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Urban American Indian Adolescent Girls: Framing Sexual Risk Behavior

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Abstract

Purpose—American Indian (AI) adolescent girls have higher rates of sexual activity, births and STIs compared to the national average. The purpose of this study was to explore factors that influence urban adolescent AI girls' sexual risk behavior (SRB).

Design—A qualitative study was conducted using grounded theory methodology to reveal factors and processes that influence SRB.

Methods—Talking circles, individual interviews, and event history calendars were used with 20 urban AI 15-19 year old girls to explore influences on their sexual behavior.

Findings—The generated theory, Framing Sexual Risk Behavior, describes both social and structural factors and processes that influenced the girls' sexual behaviors. The theory extends Bronfenbrenner's ecological model by identifying microsystem, mesosystem, and macrosystem influences on sexual behavior, including: Microsystem: Being “Normal,” Native, and Having

Goals; Mesosystem: Networks of Family and Friends, Environmental Influences, and Sex Education; and Macrosystem: Tribal Traditions/History and Federal Policy.

Discussion—Urban AI girls reported similar social and structural influences on SRB as urban adolescents from other racial and ethnic groups. However, differences were noted in the family structure, cultural heritage, and unique history of AIs.

Implications for Practice—This theory can be used in culturally responsive practice with urban AI girls.

American Indian (AI) adolescent girls have higher rates of sexual activity, pregnancy, and STI than the general United States adolescent population (Centers for Disease Control [CDC], 2010; CDC, 2011) and these rates are higher in urban populations (Rutman, Park, Castor, Taulii, & Forquera, 2008). Little is known about American Indian adolescent girls' sexual risk behavior and even less about those living in urban areas. An increased understanding of adolescent sexual risk behavior is needed to effectively address issues of unintended pregnancy, HIV/AIDS, and sexually transmitted infections (STI) in high risk populations, such as American Indians.

Background

Urban AI adolescent girls reported greater sexual risk behaviors, other risk behaviors (e.g. substance use and violence), and pregnancy compared to reservation AIs and other racial groups (CDC, 2010; CDC, 2011; Gruber, DiClemente, & Anderson, 1996; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2009; Rutman et al., 2008). Rutman et al. (2008) concluded that urban AI adolescent girls were at a twofold increased risk for sexual risk behavior as well as for violence at school, drug use, rape, assault, and pregnancy and a threefold increased risk of suicide, feeling unsafe at school, and involvement in fights that required medical care. Similarly, Gruber et al. found that urban-based AIs, particularly girls, were more likely to engage in risk behavior, including substance use, physical violence, and early initiation of sexual behavior, compared to their Black, White, and reservation based AI counterparts.

In addition, of the studies conducted with urban AI adolescents that focus on sexual risk behavior (Aguilera & Plasencia, 2005; Garwick, Rhodes, Peterson-Hickey, & Hellerstedt, 2008; Gruber et al., 1996; Hellerstedt, Peterson-Hickey, Rhodes, & Garwick, 2006; Marsiglia, Nieri, & Stiffman, 2006; Nelson & Tom, 2011; Ramisetty-Mikler & Ebama, 2011; Rutman et al., 2008; Rutman et al., 2012) few were guided by a culturally informed theoretical model. American Indians are not just different racially, but also politically and historically, and this can affect the research perspective (Jackson, 2002; Stubben, 2001). Although multiple theoretical models have been developed for AIs by health researchers, these theories tend to focus on a specific tribe, adult populations, reservation based AIs, and make assumptions about previous life experiences (Kaufman et al., 2007; Lowe, 2002; Walters & Simoni, 2002). This diversity highlights the need for a culturally specific theory to frame research with the urban AI adolescent girl population. The purpose of this grounded theory study was to explore how individual, family, environmental, community, tribal, and national factors and processes influence urban adolescent AI girls' sexual risk behavior.

