However, it is important to note that of the third who recalled such conversations, most daughters received very limited or inaccurate information.

The youth recalled mothers as the more typical source of information. This is in keeping with previous research on other racial and ethnic groups (Graber, et al. 2010; Hutchinson and Montgomery 2007). Earlier sexual health research on the Hmong (Spring, 2001) also indicates that traditional Hmong culture does not promote sexual health conversations between fathers and their daughters. Nonetheless fathers were noted to be involved in such conversations. Daughters remembered fathers as collaborating with mothers, and seldom as sole informants.

These discrepant findings may reflect a generational difference in the participants of the two studies. Spring (2001) focused on the experience of older Hmong women with an average age of 30 compared to the youth of this study. Father involvement may reflect a greater degree of acculturation for the younger cohort. The retrospective findings of the studies may also be influenced by the age of the participant. The adolescent experience of the youth participating in this study is much more current than that of the older women. More research beyond these two studies is necessary to clarify this discrepancy.

Content

For the respondents who had conversations about sexual health, the information was most often scientifically inaccurate and/or very limited with culture oft cited as the reason. Traditional Hmong culture construes words such as “intercourse” or “penis” as very impolite, coarse, too direct, and embarrassing for both speaker and listener. People who use these words are thought to be immature and naïve (Spring 2001; Spring and Lochungvu 2003). Yet the use of culturally-appropriate vocabulary and metaphors can obscure the meaning for more Americanized teens, who often view traditional approaches as immature and inapt. When Chia’s parents used terms such as “hot dog” in their conversations, she conveyed feeling disrespected by her parents – “... talked to you as like their children.”

From the adolescent's perspective, the traditionally appropriate phrasing used in sexual health conversations appears to jeopardize the quality of the parent-adolescent relationship.

The youth also spoke about parents' use of euphemisms and metaphors when discussing sexual health. In some cases parents appeared to use inaccurate information as a fear appeal to promote healthy sexual behaviour, particularly abstinence. Zoua clearly believed that holding hands could cause pregnancy and was afraid of the consequences shared by her mother until her husband told her otherwise. Zoua expressed shame as a result of her mother's inaccurate information, which she interpreted as lying.

The youths' reactions to their parents' traditional approaches to sexual health discussions are comparable to those reported in an observational study by Affifi and her colleagues (2008). These earlier findings revealed that adolescents typically respond to fear appeals (even those with accurate information) with sarcasm or impressions that the parents were being condescending. Although parents may mean well, it appears that providing such information actually erodes the parent-adolescent relationship.

The conversations identified by the teens allude to challenges that might arise in attempting to develop a quantitative measure that captures the depth and breadth of parent-adolescent sexual health conversations – particularly for Hmong female adolescents. The Parent-Teen Sexual Risk Communication Scale [PTSR-III], one of the few tested scales for parent-adolescent communication about sexual health, asks teens, "Between the ages of 10 to 18, how much information did your mother /father give you about"(a specific topic area; Hutchinson 2007; Hutchinson and Montgomery 2007). Such measures fail to account for the accuracy of the information received in that topic area. Indeed some of our study's respondents heard quite a bit about pregnancy, for example, but the limitations of accuracy would remain undetected by current survey measures.

Barriers

Daughters viewed parental knowledge as an important factor of the limited or inaccurate information shared by their parents. This viewpoint echoes the results of a 2002 survey of 192 Hmong parents of adolescents. Here less than half of the parents agreed that "Hmong parents have the knowledge to educate their teens about sexual health" (Meschke 2003). Others studies have reported that Hmong who have not been exposed to Western education have limited scientific knowledge of sexuality and reproduction (Spring 2001; Spring and Lochungvu 2003). Indeed the daughters perceived the lack of sexual health conversations as an intergenerational issue. Parents who received limited or no sexual health education as youth might be encouraged by their experience to believe that their children will be healthy without discussing this topic.

