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Rompe el Silencio (Break the Silence)—Increasing Sexual Communication in Latina Intergenerational Family Dyads

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HIV interventions have fallen short in significantly decreasing risk for Latino populations. The *Rompe el Silencio* (Break the Silence) cultural assets-based HIV/AIDS prevention program was developed using community-based participatory research methods. Qualitative analyses of focus group data identified salient factors related to sexual behavior and communication. Integration of focus group results with theoretical constructs guided the development of an intervention to reduce risk behaviors by increasing communication within Latino families. Fifty Latina family dyads from Los Angeles County participated in pilot testing of the intervention. Findings indicated significant increases in sexual risk knowledge, frequency of sexual risk communication, and number of sexual risk-related topics discussed. *Rompe el Silencio* represents a female-focused, family-based, and culturally relevant intervention to combat HIV risk within Latino communities.

Las intervenciones para prevenir el VIH/SIDA no han disminuido la prevalencia de infección dentro de la diversa población latina. Rompe el Silencio: *Break the Silence* es un programa de prevención de VIH basado en valores culturales, que se desarrolló con métodos de investigación basados en la participación de la comunidad, en colaboración con promotores de salud. Un análisis cualitativo de los resultados de los grupos de enfoque identificó factores prominentes en relación a patrones de comportamientos y comunicación acerca de riesgos sexuales. La integración de los resultados de los grupos de enfoque, junto con modelos teóricos, guió el desarrollo de una intervención culturalmente congruente para reducir comportamientos de riesgo y aumentar la comunicación en las familias. Cincuenta pares de mujeres de familias latinas del Condado de Los Ángeles, California participaron

en una intervención piloto. Los resultados mostraron un aumento significante en el conocimiento de riesgos sexuales, la frecuencia de comunicación acerca de riesgos sexuales y el número de temas relacionados con sexo riesgoso. Rompe el Silencio es una intervención para combatir el riesgo de contagio del VIH enfocado en mujeres dentro del contexto cultural de familias latinas.

Keywords: HIV/AIDS; prevention; Latino(s)/Hispanic; women; community-based participatory research; youth

Relative to their representation in the U.S. population, Latinos are disproportionately impacted by the HIV/AIDS epidemic. In 2007, Latinos constituted 15% of the U.S. population yet they comprised 19% of the cumulative AIDS cases and 19% of people living with AIDS (Centers for Disease Control and Prevention, 2009). In 2004, the Kaiser Family Foundation estimated that at least half of all new HIV infections occurred among those younger than the age of 25 years, with Latina/Latino adolescents at an especially high risk (Rios, 2005). Compared to non-White adolescents, Latino high school-aged youth have reported a higher prevalence of sexual intercourse (52% vs. 43.7%) and a greater likelihood of having four or more sexual partners. Most Latino adolescents (70%) report having had sex by 12th grade (Eaton et al., 2008) and have been shown to be at greater risk for sex without a condom compared to their African American and White peers (Bartlett, Buck, & Shattell, 2008).

In addition to the socioeconomic causes associated with the disproportionate impact of HIV/AIDS in the U.S. Latino community, culturally driven gender roles, patterns of partner and parent–adolescent communication, and traditional family interactions also play a role in HIV and sexual health risk (Rios-Ellis, 2006). Traditional gender roles include *machismo*, described as having characteristics emphasizing "masculinity" such as male dominance and physical strength, and *marianismo*, characterized by an emphasis on "femininity" such as expressiveness and fostering cooperation (Unger et al., 2006). Sexual prowess, aggression, and overbearing control associated with *machismo* as well as sexual chastity, passiveness, and avoidance of sexual discussions associated with *marianismo* are specific manifestations of these gender roles that have been linked to multiple sexual partners and unprotected sexual behavior (Flores-Ortiz, 2004; Villarruel, Jemmott, Jemmott, & Ronis, 2004).

In addition to creating an imbalance of power in sexual relationships, these traditional gender roles do not support discussion of sensitive topics. An inability to communicate effectively about sexual health risks may increase the chances that girls experience unwelcome sexual pressure, sexual encounters, or unprotected sex (Blythe, Fortenberry, Temkit, Tu, & Orr, 2006). Studies have also shown that Latino parents experience difficulty talking about sexuality and contraception with their children (Galanti, 2003; Moreno, 2007; Sangi-Haghpeykar, Horth, & Poindexter, 2001) or view sexual health as a topic that should not be discussed because of cultural traditions and beliefs. For Latinos, in particular Latina women, *vergüenza*, defined as shame, embarrassment, and lack of knowledge within the context of sexuality (Bourdeau, Thomas, & Long, 2008), can be a major barrier to open communication about sexual matters with family members and sex partners.