Theoretical Guide

Glaser's (1978) grounded theory methodology guided this study. In addition, symbolic interactionism and Bronfenbrenner's (1977) ecological model shaped the project design, including the guides for the talking circles, interviews and event history calendars (EHC). Symbolic interactionism (Blumer, 1969; Mead 1934) provided focus on the social interactions of the adolescents in the context of the larger society. Bronfenbrenner's (1977) ecological model facilitated exploration of the AI adolescent girls' sexual risk behavior by examining the social contexts (including the influence of social structures and of the family, tribe, and national policy) of the sexual risk behaviors and interactions of AI adolescent girls.

Method

Sample and Setting

Access for this study was granted by the director of an American Indian health and community center and approval by the University institutional review board. A certificate of confidentiality was obtained from the National Institute of Nursing Research. Twenty 15-19 year old participants were primarily recruited from the AI health and community center located in a large metropolitan area in the Midwestern United States. Participants primarily self referred after seeing flyers posted throughout the center although many were referred from the youth group and by the medical staff. Those living outside of the service area were referred by staff in their own community who received notification about the project from the PI and the staff.

Adolescent girls were eligible to participate in the study if they were: between 15-19 years of age, self-identified as urban AI, had parental permission to participate in the research study (if under the age of 18), and were able to speak, read, and write English. The twenty AI girls in this study ranged in age from 15 to 19 years old; most were full time students, lived with either one or two parents, were eligible for subsidized lunch, and were on Medicaid (See Table 1). Nine of the participants denied any history of sexual activity and 11 reported oral sex, vaginal sex, or both (See Table 2). Participants were able to identify multiple tribal affiliations and reported connections with tribes from across the U.S., with most participants having representation in tribes from the upper Midwest. All participants currently lived in non-reservation areas within a large urban or suburban area.

Data Collection and Recording

Informed consent/assent was received from the participants and the parents of minors participating in the study. Participants were given a gift card to a local store for participating in the initial study and follow up interviews. The girls and their family members were also offered a full meal during the study. Family members and participants were invited to eat and socialize while consent/assent was obtained and prior to data collection beginning. Data collection included completion of demographic information, an event history calendar (EHC), and talking circle or individual interview participation. Prior to beginning the talking

circle or individual interview, adolescents individually completed a demographic form and an EHC in an area that provided privacy and confidentiality.

The EHC is based upon previous life history calendar research with adolescents as well as themes that Martyn and colleagues derived qualitatively (Martyn, 2009; Martyn & Martin, 2003; Martyn, Reifsnider, Barry, Trevino, & Murray, 2006). The EHC helped prepare the adolescent for the talking circles and interviews by providing an opportunity to chronicle their life events over a three year period and reflect on the interaction between life events, relationships, living situation, sexual activity, and other risk behaviors (Martyn & Martin, 2003, Martyn, 2009). The EHC also provides a column for a fourth year so that adolescents can note future goals or plans (See Figure 1). The current study also utilized the EHC to gain valuable historical contextual information from the adolescents that was not revealed in the talking circles or individual interviews.

After completion of the EHC, the girls participated in a talking circle or individual interview that explored the psychosocial and contextual factors that influenced AI adolescent girl sexual behavior. Talking circle and interview questions were developed using Bronfenbrenner's ecological model and symbolic interactionism as a guide. Questions were developed and reviewed by an AI advisor and experienced researcher. After initial approval, the questions were reviewed by the staff at the data collection site for appropriateness and cultural sensitivity. Questions were revised after feedback from the recruitment site (See Table 3).

Initially, talking circles were planned as the primary data collection method. However, based upon the requests of the AI girls in the community, individual interviews were added to respect each individual's right to confidentiality. Talking circles are a traditional method of group communication in AI society that allows all participants to speak and to be heard. This culturally appropriate method of conducting focus groups has been successfully used in other urban and reservation AI research projects (Becker, Affonso, & Blue Horse Beard, 2006; Haozous, Eschiti, Lauderdale, Hill, & Amos, 2010; Hodge, Fredericks, & Rodriguez, 1996; Picou, 2000; Strickland, 1999). During the talking circle, everyone was given the opportunity to talk and share their story. Unlike focus groups, the interaction between participants is not as important as allowing each member to share their personal experience on the topic. In talking circles, each person's voice is equal and each member has equal opportunity to address the question. An object is used during talking circles to show which person currently is given the right to share their story. In this study, a shell was passed from one participant to the next and the person with the shell was the person who had the floor to talk. Once the participant finished speaking, they passed the shell to the next person in the circle.