Culture in relation to parental knowledge, attitudes, and language expression in the arena of sexual health also hindered related discussions. Current culturally appropriate sexual health programs do not target the parent-adolescent dyad. These include family planning videotapes for married Hmong (Spring and Deinard 1992) and a Hmong specific sexual health curriculum for early adolescents (Meschke 2003). Future intervention efforts should explore the development of non-threatening and culturally appropriate strategies to support sexual health discussions in Hmong families. For example, multimedia materials may be beneficial in modelling discussions, vocabulary, or sexual health material of parents and their adolescents. More data, particularly from the parents, will be necessary to more clearly formulate this undertaking.

Daughters also inferred that parents thought sexual health conversations might encourage their daughters to be sexually active or was not proper information for a "good daughter". In

exploring the concept of “good adolescent” in the Hmong community, Xiong and his colleagues (2005) reported that both parents and youth identified the attributes of obeying and respecting parents, staying home and not going out, dressing appropriately, and being polite and modest. Through the lens of Hmong culture adolescent engagement in sexual behaviour is less than congruent with these criteria. The parents’ tendency to stress abstinence in their sexual health messages is in keeping with the promotion of a “good adolescent.”

The daughters’ mention of parental discomfort (Kirkman, Rosenthal and Feldman 2005) and fear of consequences for youth (Miller, et al. 1998) are comparable to previous research with non-Hmong families. The parents’ discomfort and fear may reflect the ever increasing pool of sexual health information and its heightened importance. The discomfort of parents in immigrant families may be enhanced by adolescent culture and the acculturation disparity, making parent feel more alienated and less at ease in sharing what knowledge they have with their children. To better understand these dynamics, future studies of immigrant families should incorporate parents’ views of sexual health education in their families.

Based on these findings and the interweaving of culture throughout all the barriers discussed, the Hmong community is likely to benefit from a culturally appropriate adolescent sexual health promotion efforts with a parent component. Such a program could include information to debunk the myth that sexual education leads to sexual risk-taking and provide assistance in creating culturally appropriate explanations for important topics such as puberty, pregnancy, and STIs that may otherwise be taboo. The strategies should equip parents with scientifically-based information about sexuality and reproduction with a vocabulary that is accurate and comfortable to them and non-offensive to both parents and their adolescents. Indeed, youth who perceived their parents as communicating competently have been more receptive to the conversation (Afifi, et al. 2008).

Limitations

The results of this study are based on the semi-structured interviews of 44 pregnant and parenting Hmong adolescents. These data initially were collected to contribute to a needs assessment of Hmong teen pregnancy. Hence, as with any secondary data, sampling, design, and the ideal probes for further elaboration on the topic of interest were less than ideal.

In 2000 11.7% of Hmong teens (15-19 years) gave birth in Ramsey County, Minnesota – the highest rate of any racial or ethnic group (Meschke, 2003). In response to these high birth rates, these interviews were designed to provide insight into the experiences of pregnant and parenting Hmong adolescent females. Yet the selection criteria for the sample also limits its representativeness. Based on the restricted sample and the use of qualitative data, the results cannot be generalized to the Hmong or the greater immigrant population.

This study is retrospective and the respondents were not asked to share when the actual conversation about sexual health occurred. Because the respondents ranged from 14 to 20 years in age, they may be reporting on events that occurred five to ten years ago. On the other hand, the young teens, although parents or soon to be parents when interviewed, still had many years of adolescence ahead of them, and thus conversations with their parents have been forthcoming. As Souza shared, her mother didn’t discuss sexual health with her until after the birth of first baby.

In general it is not certain if the teens are more likely to under- or over-report the sexual health information that they received in their family’s home. Parents were not interviewed to confirm or dispute the information shared, however with an interest in examining parent-adolescent sexuality discussions its potential influence on adolescent sexual health

behaviours, the voice of the adolescents seems most relevant. Future studies would ideally address all participants in family sexual health conversations.

Finally, causality between communication and adolescent sexual health cannot be determined because of the cross-sectional nature of the data. Although previous literature indicates that parent-adolescent communication about sexual health promotes healthy sexual behaviour for teens, these data do not test this hypothesis. The data serve to enhance our understanding of the phenomenon of these conversations and associated barriers in the context of immigrant families – specifically as reported by pregnant or parenting Hmong teen daughters.