Although some aspects of Latino culture may increase risk, other cultural characteristics provide a dynamic that can be harnessed to reduce risk. Examples of such attributes of traditional family interactions include *familismo* and *respeto*, both significant and highly valued in Latino cultures. *Familismo* emphasizes family unity and the degree to which a person experiences family attachment (Jacobs, 2008). *Respeto* is defined as respect for one's elder relatives and persons of authority (Calzada, Fernandez, & Cortes, 2010; Finch & Vega, 2003; Marín & VanOss Marin, 1991; Martinez & Eddy, 2005; Yasui & Dishion, 2007). Within the contexts of *familismo* and *respeto* in the home, Latino parents have the potential to not only positively impact their children's sexual health knowledge and behavior but also to open avenues for dialogue and risk reduction and build trust or *confianza* between parents and their adolescents (Bracero, 1998; Guilamo-Ramos et al., 2006). This can be accomplished through the reinforcement and integration of culturally sanctioned traits within communication patterns.

Parallel findings were demonstrated in a similar pilot study implemented in Chicago and incorporating 34 intergenerational pairs to assess parent communication about sex and its effects on sexual risk taking. Results revealed that African American and Latino parents engaged in fewer conversations about sex with their teens. The pilot findings suggest the importance of family-based interventions in improving parent–adolescent communication regarding sex and risky sexual behavior among Latino adolescents (Wilson & Doneberg, 2004). Research has in fact shown that Latino parents can have a major influence in shaping the sexual attitudes and contraceptive behavior of their adolescent children. Programs that build on Hispanic cultural expectations of parents as family leaders, educators, and authority figures have been found effective in mitigating unsafe sexual behaviors (Bourdeau et al., 2008; Burgess, Dziegielewski, & Green, 2005; East, 1998; Lescano, Brown, Raffaelli, & Lima, 2009;

Prado et al., 2007). *Familismo* and *respeto* may be critical constructs to employ when creating intergenerational HIV interventions targeting Latinos because they may play an important role in influencing communication between family dyads.

Few HIV prevention interventions intended for minority communities focus on the reinforcement of positive cultural characteristics to influence health behavior change. Although the need to draw from positive cultural traits is acknowledged, the deficit approach is still prevalent in intervention strategies (e.g., focusing solely on *machismo*'s aggressive and *marianismo*'s passive elements). Interpreting sexual risk-reduction interventions from a culturally relevant lens would likely benefit from examination of both positive and negative traits and the potential to bolster and optimize prevention efforts through the integration of positive cultural attributes.

Developing effective culturally tailored strategies to reduce sexual risk among Latinas is imperative given the disproportionate impact of HIV on Latinos. The *Rompe el Silencio* (Break the Silence) intervention was therefore developed with important Latino cultural concepts such as *familismo*, *respeto*, and *confianza* as core components. Although other culturally relevant HIV prevention interventions exist such as *Cuídate!* (Villarruel, Jemmott, & Jemmott, 2005; Villarruel, Jemmott, & Jemmott, 2006) targeting Latino youth and *Salud, Educación, Prevención y Autocuidado* (*SEPA*; Peragallo et al., 2005) for Latina adults, both of these focus on improving communication with sexual partners, not within the family. The *Rompe el Silencio* HIV prevention pilot intervention was developed to improve both sexual risk knowledge and communication within the family as well as with sex partners. This article provides an overview of the development, implementation, and pilot results of this program.

Phase I: Formative Assessment for Intervention Development

Aim

The development and delivery of culturally and linguistically appropriate primary HIV prevention services to Latinas requires an understanding of different perceptions, attitudes, and behaviors that are influenced by diverse Latino cultural practices and values (Rios, 2005). Focus groups provide an avenue to examine the nexus of knowledge, behaviors and cultural values, and significant information with regard to a culturally relevant intervention design (Barker & Rich, 1992; Rios-Ellis et al., 2008; Willgerodt, 2003). Thus, the first phase of this study included a formative assessment to identify salient factors related to sexual behavior and communication via focus groups.

Method

Sample and Recruitment

Focus groups were conducted with Latina women and female adolescents, aged 12 and older, in the East Los Angeles region. Latina participants were recruited by *promotoras de salud* (peer health educators) through word of mouth and posting flyers in two community-based organizations in East Los Angeles that provide health services to Latino families.

Procedure

Focus group instruments were developed in Spanish by bilingual research staff and reviewed by a pan-Latino, bilingual/bicultural project group to ensure Spanish language universality and participant comprehension. Any terms that were deemed ambiguous or uncommon to Latinos from one or more countries by Latino staff from Mexico, Central or South America, or the Caribbean were changed or defined for clarity. Materials were then translated to English, and discrepancies noted in the translation process were discussed and vetted until the project team reached agreement. All project materials and procedures were reviewed and approved by the Institutional Review Board of California State University, Long Beach.

To facilitate conversation as well as increase understanding of gender-related and cultural dynamics of sexual risk communication between the intergenerational dyads, focus groups were divided into adolescents aged 12–15 and 16–19, and adult women 20–34, 35–50, and 51 years and older. In an effort to enhance the development of the intervention and garner additional insight specific to the multiple contexts of HIV risk, an additional focus group was held with HIV-infected Latinas aged 40–65. A highly trained bilingual/bicultural focus group moderator presided over all meetings and was assisted by two trained bilingual/bicultural research staff. During the discussions, self-selected aliases were used to protect participant confidentiality.