The talking circles and interviews were audio-recorded. A professional transcriptionist transcribed all the talking circle and interview data, yielding 478 pages of data for analysis. Immediately following the talking circles and interviews, the researcher debriefed with a colleague experienced in the grounded theory method and recorded memos of impressions and observations. In addition, to enhance cultural sensitivity in data analysis, an AI research assistant reviewed the transcripts and offered impressions of influences on sexual risk

behavior that were incorporated into memos. Seventy four pages of memos from the primary author and AI research assistant supplemented the data transcripts.

Data Analysis

The constant comparative method of data analysis was used simultaneously with data collection to enhance validity (Lincoln & Guba, 1985). The EHCs, transcripts, and memos were analyzed using three levels of coding. Open coding of the data (Level I) involved line by line analysis of the EHCs and transcribed data from the talking circles and individual interviews in order to identify processes and contextual factors in the data relevant to urban AI adolescent girls' perceptions of sexual risk behavior (Glaser, 1978). During the research project, these processes/contextual factors or substantive codes were compared with other data, including the memos by the PI and research assistant, and assigned to categories (Level II). The categories were compared to other categories to ensure that they were mutually exclusive (Glaser, 1978). Reduction of the number of categories occurred in order to identify the primary social processes or core variables that explained the social scene (Level III) (Glaser, 1978). Conceptualization of the relationship among the three levels of codes occurred through development of the more theoretical Level III codes (Glaser, 1978; Hutchinson, 1993).

Results

Ten girls participated in three talking circle groups, of those four were sexually active. The other ten participants opted to participate in individual interviews. Recruitment ended when data saturation was reached (Lincoln & Guba, 1985). Eight participants were selected to return for a follow up interview for member checking, clarification, and further exploration of data and for peer validation of the data analysis. The eight participants who returned for follow up interviews were selected because they expressed interest in their initial interview to meet again with the PI and/or the ideas and themes they discussed in the initial meeting resonated with the preliminary research results. Using the methods described above the generated theory, Framing Sexual Risk Behavior, emerged.

Framing Sexual Risk Behavior: A Grounded Theory

Two assumptions underlie the developed grounded theory model. The first assumption is that reciprocal interactions between the systems of the model influence how each urban AI adolescent girl views sexual risk behavior. The second assumption is the form, content, and strength of the processes affecting the urban AI adolescent varies depending on individual factors and environmental surroundings. American Indian girls' sexual risk behavior in this study was most influenced by the groups and organizations in their environment.

In this study, the basic social process (BSP) for the urban AI adolescent girls, regardless of their social, economic, or tribal status, focuses on the exposure to messages about sexual behavior from both social and structural influences. These are positive (discouraging sexual risk behavior) and negative (encouraging sexual behavior) messages that influence how the adolescent reacts to and negotiates her own sexual behavior. In addition, for the urban AI girls in this study the strength and content of the messages they receive effects their

perceptions about sexual risk behavior. The generated theory, Framing Sexual Risk Behavior, emerged and was consistent with Bronfenbrenner's ecological model (See Figure 2).

Microsystem

The urban AI adolescent girl's sexual risk behavior was influenced by her social and structural systems. The microsystem, including long term goals, identification of being a normal teenager, and cultural identity, helped the participants determine who they are and influenced them to abstain from sex, have safe sex, or have unsafe sex.

Being normal—Participants believed that they were normal adolescents who lived lives similar to other urban dwelling adolescents. All the participants had friends who were not AI and most had family members who were not AI. Yet, despite the interracial company the girls kept, they could not see a difference between themselves and adolescents from these other racial and ethnic groups. The girls felt that their day to day lives were no different than others nor were their decisions about sexual behavior. However, although AI adolescents felt normal, they also had a sense of what it meant to be an AI woman. The girls in this study remarked on their intentions to become “strong Native women.” The idea of being strong resonated with many of the girls, particularly those who were not sexually active. These girls in particular spoke of making their people proud by pursuing their goals, particularly finishing college and becoming a role model for other AI youth.