Summary

Parent-adolescent communication about sexual health issues is an infrequent occurrence in the Hmong community. Pregnant and parenting adolescent daughters recall when information is shared, it is often inaccurate and very little detail is provided. Fear appeals often are incorporated in the information, including exaggerated or inaccurate effects of STIs and threats of abandonment if the daughter becomes pregnant. Comparable to previous studies of non-immigrant families, parental knowledge, discomfort, and fear were all cited as challenges to sexual health discussions, however the daughters couched each of these areas in the context of the Hmong culture. Given the severity of consequences associated with unprotected sexual behaviour, these interviews identify significant opportunities to expand the sexual health education opportunities of Hmong youth. These findings should provide a helpful backdrop for practitioners who intend to promote effective and culturally competent sex education for this community.

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References

- Afifi TD, Joseph A, Aldeis D. Why can't we just talk about it? An observational study of parents' and adolescents' conversations about sex. *Journal of Adolescent Research*. 2008; 23:689–721.
- Bandura A. Social cognitive theory. *Annals of Child Development*. 1989; 6:1–60.
- Buki LP, Ma T, Strom RD, Strom SK. Chinese immigrant mothers of adolescents: Self-perceptions of acculturation effects on parenting. *Cultural Diversity and Ethnic Minority Psychology*. 2003; 9:127–140. [PubMed: 12760325]
- Bussey K, Bandura A. Social cognitive theory of gender development and differentiation. *Psychological Review*. 1999; 106:676–713. [PubMed: 10560326]
- Cha E, Kim KH, Patrick TE. Predictors of intention to practice safer sex among Korean college students. *Archives of Sexual Behavior*. 2008; 37:641–651. [PubMed: 17680355]
- Chung PJ, Travis R, Kilpatrick SD, Elliott MN, Lui C, Khandwala SB, Dancel TM, Vollandt L, Schuster MA. Acculturation and parent-adolescent communication about sex in Filipino-American families: A community participatory research study. *Journal of Adolescent Health*. 2007; 40:543–550. [PubMed: 17531761]
- Dinh KT, Nguyen HH. The effects of acculturative variables on Asian American parent-child relationships. *Journal of Social and Personal Relationships*. 2006; 23:407–426.
- Dinh KT, Sarason BR, Sarason IG. Parent-child relationships in Vietnamese immigrant families. *Journal of Family Psychology*. 1994; 8:471–488.