Focus groups were aimed to glean information from participants regarding (a) perceived HIV risk within the Latino community, (b) differences in male and female roles and their impact on HIV risk, (c) sexual risk communication within the family as well as challenges to open communication, and (d) suggestions for intervention content and administration. Using a standardized semi-structured protocol, participants were asked questions such as "*What are the differences between Latino male and female roles and how do these affect HIV risk?*" "*What were the messages you received about sexuality from your family?*" and "*What difficulties or barriers do parents have when they want to talk with their children about sex?*" Participants were asked to provide recommendations concerning effective HIV prevention methods targeting Latinas and strategies for increasing sexual health communication between

partners and across generations within the Latino family, with particular emphasis on female-centered dialogue.

Data Analyses

Focus group dialogue was transcribed by a bilingual court reporting service and checked for accuracy by bilingual/bicultural staff. Transcriptions were analyzed using a directed content analysis approach (Hsieh & Shannon, 2005) and substantively coded for prominent themes and concepts to guide the development of a thematic categorical matrix by two bilingual project staff. Maintaining an emic approach by describing behaviors and shared cultural perceptions in terms that are meaningful to Latinos and by using constant comparison methods, additional thematic categories emerged during deliberations over key constructs and were added to the matrix used to facilitate final analyses. Memoing or the recording of researchers' thoughts and ideas as they evolve during the data analysis process was also conducted to further define ideas and potential relationships as well as to identify key elements for intervention content (Glaser, 1998). Discrepancies in coding were flagged and debated until the coders reached universal consensus.

Results

Eight 2-hour, age-specific, focus groups were held with 66 Latina adults (n = 43) and adolescents (n = 23; Table 1). The 66 participants in the focus groups ranged in age from 12 to 91 years, with the majority (53%) born in Mexico; a smaller group (10.5%) born in El Salvador, Guatemala, Puerto Rico, or the Dominican Republic; and the remainder born in the United States (36.5%). Approximately half of the U.S.-born participants (18% of total sample) reported that one or both of their parents were born in Mexico. English was the preferred language of communication among the adolescent participants whereas adults were more often Spanish monolingual or maintained a preference for Spanish. The following paragraphs briefly summarize the key findings and provide examples of the salient concepts used to inform intervention development.

TABLE 1. Focus Group Characteristics

Participant Age Group	Focus Group Language(s)	n
12–15	English	4
12–15	Bilingual Spanish/English	10
16–19	English	9
20–35	Predominantly Spanish	7
20–35	Spanish	9
30–35	Spanish	10
51 and older	Spanish	10
35 and older[a]	Spanish	7

[a]HIV-infected group.

Perceived HIV Risk Within the Latino Community

Adolescents. Participants perceived themselves and their communities to be at very low risk for HIV infection. They reported a lack of available prevention information targeting Latinas like themselves who do not fall into high-risk groups such as men who have sex with men (MSM) and injection drug users (IDUs).

Adults. The adult females were invariably worried about their sexual health as well as that of their children and youth in their communities. Furthermore, women perceived their risk as largely controlled by their male partners whose fidelity and willingness to use condoms were out of the female's purview. Participants reported little control over sexual intercourse perceiving sex as a "*deber de la mujer*" (a women's duty) versus her "*querer*" (desire).

HIV-Infected Women. HIV-infected females reported lack of education as the most frequent HIV risk factor. Similar to the other adult group, HIV-infected women emphatically agreed that *machismo* is a risk factor for all women, whether they are married or single. The HIV-infected group also perceived that as women, they are subject to sexual and domestic violence, infidelity, and are treated like sex objects, which exacerbates their risk.

Differences in Male and Female Roles and Their Impact on HIV/AIDS Risk

Adolescents. When asked how the image of women in Latina culture influenced risk, adolescents found two distinct and limiting manifestations of how they were portrayed in society. Although some participants asserted that Latinas were viewed as "*caliente*" (or hot and sexy), others reported being depicted as accepting and submissive. One participant stated, "*I don't want to be seen as invisible, but at the same time, I don't want people to think I am a whore.*" Adolescents agreed that adult Latinas were perceived as dependent homemakers and having to meet the needs of their male partners who "*can do whatever they want.*" Several participants discussed the risk resulting from Latinas' beliefs in the fidelity of their male partners. Adolescents acknowledged the benefits of having a boyfriend both in terms of increasing popularity and self-esteem. Additional comments were made regarding unequal gender role expectations in their relationships and concluded that women's economic dependence on their male partners, combined with low cultural expectations of male fidelity, raised the potential of HIV risk.

Adults. Latina adults discussed cultural expectations in terms of having to *aguantar* or "put up with" male

infidelity, *machismo*, and reluctance to use condoms. Similar to the adolescents, Latina adults reported economic dependence on their male partners and struggling to survive as circumscribing their ability to leverage, demand fidelity, and negotiate safer sex.

HIV-Infected Women. The HIV-infected adults emphasized that the nexus of cultural expectations and tolerance of Latino infidelity and maltreatment had put them at risk for HIV. Most agreed that males do not protect themselves and are careless about their sexual involvement. HIV-infected women who were infected by their partners agreed that males did not disclose their status voluntarily. They also believed that women are at increased risk for HIV because of male penetration and female reproductive anatomy.