Having goals—The significance of having long term goals emerged from the girls' event history calendars, interviews and talking circles. The girls who specified long term goals reported less risky sexual behaviors and had a clear plan to complete their goals. In addition, the goals of those reporting fewer risk behaviors tended to be more academic.

Girls in this study saw the consequences of sexual risk behavior, particularly early childbearing, as an impediment to achievement of their goals and future success. They were aware of the negative effects early child bearing could have on goals from observing their parents, aunts, sisters, and friends. Some were children of teen parents and as an 18 year old who was not sexually active said, “My mom had me at a young age and it was hard for her to take care of us, not having an education and not having a good job.” She was graduating from high school and had already been accepted into four different colleges. She explained, “I will be like the first on my mom's side to go to college...so I don't want to take the risk of having sex and getting pregnant. I want to finish college.”

Those with future plans felt they were extremely important in how each identified herself. When participants spoke of their goals, they spoke of their life, the meaning of the goals and the rationale for their goals. Even those who had unrealistic goals (e.g., an 18 year old who dropped out of school but had plans to become a nurse and a 17 year old who was actively planning a pregnancy but said she needed to get her life together before having a baby) spoke of their goals as imperative to their life story.

Cultural identity—Cultural identity emerged as a critical component in how participants “defined or described” themselves. This identity formation helped the girls in this study

determine who they were and what they wanted to be. Subsequently, this identity influenced their decisions about sexual behavior. Those who identified strongly with being AI reported less sexual risk behavior than those who were not connected to their culture. The majority of participants stated that they were of mixed racial and ethnic heritage. However, most described being AI as integral to who they were as individuals. A 17 year old participant said, "It's really weird because I feel like really connected to my Native culture but I'm not necessarily a part of it, so I don't know why I feel so connected." Another participant, age 16 said, "I say I'm Native because I think that's basically what I am. I know some languages and some other culture and stuff." Girls felt that their AI heritage was a key part of their identity.

Mesosystem

Six components of the mesosystem were identified by participants as influencing sexual behavior. The mesosystem, particularly family and friends, emerged as powerful influences on the adolescents in this study. Adolescents are aware of the various messages, both positive and negative, from social and structural systems surrounding them. These messages are interpreted by the adolescent in the context of their life and influence their sexual behavior.

Family—Family was an important influence on AI adolescent girls' sexual behavior and knowledge about safe sex. Girls in this study cited the family as the most important influence on their sexual behavior. Three important themes emerged related to family influence: 1) networks of family influences; 2) talking about sex with at least one family member, usually another female; and 3) mixed messages about sexual behavior from different family members, including those who discouraged and those who encouraged sex.

Girls in this study described a network of family members that included mothers, fathers, grandmothers, sisters, aunts, and cousins who influenced their sexual behavior. For example, one 15 year old participant identified her cousins as her primary sources of sexual information, while an 18 year old identified her father and grandmother as people who influenced her decision to abstain from sexual activity. In addition to having a wide network of family members available who influenced sexual behavior, all of the participants in this study reported at least one female family member that they could openly discuss sex with. These family members included mom, aunts, grandmothers, sisters, and cousins.

However, even though girls reported having family members available to discuss sex, they often received mixed messages about sex. Girls in this study were more likely to receive messages discouraging sex from their elders (e.g., grandparents, parents, aunts) and messages encouraging sex from those family members close to their own age (e.g., sisters, cousins). One participant, age 17 said, "I did it because all my sisters were doing it. Now it's just like I have already done it. When I was younger I guess I just wanted to be like my sisters." Overall, girls in this study felt that their family, regardless of the messages they received from them, were highly influential in their sexual behavior.