- Dittus PJ, Jaccard J, Gordon VV. The impact of African American fathers on adolescent sexual behaviour. *Journal of Youth and Adolescence*. 1997; 26:445–465.
- Dutra R, Miller KS, Forehand R. The process and content of sexual communication with adolescents in two-parent families: Associations with sexual risk-taking behaviour. *AIDS and Behavior*. 1999; 3:59–66.
- Farver JA, Narang SK, Bhada BR. Acculturation and psychological functioning in Asian Indian adolescents. *Social Development*. 2002; 11:11–28.
- Fisher TD. A comparison of various measures of family sexual communication: Psychometric properties, validity, and behavioural correlates. *Journal of Sex Research*. 1993; 30:229–238.
- Fox GL, Inazu JK. Patterns and outcomes of mother-daughter communication about sexuality. *Journal of Social Issues*. 1980; 36:7–29.
- Graber JA, Nichols TR, Brooks-Gunn J. Putting pubertal timing in developmental context: Implications for prevention. *Developmental Psychobiology*. 2010; 52:254–262. J. [PubMed: 20196112]
- Guilamo V, Dittus P, Jaccard J, Goldberg V, Casillas E, Bouris A. The content and process of mother-adolescent communication about sex in Latino families. *Social Work Research*. 2006; 30:169–181.
- Hmong National Development, Inc.. the Hmong Cultural Resource Center. Hmong 2000 Census publication: Data and analysis. Hmong National Development, Inc.; Washington, DC: 2004. <http://hmongstudies.org/2000HmongCensusPublication.pdf>
- Hutchinson MK. The parent-teen sexual risk communication scale (PTSRC-III): Instrument development and psychometrics. *Nursing Research*. 2007; 56:1–8. [PubMed: 17179868]
- Hutchinson MK, Montgomery AJ. Parent communication and sexual risk among African Americans. *Western Journal of Nursing Research*. 2007; 29:691–707. [PubMed: 17563402]
- Hutchinson MK, Cooney TM. Patterns of parent-teen sexual risk communication: Implications for intervention. *Family Relations*. 1998; 47:185–194.
- Jaccard J, Dittus PJ, Gordon VV. Maternal correlates of adolescent sexual and contraceptive behaviour. *Family Planning and Perspectives*. 1996; 28:159–165. 185.
- Jaccard J, Dittus PJ, Gordon VV. Parent-adolescent congruency in reports of adolescent sexual behaviour and in communications about sexual behaviour. *Child Development*. 1998; 69:247–261. [PubMed: 9499570]
- Jaccard J, Dittus PJ, Gordon VV. Parent-teen communication about premarital sex: Factors associated with the extent of communication. *Journal of Adolescent Research*. 2000; 15:187–202.
- Johnson SK. Hmong health beliefs and experiences in the Western health care system. *Journal of Transcultural Nursing*. 2002; 13:126–132. [PubMed: 11951715]
- Karofsky P, Zeng L, Korsorok M. Relationship between adolescent-parental communication and initiation of first intercourse by adolescents. *Journal of Adolescent Health*. 2000; 28:41–45. L. [PubMed: 11137905]
- Kirkman M, Rosenthal D, Feldman SS. Being open with your mouth shut: The meaning of openness' in family communication about sexuality. *Sex Education*. 2005; 5:49–66.
- Lay CH, Safdar FS. Daily hassles and distress among college students in relation to immigrant and minority status. *Current Psychology: Developmental, Learning, Personality, Social*. 2003; 22:3–22.
- Leland NL, Barth RP. Characteristics of adolescents who have attempted to avoid HIV and who have communicated with parents about sex. *Journal of Adolescent Research*. 1993; 8:58–76.
- McDermott Sales J, Milhausen RR, Wingood GM, DiClemente RJ, Salazar LF, Crosby RA. Validation of parent-adolescent communication scale for use in STI/HIV prevention interventions. *Health Education and Behavior*. 2008; 35:332–345. R. A. [PubMed: 17200099]
- McInnis K. Ethnic Sensitive Work with Hmong Refugee Children. *Child Welfare*. 1991; 70:571–580. [PubMed: 1935334]
- McKee MD, O'Sullivan LF, Weber CM. Perspectives on confidential care for adolescent girls. *Annals of Family Medicine*. 2006; 4:519–526. [PubMed: 17148630]