How Families Communicate About Sex and Challenges to Communication

Adolescents. Only 7 of the 23 adolescents had discussed sex with their parents, whereas others reported their parents perceiving sex education as something that is handled in the school setting and is limited to biological explanations related to pregnancy and childbearing. Youth reported receiving vague and general warnings, such as "*Be careful*," "*Don't get pregnant*," or "*Don't do it*," but no specific information as to how to delay sex or avoid an unplanned pregnancy. Adolescents said their parents gave mixed messages regarding sex, promoting negative perceptions about sexuality and double standards supporting traditional gender norms. These resulted in the fear that merely asking their mothers about sex would result in the mother's perception of her daughter's sexual activity. Further, youth did not perceive their parents as knowledgeable enough to provide credible and needed sexual risk-related information. Additionally, to initiate a conversation about sex with one's parents would risk "*vergüenza*" or embarrassment on behalf of both parent and adolescent. Participants also stated that they wished their parents would trust and understand them, be more open-minded, listen to and support them, and not expect that they are learning everything they need to know about sexual health in school.

Adults. Women discussed difficulties engaging in clear sexual communication with their partners and children and felt ill-prepared to initiate and provide risk-reduction education. They reported low efficacy and substantial barriers (e.g., lack of HIV knowledge, jeopardizing relationships) to initiating HIV risk–reduction communication. Some women used sexual-based fear tactics with their children for lack of better sexual communication skills. One participant stated that she tells her son "*If you have sex with too many women, your penis will fall off*" to deter him from sexual activity. They also spoke of the restrictions placed on them because of their need to conform to religious expectations regarding both fertility and condom use.

HIV-Infected Women. HIV-infected adults reported never having received information from their parents about sex. They also agreed that a challenge to accurate communication is knowledge about the topic and that parents are not comfortable speaking with their children. One participant's older son questioned her as to why she had given him the wrong information, and her response was "*I didn't get any information*." When communicating with partners, HIV-infected women said that although they did wonder about infidelity during their relationships, they didn't question their partner's previous sexual history. HIV-infected women found it very difficult to tell their children about their HIV status, especially if their children were young.

Intervention Recommendations

Adolescents. Adolescents wanted to learn more about condoms, sexually transmitted infections (STIs), and increasing self-esteem and confidence. They requested activities to help build their parents' sex education confidence levels to enable parents to initiate sexual health-related dialogue. Youth suggested small classes to encourage interaction and questions, gender-specific classes, educating girls within middle school "*before it's too late*," and the promotion of family classes to challenge traditional taboos related to sexual communication. Although a strong recommendation was made for family classes, particularly with relatives of the same gender, adolescents suggested separating mothers and daughters for certain parts of the intervention for fear of maternal reactions before bringing both generations together so as to hear "both points of view."

Adults. Given the multiple time demands on Latinas' daily lives, recommendations focused more on practical logistics that enable participation rather than on the content of the intervention. Adults suggested that youth-specific interventions target younger aged adolescents. Some adults reported that it was easier to speak about sex with very young children because they did not have to be as explicit, implying that they had neither the communication skills nor the knowledge necessary to prepare their adolescent girls for eventual risks.

HIV-Infected Women. Three women suggested testimonials with families. One participant emphasized that when people see it on paper, they don't feel it, and that experiencing HIV vicariously through an HIV-infected individual would help increase attention. Another suggested educating fathers and then mothers in that order to promote the transference of correct information. HIV-infected participants also recommended working within religious settings to access women who are very tied to their religion, in addition to involving religious leaders.

Take Home Messages

All groups preferred the program be conducted in a small group format and welcomed the opportunity to participate in a family-based intervention that would

incorporate multiple generations. Even though HIV-infected women suggested working within churches, they discussed the need for a "safe space" wherein they could openly talk about sex without fearing retribution or the need to conform to cultural or religious expectations. Adults requested Spanish language sex education classes that incorporated condom use. Adolescents and adults recognized the importance of sexuality and sexual health and wished that they could increase their ability to communicate effectively without embarrassment. Whereas youth asked that their parents' trust, listen, and understand them, adults asked for their children's respect and patience.

The focus group findings were integrated with the results of a previous qualitative national needs assessment of Latinas and HIV/AIDS (Rios-Ellis, 2006; Rios-Ellis et al., 2008) and used to develop a theory-based (Cristancho, Garces, Peters, & Mueller, 2008; Karliner, Edmonds Crewe, Pacheco, & Cruz-Gonzalez, 1998; Martyn et al., 2009; Rhodes & Malotte, 1996) pilot intervention for Latina intergenerational dyads.

Phase II: Implementation and Pilot Results

Aim

The pilot intervention, *Rompe el Silencio*, incorporated an intergenerational approach to increase HIV/AIDS family-based communication among Latina adult and adolescent dyads ages 12 years and older, address cultural perceptions of gender-specific control of the contexts of HIV risk, and reinforce potential cultural traits that could enhance protective behaviors and sexual risk communication. Integral to the intervention were joint group discussions and activities to facilitate interfamilial sexual health-related communication in the dyads and promote mutual support for risk reduction efforts. The intervention was pilot tested with Latina family dyads in the Los Angeles County region.