Friends—In this study, the influence of friends on sexual behavior was most commonly identified after family influence. Three important themes emerged related to friend

influence: 1) friends discourage sexual risk behavior; 2) friends encourage sex; and 3) friends are often family members. Many participants in this study, particularly those who were not sexually active, cited their friends as an important influence for avoiding sexual risk behavior. Having friends who were not engaging in sexual activity helped participants feel comfortable with their own decision to abstain. A 16 year old who was not sexually active stated “my friends don't have sex.”

However, friends also encouraged sexual behaviors. Many girls felt pressure to have sex to fit in with their friends or for acceptance from their partners or boys in school. Multiple participants also reflected on how their decision to initiate sex in early adolescence was shaped by friend influence. An 18 year old with four sexual partners over a three year period stated that friends were a primary influence in her decision to have sex. She said, “I made a lot of bad decisions like who I chose to hang around...I just gave into all the peer pressure when I was younger.”

Finally, although participants identified friends from school and their neighborhood, many of the girls in this study reported considerable overlap between their friendship groups and their family. Many participants identified their sisters and cousins as their friends and therefore the influence of friends and family were not mutually exclusive. This lack of exclusiveness blurs the lines between where the sphere of family influence ends and where the friend influence begins. Therefore, it is important to consider the two in tandem rather than separately.

Neighborhood—In this grounded theory study, neighborhood was noted as an influence on sexual behavior by participants although participants described family and friends as more influential. The majority saw some connection between their sexual behavior and their neighborhood. Those who grew up in “suburban” neighborhoods (e.g., religious communities, neighborhoods deemed “safe” by participants) felt that this influenced them to abstain from sexual activity. Participants residing in “suburban” regions who were sexually active felt that their actions conflicted with the values of their community or neighborhood.

Those who lived in “inner-city” areas (e.g., urban neighborhoods deemed “unsafe” by participants) responded in two distinct ways regarding sexual behavior. One reaction by participants was to follow the normative sexual behaviors of the community to fit in and feel accepted. The second reaction was to ignore common sexual behaviors and make decisions based upon a desire to exit the neighborhood and lifestyle. When girls accepted the neighborhood's values as their own, the girls felt that they were part of the neighborhood and therefore protected. Those who chose to ignore the normative behavior of others in their neighborhood used their desire for better opportunities as their reason to abstain from sex or have safe sex. Many participants pointed to their siblings and cousins who had babies as teenagers and were now “stuck” in their neighborhood. One participant, age 17 said, “I don't want to live in the hood and all that...my sisters are stuck there because they had babies. That isn't gonna happen to me.”

School—School emerged as an influence similar to that of the neighborhood. Three major themes emerged related to school: 1) belief that most teens in schools are having sex; 2) sex

education courses are not enough for an adolescent's understanding of sexual risk behavior; and 3) out of school organized youth groups are needed to supplement school based sex education programs.

In this study, participants overwhelmingly cited the school as a place where sexual behavior was on display and where introductory learning about reproduction, sexual consequences, contraception, and abstinence occurred. One non-sexually active 16 year old felt that school was a major factor that influenced sexual behavior and said, "I think its [school] got a big influence. No matter what school you go to, poor or rich....it's the same in every school. Peer pressure about sex and everyone is having it." In addition, many of the girls believed that the school environment helped influence their own decisions about sexual behavior although most stated that their sexual education was inadequate. For example, a 15 year old who was sexually active said that her official sex education course had just started two months prior to the interview. She had already been sexually active for a year when her school based sex education course took place.

Mass media—One issue that arose from the school and neighborhood questions was the influence of the mass media and popular culture on sexual behavior. The girls in this study believed that media, particularly TV shows, influence AI adolescent sexual behavior. Current shows such as "16 and Pregnant," "Jersey Shore," and "Teen Mom" arose in the interviews and talking circles as media that teens watched regularly. The majority of participants admitted to watching reality shows and felt that TV was one way that they learned about sexual behavior. One participant, age 18 who was sexually active and was pregnant at the follow up interview felt that TV shows were a significant influence on sexual behavior in adolescents. Shows like "Teen Mom" sent messages to adolescents about the acceptability of sexual behavior. She explained, "Because you see all these teen moms having babies and it looks like they're doing okay, so that influence you to have sex."