- McNeely C, Shew ML, Beuhring T, Sieving R, Miller BC, Blum RW. Mothers' influence on the timing of first sex among 14- and 15-year olds. *Journal of Adolescent Medicine*. 2002; 31:256–265.
- Meschke, LL. Hmong Pregnancy Planning Grant. Lao Family Community of Minnesota; St. Paul, MN: 2003. <http://www.laofamily.org/pregnancyreport/FINALREPORT.pdf>
- Meschke LL, Bartholomae S, Zentall S. Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Family Relations*. 2000; 49:143–154.
- Miller KS, Kotchick BA, Dorsey S, Forehand R, Ham AY. Family communication about sex: What are parents saying and are their adolescents listening? *Family Planning Perspectives*. 1998; 30:218–222. [PubMed: 9782044]
- Miller KS, Forehand R, Kotchik BA. Adolescent sexual behaviour in two ethnic minority samples: The role of family variables. *Journal of Marriage and the Family*. 1999; 61:85–98. B. A.
- Miller PC, Benson B, Galbraith KA. Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review*. 1998; 21:1–38.
- Morse, JM.; Richards, L. Readme first for a user's guide to qualitative methods. Sage Publications; Thousand Oaks, CA: 2002.
- Nyce JM, Hollinshead WH. Southeast Asian Refugees of Rhode Island: Reproductive Beliefs and Practices Among the Hmong. *Rhode Island Medical Journal*. 1984; 67:361–365. [PubMed: 6592713]
- Orgocka A. Perceptions of communication and education about sexuality among Muslim immigrant girls in the U.S. *Sex Education*. 2004; 4:255–271.
- Qin DB. "Our child doesn't talk to us anymore": Alienation in immigrant Chinese families. *Anthropology and Education Quarterly*. 2006; 37:162–179.
- Reeves, TJ.; Bennett, CE. We the people: Asians in the United States. Census 2000 Special Reports. U.S. Census Bureau; Washington, DC: 2004. <http://www.census.gov/prod/2004pubs/censr-17.pdf>
- Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, Udry JR. Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*. 1997; 278:823–832. [PubMed: 9293990]
- Rice, PL. Hmong women and reproduction. Greenwood Publishing Group, Inc.; Westport, CT: 2000.
- Robinson BE, Freske P, Scheltema K, Heu HLCY. HIV/STI Knowledge, Attitudes, and Risk Behaviors in Hmong-American Adolescents: An Unstudied Population. *Journal of Sex Education and Therapy*. 1999; 24:37–46.
- Rosenthal D, Feldman SS. The importance of importance: Adolescents' perceptions of parental communication about sexuality. *Journal of Adolescence*. 1999; 22:835–852. [PubMed: 10579894]
- Rosenthal DA, Feldman SS, Edwards D. Mum's the word: Mothers' perspectives on communication about sexuality with adolescents. *Journal of Adolescence*. 1998; 21:727–743. [PubMed: 9971729]
- Sam, DL.; Oppedal, B. Acculturation as a developmental pathway. In: Lonner, WJ.; Dinnel, DL.; Hayes, SA.; Sattler, DN., editors. *Online Readings in Psychology and Culture*. 2002. (Unit 8, Chapter 6) <http://www.wvu.edu/~culture>
- Somers CL, Paulson SE. Students' perceptions of parent-adolescent closeness and communication about sexuality: Relations with sexual knowledge, attitudes, and behavior. *Journal of Adolescence*. 2000; 23:629–644. [PubMed: 11073703]
- Spring, MA. Unpublished dissertation. University of Minnesota; Minneapolis, MN: 2001. Reproductive health and fertility of Hmong immigrants in Minnesota.
- Spring, MA.; Lochungvu, M. Controlling Fertility. In: Culhane-Pera, KA.; Vawter, DE.; Xiong, P.; Babbitt, B.; Solberg, MM., editors. *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers*. Minnesota Center for Health Care Ethics and Vanderbilt University Press; 2003. p. 73-79.
- Spring, MA.; Deinard, A. Contraceptive Information for Hmong Couples in America. University of Minnesota; Minneapolis, MN: 1992. Hmong language videotape
- Strauss, AL.; Corbin, JM. Basics of qualitative research: Grounded theory procedures and techniques. Sage Publications; Newbury Park, CA: 1990.

- Tardif CY, Geva E. The link between acculturation disparity and conflict among Chinese Canadian immigrant mother-adolescent dyads. *Journal of Cross-Cultural Psychology*. 2006; 37:191–211.
- U.S. Surgeon General. The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior. U. S. Surgeon General; 2001.
<http://www.surgeongeneral.gov/library/sexualhealth/call.pdf>
- Xiong ZB, Eliason PA, Detzner DF, Cleveland MJ. Southeast Asian immigrants' perceptions of good adolescents and good parents. *The Journal of Psychology*. 2005; 139:159–175. [PubMed: 15844762]
- Young Pistella CL, Bonati FA. Adolescent women's recommendations for enhanced parent-adolescent communication about sexual behavior. *Child and Adolescent Social Work Journal*. 1999; 16:305–315.