Method

Sample and Recruitment

Participants were recruited in collaboration with three community partners in Los Angeles County that provide bilingual multicultural services to Latino families. Recruitment methods included outreach within each organization's community programs, distribution of flyers and presentations at community events (e.g., health fairs), and word of mouth. Potential participants were screened using the following eligibility criteria: females of Latino/Hispanic origin aged 12 years and older, family dyads consisting of more than one generation, and residents of Los Angeles County. Informed consent was collected for participants aged 18 years or older, and parental consent and assent were collected for adolescents younger than 18 years.

Intervention

The intervention was conducted by bilingual/bicultural facilitators in Spanish and English according to participant preference. Participants were given a $20 gift card for attendance.

Rompe el Silencio is an 8-hour intervention administered in two sessions with an introduction and two educational modules per session. Sessions were held in local schools and community centers with sufficient space for participants to meet as a group and separate intermittently to facilitate generation-specific activities and dialogue. Scheduling and incentives were based on participant feedback. To maximize continuity and minimize attrition, participants were invited to return for the subsequent session within a 2-week period. They were provided with copies of the presentations and activities as well as HIV/AIDS educational brochures targeting Latinas and adolescents. Participants were also given onsite HIV testing and counseling as well as referrals if they chose not to be tested the day of the intervention.

Session 1 addressed values related to sex and sexuality, increasing knowledge and understanding of sexuality, and barriers to and strategies for improving communication about sex in Latino families. This session included active practice through mother–daughter role playing as well as age-differentiated break-out sessions in which youth and adults identified life goals for themselves and their mother/daughter relating to sexuality and reproduction. Session 2 focused on sexual health and risk reduction and incorporated educational modules on HIV incidence in Latinos and among Latina women, reproductive anatomy, infection avenues for HIV/AIDS and STIs, risk reduction strategies (e.g., condom use negotiation, proper condom placement), and sexual assault. Both sessions included small group activities, discussion, and interactive lectures and ended with a short debriefing discussion. Activities and discussion topics were designed to encourage communication, facilitate dialogue regarding sexual health between the family dyads and intergenerational groups, and promote mutual support for risk reduction. Activities were aimed to increase knowledge and provide participants with general sexual health education.

Procedure

Data were collected using self-administered surveys at pre-intervention and immediate postintervention. Bilingual/bicultural research assistants gauged participant literacy level throughout the consent and assent processes through

dialogue and offered to verbally administer the survey when needed. Consent and assent forms were separated from the surveys. When assistance was required, surveys were administered in private offices. A bilingual interviewer conducted a follow-up telephone survey approximately 1 month following the intervention.

Measures

Because of the unique needs of the study population and intervention content, measures were modified and developed specifically for the *Rompe el Silencio* intervention. To maintain comparability, items needed to be relevant and understandable for both adults and adolescents. Additionally, because of constraints of the setting, brevity of the survey was important; therefore, items were chosen to evaluate the specific content of the intervention with the fewest items possible.

Knowledge. Measurement of HIV risk (e.g., multiple partners), transmission (e.g., bodily fluid), prevention (e.g., condom use) and testing (e.g., blood tests) knowledge was conducted using seven true/false and three multiple-choice items on the preintervention and postintervention surveys. True/false items were selected from the HIV-Knowledge Questionnaire (HIV-K-Q; Carey, Morrison-Beedy, & Johnson, 1997), a valid (convergent and discriminant validity) and reliable (internally consistent and stable) instrument appropriate for use with low-literacy adults. The three multiple-choice items covered additional topics that were asked by multiple items on the HIV-K-Q; we used the multiple-choice format to combine items and, thus, shorten the number of items on the survey. The items were chosen for their relevance to the intervention topics.

Communication. Sexual communication between family dyad members was assessed via one question at preintervention and at 1 month following the survey. Respondents were asked to estimate the number of times in the previous month they had talked about sex with their co-peer study participant (respectively, mother/aunt or daughter(s)/niece). Although more extensive HIV-related communication scales are available, we chose a single item approach, which has been used previously (Holtzman & Rubinson, 1995) to keep the survey brief.

Comfort With Communication. Although measures exist to measure HIV communication, our specific assessment focused on *comfort* with these communications. Therefore, the scale items to measure comfort level with HIV-related communication were created using information gleaned from focus group data to develop relevant and appropriate items. All three surveys contained four questions addressing sexual communication comfort level whether or not the person feels comfortable when talking about sex to (a) family and/or (b) partner (if applicable) and whether there are certain sexual risk topics that cannot be discussed with their intervention partner (c) family and/or (d) partner (if applicable). Items included a five-point Likert scale ranging from "*totally disagree*" (1) to "*totally agree*" (5). The average of these four responses was used as the outcome score.

Intervention Feedback. Using a five-point scale, participants reported level of agreement with statements rating intervention content. Evaluation included changes in knowledge, intentions to test for HIV, and interest and helpfulness of material, discussions, and activities. Percentage agreements on individual feedback items are presented.