Health care—Health care emerged as an influence on sexual behavior. This study revealed two themes for urban adolescent AIs with regards to health care: 1) trusting the health care providers; and 2) access to health care services. The majority of participants trusted their health care provider and the larger medical system. Participants felt that health care providers had their best interests in mind and believed that the girls' safety was of utmost importance. In addition, all participants said that health care access was important for receiving health care information and practicing safe sex. Girls in this study believed that health care access was necessary for good sexual health. A 17 year old sexually active participant said, "Having access to health care makes it easier to have safe sex...They [the doctors] could help me, teach me, have the doctors tell how to practice safe sex." Another 17 year old who was also sexually active believed that having low cost, accessible services was a necessity for good health.

Macrosystem

Although federal policy drives support for many AI services (e.g. tribal health care, blood quantum, federal recognition of tribes) and the environment in which they lived (e.g., food availability via subsidized meals, housing, health care via Medicaid, school education),

adolescents did not identify a link between policy and their own personal lives. Within the ecological model, it is logical to conceptualize that the macrosystem would influence the other systems surrounding the adolescent (e.g., the mesosystem and microsystem). Federal and state policies towards AIs trickle down to the individual in a number of forms, such as health care and government assistance. Given the age and development of the participants, the connections between government policy and their daily lives may not be immediately obvious or relevant for them.

Discussion and Recommendations

Framing Sexual Risk Behavior, the theoretical model that evolved from the study data, has the potential to assist both clinicians and researcher's understanding of sexual behavior in urban adolescent AI girls. Similar to other racial/ethnic groups, factors that influence the urban AI adolescent population's sexual risk behaviors are consistent with Bronfenbrenner's ecological model (Heinrich, Brookmeyer, Shrier, & Shahar, 2006; Jordahl & Lohman, 2009; Kao, Guthrie, Loveland-Cherry, & Caldwell, 2012). Other findings from this study are consistent with research with urban adolescent girls that indicates parental communication and sexual risk behaviors have an inverse relationship, emphasizing the importance of family in modifying sexual risk behavior in adolescents (Khurana & Cooksey, 2012; McIntosh, Moore, & Elci, 2009). The urban AI adolescent girls described many similarities with other racial/ethnic groups such as the high value placed on family and peer opinion and relationships (with family opinion being most important), the role of parental expectations in their decision to abstain from sex or practice safe sex, and the influence of messages about sexual behavior received from their family members and friends (Coley, Lombardi, Lynch, Mahalik, & Sims, 2013; Kao, Loveland-Cherry, & Guthrie, 2010; Khurana & Cooksey, 2012; Miranda-Diaz & Corcoran, 2012; Roche, Ahmed, & Bloom, 2008).

Distinct differences emerged between AI urban families and non-AI urban families, including the importance of the large network of family members and openness to talking about sex with at least one female family member. In addition, contrary to previous literature with AI populations (Canales, Weiner, Samos, & Wampler, 2011; Guadagnolo et al., 2009; Rutman, Tauaii, Ned, & Tetrack, 2012), this study revealed that urban adolescent AI girls trusted their health care provider and believed that health care access was imperative to their personal well-being. According to Shafii and Burstein (2009), adolescence is a critical time to support patients' sexual health. Health care providers are uniquely positioned to provide resources and education to adolescents about safe sexual practices in a safe, confidential setting (Shafii & Burstein, 2009).