Data Analyses

One-tailed *t* tests were conducted in both groups (independent *t* test) and within dyads (paired *t* test) to assess changes in HIV knowledge and frequency of communication. One-tailed paired *t* tests for adults and separately for adolescents comparing pretest scores with the follow-up scores were conducted. Descriptive analyses provided feedback regarding intervention content. Analyses were limited to those who completed both the preintervention and postintervention surveys (adults, $n = 44$ and adolescents, $n = 49$), unless otherwise noted. Data were collected using self-administered participant surveys at preintervention and immediate postintervention. A bilingual interviewer conducted a follow-up survey approximately 1 month after the intervention. New arrivals to the second session of the intervention also completed a preintervention survey prior to participation.

Results

Four groups of family dyads participated in the pilot intervention for a total of 50 family dyads consisting of 50 adult and 56 adolescent participants ($n = 106$). All of the dyads were composed of a mother with one or more daughter(s). A small number ($n = 3$) also included a niece. Other female relatives were permitted to participate based on the importance of the extended family within Latino culture. Session attendance varied and comprised 34 adults and 41 adolescents in both sessions (68% and 73.2%, respectively), 6 adults and 7 youth did not return for the second session (12% and 12.5%, respectively), and 10 adults and 8 adolescents attended the second session (20% and 14.3%, respectively) only.

As presented in Table 2, the mean ages were 40.7 years for adults and 14.8 years for adolescents. Most adults (97.7%) were born in Mexico, whereas most adolescents (87.8%) were born in the United States. Among foreign-born participants, the mean lengths of time in the United States were 18.9 years for adults and 15.3 years for adolescents.

TABLE 2. Intervention Participant Characteristics

Demographic Characteristics	Adults, $n = 44$ *n (%)*	Adolescents, $n = 49$ *n (%)*
Age[a]	40.70 (5.03)	14.76 (1.99)
Range	32–56 years	12–20 years
Birth place		
United States	0	43 (87.8%)
Mexico	43 (97.7%)	6 (12.2%)
El Salvador	1 (2.3%)	0
Range of years in United States	1–35	12–17
Length of time in Unites States[a]	18.86 (7.06)	15.25 (2.36)
Languages spoken		
English only	1 (2.3%)	1 (2.0%)
Spanish only	36 (81.8%)	1 (2.0%)
Both English and Spanish	7 (15.9%)	47 (95.9%)
Language "most comfortable" speaking		
English	1 (2.3%)	17 (34.7%)
Spanish	41 (93.2%)	3 (6.1%)
Both English and Spanish	2 (4.5%)	29 (59.2%)

[a]mean (*SD*).

Significant increases (see Table 3) in correct responses given for knowledge questions were observed for both adults ($t = 7.66$, $p < .0001$) and adolescents ($t = 7.56$, $p < .0001$). A significant difference in HIV/AIDS-related knowledge within the generational dyads was also observed on the posttest ($t = 4.10$, $p < .0001$) wherein adolescent females ($M = 0.818$) scored below their older counterparts ($M = 0.895$). These results indicate that the intervention was successful in increasing HIV-related knowledge, but that activities to bolster knowledge retention among youth participants may be needed. Significant increases in the reported number of conversations were also observed in both groups (adults: $t = 4.00$, $p < .0001$, adolescents: $t = 2.78$, $p = .004$). The number of sexually-related topics reported by adults having been discussed in the household increased on average from 4.17 at pretest

TABLE 3. Pilot Intervention Findings

Question	Adults $n = 44$[a] t (p value)	Adolescents $n = 49$[a] t (p value)
HIV knowledge: number of correct responses[b]	7.66 (< .0001)	7.56 (< .0001)
Sex-related communication: number of conversations[c]	4.00 (< .0001)	2.78 (.004)
Sex-related communication: number of topics addressed in conversations[c]	4.08 (< .001)	3.78 (< .001)
Sex-related communication comfort level[d]	−5.31 (< .0001)	−1.79 (.076)
Sex-related communication comfort level[e]	−5.19 (< .0001)	−1.54 (.127)

[a]*n* varies for each analysis depending on availability of complete data.
[b]One-tailed paired *t* test comparing reported number of conversations in presurveys and postsurveys.
[c]One-tailed paired *t* test comparing reported number of conversations in presurveys and follow-up surveys.
[d]One-tailed paired *t* test comparing pretest and follow-up average responses for full sample.
[e]One-tailed paired *t* test comparing pretest and follow-up average responses for reduced model that excluded those who did not attend day one.

to 6.70 by follow-up ($t = 4.08$, $p < .001$). Of the 40 youth participants, 23 (57.5%) reported at follow-up that they had talked to their mothers about sex with less restraint when compared to preintervention.

Communication comfort level also increased significantly between pretest and follow-up for the full sample ($t = -5.31$, $p < .0001$) of adult participants and among adults who attended the first day of the intervention when the tools for increasing communication comfort were discussed ($t = -5.19$, $p < .0001$). No changes in communication comfort level were observed in both the full ($t = -1.79$, $p = .076$) and reduced ($t = -1.54$, $p = .127$) samples of adolescents. These results indicate that the intervention was successful in increasing interfamilial communication about sexually related topics. It is unclear whether the lack of significant change in communication comfort level for teens is caused by the short time frame of the measurements, the small sample size, or inability of the intervention to make a significant difference to Latina teens.

Despite the sensitive nature of the material, participants were still highly satisfied with the intervention. Approximately 70% of participants "completely agreed" that they had "learned a lot," found the "information interesting," "materials helpful," "discussions useful," and "activities helpful."

Discussion

Summary

Rompe el Silencio was developed to facilitate culturally relevant HIV prevention and sexual health communication within Latina intergenerational family members. Focus groups were used to glean contextual information and inform intervention development. Second, data were analyzed to identify relevant methods and content for a needs-based, theoretically driven, cultural assets-focused pilot intervention. Third, the intervention was implemented and evaluated using pretest and posttest measures and 30-day follow-up surveys.

Focus group data yielded important contextual information and provided an opportunity to understand salient differences in the lives of Latina adolescents when compared to their adult counterparts. This process also enabled the creation of culturally relevant activities to facilitate female family-based dialogue and social support regarding sexuality and sexual health. Key findings included the importance of examining the origin of sexual values, beliefs, and knowledge. Adolescents reported a lack of available and acceptable communication strategies when attempting to talk with their parents about sex. Moreover, there was a need for adults to develop communication skills and strategies to help both themselves and youth remain protected from sexual risk. Thus, the intervention was designed to engage Latina intergenerational family members in culturally grounded dialogue and activities to increase HIV-related knowledge, personalization of HIV risk, and comfort level and frequency of sexual risk communication among women in immediate and extended families. Because women often initiate dialogue within the home, a secondary purpose was to prompt sexual risk dialogue among all family members.

Evaluation of the intervention indicated that HIV/AIDS knowledge improved for both adolescent and adult participants. Furthermore, an increase in adult comfort with sexual health-related communication within the Latina intergenerational family dyad was sustained at the 1-month follow-up interval, and both groups reported increases in communication with equal initiation of sexual risk and sexuality-related discussions by adults and adolescents.

Dialogue regarding the harmful effects of limited family-based sexual education was enabled by increased understanding of the origin of sexual values and messages through sexual risk communication in a culturally and linguistically relevant manner. Expression of adult and adolescent ideals regarding family-based sexual health communication allowed for greater understanding of the information-related needs of youth as normative sexual development as opposed to an indication of actual sexual behavior. This insight, coupled with a population-specific portrayal of Latina risk, facilitated greater HIV understanding, personalization of risk, and ongoing intergenerational sexual health-related conversations following the intervention.

No significant increases in adolescent communication comfort levels were observed. However, the slight statistical trend suggests that analysis in a larger sample may have reached significance. Another possibility is that the 30 days between baseline and follow-up was insufficient to allow for comfort levels to increase among both generational groups, considering they had been moderately uncommunicative in terms of sexual health and risk for several years. This may have also resulted from the participants' exploration of topics that perhaps were more sensitive in nature than previous discussions, thus decreasing comfort levels. Regardless of a relative lack of comfort, the fact that communication increased and both youth and adults were initiating conversations supports the effectiveness of this intervention.

Limitations

Findings are based on a small, nonrandom, convenience sample of intergenerational Latinas in specific regions of Los Angeles County, limiting generalizability to Latina family dyads of other regions. Furthermore, participants in the intervention do not constitute a representative sample of Latinas at risk for HIV. However, these participants are members of the largest group of U.S. minority women who are affected by high rates of heterosexually transmitted HIV, other STIs, and unplanned teen pregnancies. Further, because of its pilot nature, a nonexperimental design was used rendering an inability to compare results to a control group.

Because of constraints of time and survey length, the knowledge items were abbreviated and modified from the validated version of the HIV-K-Q and only one item was used to assess frequency of communication. Further, because of a lack of validated scales available for the target population that assess comfort with communication, items were created to measure this construct. Although psychometric quality of created items was not evaluated, the fact that item development was informed by focus group data supports the validity and relevance of the measure for this study population. These measurement issues present potential points of weakness for the study; however, the brevity and applicability of the survey also had potential to increase survey completion rates and strengthen validity of answers.

Although the intervention was promoted as a 2-day class with specified dates, some family dyads did not return or were new arrivals for the second session. Latina participants found it difficult to carve out two half-day sessions from other family and work-related priorities. Additionally, several women reported not being able to fully disclose participation to their male partners. At times, this limited the woman's ability to fully experience the intervention and alludes to the need for additional strategies, such as male involvement, as well as increased and graduated incentive structures to bolster complete participation. Providing additional incentives and incorporating male family members into the intervention may have enhanced participation.

Given its pilot nature and the small number of intergenerational female dyad participants, the intervention sample size was insufficient for more sophisticated analyses such as controlling for potentially confounding factors. Because of time limitations in project duration, long-term behavior change outcomes were not measured beyond the 30-day follow-up interview. Longer term follow-up may have revealed information about sustained behavior change. Lastly, the sensitive nature of the topics may have affected self-reported data because of social desirability. However, emphasis on *confianza* and confidentiality throughout the intervention likely ameliorated this issue.