The similarities between factors that influence the sexual behavior of AI adolescent girls and non-AI adolescent girls (e.g. family, friends, neighborhood, etc.) can be used by both clinicians and researchers to develop interventions and clinical plans for AI adolescent girls. The unique culture of urban adolescent AI girls offers clinicians the opportunity to develop with the community culturally aware interventions to reduce sexual risk behavior. These interventions should consider including a female family member (identified by the patient/client) into the health care visit identifying cultural health care beliefs that could enhance treatment or adherence. Clinicians should also consider formulating personal goals with

each patient and taking time to review how health promoting behavior and healthy sexual choices will help the patient meet their long-term and short-term goals. Additionally, because there are many similarities between urban AI youth and those non-AI youth living in urban areas, previous interventions that focused on reducing unintended pregnancies and STIs with non-AI urban dwelling adolescents should be considered for modification, adaptation, implementation and evaluation. However, it would be important for researchers modifying interventions for the urban AI population to consider the differences among the various tribes in urban populations and ensure that the modifications meet the needs of a diverse group of urban AI adolescents.

Strategies clinicians can consider include attending culturally responsive training as well as taking time to learn about AI culture, particularly the history of tribes in their local area. In addition, clinicians should be experts not only on clinical care, but also on connecting urban AI adolescent girls to community based programs that emphasize the importance of culture and sexual health. Clinicians must build relationships with other providers who can collaborate with one another to provide community based interventions to reduce sexual risk behaviors. These health care collaborations should be in association with the larger AI community and involve both AI elders and AI community leaders.

Future Research Recommendations

The grounded theory developed from the findings of this study provides direction for future research. The current literature on urban AI adolescent sexual risk behavior is limited; therefore, using the Framing Sexual Risk Behavior model to investigate known influences on sexual risk behavior could be important to the health of the urban AI adolescent girl population.

Future research should also focus on the male adolescent as well as comparison of urban AI adolescents to reservation AI adolescents. Replication of the current study on reservations could confirm any similarities or differences between the two groups. Similarly, replicating the study with male adolescents could provide valuable insight into how adolescent AI boys regard sexual behavior and what they believe to be the primary influences on sexual behavior.

Framing Sexual Risk Behavior can be used to guide future research and efforts to reduce sexual risk behaviors among urban AI adolescent girls. Understanding AI culture and heritage as well as recognizing the urban AI girls' unique influences described by the girls in this study is necessary for reducing teenage pregnancy among AI adolescents.

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Year	2009	2010	2011	2012
What is your Age?	16	17	18	19
What is your Grade in School (grade, repeated grades, school changes, & if dropped out)?	10th	11th	12th	Hopefully college
What are your Activities (Jobs/Sports/Clubs/Church/etc.)? Use x---x to show when involved, for ex., x-----youth group -----x	Youth Group Track	Track Part time job at fast food restaurant	Part time job	
Where do you Stay and who do you stay with? For example, x---live w/Mom, Dad, Sister--->	Mom, Dad, Sister	Mom, Sister, Grandma	Mom, Grandma	Want to get a place of my own
Who are your Family and Friends? Other important people? (Circle who helps you)	MC (Mom), sister, LB	LB, sister, RN, CD	CD, RN, LB, sister	
What Positive Events have you had or What are your Goals?	Made honor roll, won track award	Got raise at job	Got promoted at job	Want to get a better job and go to college
What Negative Events or Losses have you had (Divorce, Accidents, Deaths, Violence experiences, Emotional problems, Others)?	Dad left Aunt died	Got in trouble at school Grandpa died so Grandma moved in with us	None	Hopefully nothing negative
What is your Sexual Activity? 1. partner (use initials) 2. when (use x---x) 3. type (oral/vaginal/anal) 4. contraception including how often used 1. partner 2. when 3. type 4. contraception 1. partner 2. when 3. type 4. contraception 1. partner 2. when 3. type 4. contraception	LB, vaginal, birth control pills	LB, vaginal, birth control pills	LB, vaginal, birth control pills	Stay with LB I hope
Have you had any of these behaviors? Smoking, Alcohol, Drugs, Cutting, Eating Problems, Others)? For ex., x--Drink Alcohol/Smoke Weed-->	Got drunk a few times	Tried weed twice Got drunk once	None	

Figure 1. Event History Calendar

Figure 2. Framing sexual behavior for urban American Indian adolescent girls: A model