Future Directions

Given the multitude of health risks that Latino immigrants face, interventions could benefit greatly through the employment of community and assets-based cultural strategies as fundamental tenets of such programs (Jacobs, 2008; Moreno, 2007). Furthermore, although participant satisfaction was very high, youth suggested the incorporation of additional elements such as film, theater, or music to pique their interest and appeal to visual learners. The integration of *familismo*, *respeto*, and *confianza* must also provide a way to overcome religious barriers because sexual health communication can be viewed as a key component of family health protection and maintenance integral to Christian-based religious beliefs.

Considering that marriage has been acknowledged as the most influential HIV risk factor in Mexico among women (Hirsch et al., 2007) and that both generations of women agreed on the gravity of risk associated with male infidelity, focusing on both genders is an urgent and essential direction for Latino-specific HIV prevention. Recent research in Los Angeles underscores the lack of difference in lifetime sexual risk between HIV-positive and HIV-negative Latinas, indicating that the traditional high-risk heterosexual profile may not apply to certain Latina groups and that control of their risk lies with their male partners (Rice, Green, Santos, Lester, & Rotheram-Borus, 2010). Although this intervention was specifically designed and funded to serve females exclusively, thus limiting the project's potential to impact all parties within the Latino family, the authors remain cognizant of the need to reinforce *familismo* and to garner the positive potential of protective factors associated with *machismo* through the incorporation of males. Although neither ideal nor condoning infidelity, encouraging male "protection" of female partners and their families through condom use when having sex outside of their primary relationship provides a way to respond to the contexts of risk experienced by many unassuming Latinas at risk for HIV infection. Involving males in the intervention may also enable improved and more consistent attendance because participation could be perceived as a family, versus a female, priority. Because multiple Latinas reported not being able to fully inform male partners of their participation, this may also ameliorate the issue of male partner discomfort with their partner's involvement in female-only interventions.

Future research and sexual health promotion efforts should continue to investigate how to capitalize on factors related to Latino resiliency, such as *familismo* and *respeto*, while including all family members in HIV prevention activities thus promoting *confianza*. Recent work continues to accentuate the need for male involvement in interventions designed to reduce female risk, particularly as female protectiveness was not shown to impact male partner behavior (Lesser, Koniak-Griffin, Huang, Takayanagi, & Cumberland, 2009). Furthermore, an emphasis solely on Latinas may limit the HIV prevention potential of *familismo* and *respeto* because the responsibility is placed solely on the gender that historically and traditionally has had little say in the creation of sexual norms and values. Although facilitating an empowering sexual health environment is an important part of HIV prevention among Latinas, it is essential that we begin to educate and place equal responsibility and expectations on both partners.

Conclusions

The combined approach through formative focus groups and the quantitative evaluation of the intervention provided insight on the desired elements and areas of

emphasis in the intervention as well as its effectiveness. A comparison of the demographic characteristics of each generational group clearly demonstrated the potential for differences in life experience and acculturative processes to affect communication and health behaviors. Whereas the adolescents were born or spent their formative years in the United States, the adult females were raised predominantly in their countries of origin. The ability of Latina immigrant mothers and their daughters to communicate openly about sex and sexual risk is therefore framed from very distinct life experiences, historical frameworks, cultural expectations, and language preferences and abilities.

The application of *familismo* to emphasize the need to increase and enhance mother–daughter communication while incorporating *respeto* and *confianza* to provide a foundation for adolescent–adult dialogue created an opportunity to break the silence that often frames sexually related Latino interfamilial discourse. Focus group data combined with former research (Rios-Ellis et al., 2008) enabled incorporation of contextual risk factors specific to Latinas into the curriculum, including dependence on male partners, *machismo* and *marianismo*, infidelity, traditional gender roles, family expectations, and unprotected sex.

Furthermore, the formative data collection period alluded to the need to find an underlying goal that would be acceptable to both Latina mothers and their daughters. The integration of the messages "wait until you are sure" and "how to know when you are ready" regarding the timing of sexual initiation were salient both for the mother, in regard to her view of sex as a marriage-bound obligation, and her daughter, who attempts to maintain her sexual health while managing U.S. sexual norms, inclusion, and peer expectations. Involving Latino community-based partners and community members was key to ensuring that these prevention efforts both resonated and reflected the contextual experience of HIV risk for Latina Angelinos. Finally, project findings alluded to the importance of the integration of cultural factors associated with resiliency and risk reduction as important strategies for the creation of culturally relevant, assets-based sexual risk-reduction interventions.

Although limited in scope, *Rompe el Silencio* offers a female-centered, family-based framework through which other Latinas of diverse ages can be involved in HIV prevention and sexual health promotion. Given recent findings regarding the similarity of risk factors among HIV-positive and negative Latinas, the lack of overall HIV knowledge, and the homophobia and hidden sexual risk that occurs in communities wherein sexual communication has not been culturally sanctioned, prevention strategies should increase focus on Latino communities nationwide. The emphasis on predetermined "high-risk" behavioral groups does not resonate with Latinas' risk profiles and the need to develop prevention skills and risk-reduction communication strategies within Latino families. This intervention provides what the authors believe is an improved paradigm to combat HIV and sexual risk within the diverse contexts and demands of the everyday lives of Latinas in their respective homes and communities.

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