Table 1**Demographic Information**

Variables (N=20)	
Age	
Mean age (years)	17.05
Range	15-19
Employment *	
Student	18 (90.0%)
Part-time work	2 (10.0%)
Full-time work	0 (0.0%)
Unemployed	2 (10.0%)
Living situation	
Lived alone	2 (10.0%)
Lived with parents	14 (70.0%)
Lived with other family	1 (5.0%)
Legal guardian	1 (5.0%)
Lived with partner	2 (10.0%)
Subsidized lunch	
Yes	12 (60.0%)
No	7 (35.0%)
Did not answer	1 (5.0%)
Health insurance	
Medicaid	13 (65.0%)
Private	2 (10.0%)
None	2 (10.0%)
Unknown	3 (15.0%)

* Participants were able to mark more than one response

Table 2
Sexual Behavior and Contraception Reported on Event History Calendars^{*}

Variables (N=20)	
Oral sex	5 (25.0 %)
Vaginal sex	10 (50.0%)
Anal sex	0 (0.0%)
Condoms (100%)	3 (15.0%)
Intercourse without contraception	7 (35.0%)
Depo provera	1 (5.0%)
Lifetime partners	
0 partners	9 (45.0%)
1-2 partners	5 (25.0%)
3-5 partners	3 (15.0%)
6-10 partners	3 (15.0%)

* Average age of those sexually active was 16.9, Average age of those not sexually active was 17.2.

Table 3
Interview Questions

Variables (N=20)	
Topic One: Knowledge and Influences	
1.	Tell me what you know about having sex.
2.	Tell me how you feel about having sex.
3.	Tell me what influences you having/not having sex.
4.	Tell me who influences you to have/not have sex.
Topic Two: Safe sex	
5	Tell me what you know about having safe sex like using contraceptives/condoms to prevent getting pregnant or getting a sexually transmitted infection or HIV/AIDS.
6	Tell me how you learned about having safe sex.
7	Tell me how you feel about having safe sex.
8	What influences your decision to have sex or abstain from sex?
9	What helps or empowers you to have safe sex or abstain from sex?
Topic Three: Risky Sexual Behavior	
10	Tell me what you know about sexually risky behaviors.
11	Tell me how you feel about sexually risky behavior?
12	(If applicable) Tell me what and who influences your decision to use or not use contraceptives/condoms during sex?
Topic Four: Family, Friends, and other Influences	
13	What does your family think about safe sex?
14	What does your family tell you about safe sex?
15	What does your family expect you to do about safe sex?
16	How does your family income, education, location of housing influence your decision to be abstinent or have safe/unsafe sex?
a.	Can you give examples?
b.	Do you have some examples you could share of your parent(s) knowledge of contraception or sex education?
17	How do your friends feel about safe sex/tell you about safe sex/expect you to do about safe sex?
Topic Five: Culture	
18	Can you tell me about the history of your tribe/culture?
19	What type of cultural/Indian events do you participate in?
20	How often do you participate in cultural events?
21	How connected do you feel to your culture/tribe?
22	Is there any history in your culture of women having sex young?
	If yes, what is the history?
23	How do you think your tribal affiliation (where you may be enrolled or what you might identify as) influences your safe or unsafe sex?
24	How has your culture influenced your safe or unsafe sex?
25	Do you think your culture influences early pregnancy/childbearing? Can you explain why?
Topic Six: Health Care	
26	How do health care and other services influence your sexual risk behaviors and safe sex?
27	How does access to health care and other services influence your knowledge about sexual risk behaviors and safe sex?
28	Does your health care provider give you information about sex?
a.	Do you believe what the provider is telling you is the correct information?

Variables (N=20)

Topic Seven: Economics and Resources

- 29** How does the economic status of the tribe you are associated with influence sexual behaviors? What about the economics of the federal government?
- 30** Are you able to find the resources to follow through with safe sex?
- a.** If yes, where?
- b.** If no, why not?
- 31** What would you tell other adolescents about sexual risk behavior?
- 32** What would you tell other adolescents about having safe sex?

Topic Eight: Final Questions

- 33** What was the most important thing we talked about today in this talking circle/interview?
- 34** Is there anything else we did not talk about that you would like to talk about now?
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