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Family and Friend Influence on Urban Dwelling American Indian Adolescent Girl Sexual Risk Behavior

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Abstract

Previous research with American Indian (AI) adolescent sexual risk behavior primarily focused on reservation dwelling youth despite 70% of AIs living off Native lands. Using grounded theory methodology, I sampled twenty adolescent AI girls via talking circles and interviews to explore the perceptions of AI adolescent girls living in an urban, Midwest area about the influence of family and friends on their sexual behavior. Similar to research with other racial groups, participants cited their family and friends as a major influence. Five unique themes emerged related to family and friend influence. Urban dwelling AI girls rely on their female family members and peers for information related to sex and receive varying messages from their networks of family and friends, which often overlap. AI youth have unique family groups yet have some similarities to other ethnic groups with regards to family and friend relationships that may allow for enhanced intervention development.

Keywords

Adolescents, youth, young adults, female; Adolescents, youth, young adults, sexuality; families; marginalized or vulnerable populations; Aboriginal peoples, North America; Grounded theory

The Indian Health Service (2013) and The National Urban Indian Family Coalition (2008) found that urban American Indian (AI) women and youth have similar challenges as reservation dwelling AIs yet have additional challenges related to urban living. The urban AI population is heterogeneous and the scattered geography of urban AIs limits access to social support networks on reservations or residing in other urban areas and resources that are not accessible outside reservation lands (e.g., Indian Health Service care) (Hartmann, Wendt, Saftner, Marcus, & Momper, 2014). Although AI tribes share similar histories of forced relocation, migration and trauma related to past abuses like compulsory attendance at boarding schools, each AI has specific traditions and beliefs that will vary widely based on her tribal history and geographic region (Kulis, Wagaman, Tso, & Brown, 2013). These intergenerational trauma histories combined with the fact that urban AI youth experience poverty, low educational attainment, and single-parent status at higher levels than other populations creates a population that is at higher risk for poor health outcomes (Ramisetty-

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Mikler & Ebama, 2011). In fact, the population suffers from alarmingly high levels of domestic violence, suicide, chronic diseases such as Type 2 diabetes, and substance use (Moghaddam, Momper & Fong, 2013).

Sexual health is also a concern for the AI population. American Indian adolescents have higher rates of sexually transmitted infections and pregnancy compared to the national average (Centers for Disease Control, 2014; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2014). The Committee on American Indian/Alaska Native Women's Health (2012) found that urban AI teens have higher rates of pregnancy and substance use in pregnancy and lower rates of routine prenatal care. Infants born to urban dwelling AI mothers are more likely to be born preterm and suffer higher rates of mortality including deaths attributed to sudden infant death syndrome.

Although family and friend influence has been shown to significantly influence adolescent sexual behavior (Buhi & Goodson, 2007; Cavanaugh, 2004; Heinrich, Brookmeyer, Shrier, & Shahar, 2006; Kan, Cheng, Landale, & McHale, 2010), there is little evidence on sexual risk behavior related to American Indian (AI) girls, particularly urban AI girls. For the purposes of this study, sexual risk behavior is defined as the non-use of appropriate contraceptive/protective techniques to reduce the risk of unintended pregnancy, HIV/AIDS or STI. It also includes lack of planning for when sexual activity will occur and with whom. Much of the current literature on AI sexual health is devoted to reservation dwelling AI youth. In the 2010 US census, 78% of AIs and Alaska Natives (AN) reported living outside AI/AN areas (this includes federal AI reservations and/or off-reservation trust lands, Oklahoma tribal statistical areas, tribal designated statistical areas, state AI reservations, and state designated AI statistical areas) (Norris, Vines, & Hoeffel, 2012).

It is well documented in Black, Hispanic, and White populations that both family and friend influence is critical in adolescent sexual risk behavior (Ali & Dwyer, 2011; Coley, Lombardi, Lynch, Mahalik, & Sims, 2013; DeVore & Ginsburg, 2005; Heinrich et al., 2006; Jordahl & Lohman, 2009; Ream & Savin-Williams, 2005). Family has been shown to be a primary influence in an adolescent's life. Those adolescents who had positive family role models, had open lines of communication with their parents or guardians, and knew family expectations related to sexual behavior were less likely to engage in sexual risk behaviors (Childs, Knight, & White, 2015; Coley et al., 2013; Kao, Guthrie, Loveland-Cherry, & Caldwell, 2012). Similarly, relationships and bonds among family members and adolescents can significantly influence adolescents and their decisions related to sexual behavior (Buhi & Goodson, 2007; Elkington, Bauermeister, & Zimmerman, 2011; Heinrich et al., 2006; Jaccard, Blanton, & Dodge, 2005; Saftner, Martyn, & Lori, 2011; Teitelman, Ratcliffe & Cederbaum, 2008). Finally, parent-adolescent communication has been shown to be a fundamental way to reduce sexual risk behavior in adolescents (Grossman, Frye, Charmaraman & Erkut, 2013; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Jaccard, Dodge, Dittus, 2002; Kao et al., 2012; McIntosh, Moore, & Elci, 2009; Seiving, McNeely & Blum, 2000).

Despite the plethora of data available on parent-child relationship and sexual risk behavior for other races and ethnicities, little information is available on family influence on sexual

behavior for AI youth (Chewning, et al., 2001; Hanson, McMahon, Griesse, & Kenyon, 2014; Hellerstedt, Peterson-Hickey, Rhodes, & Garwick, 2006; Marsiglia, Nieri, & Stiffman, 2006; Oman et al., 2006). In fact, the data that is available is conflicting with some finding minimal family influence on sexual risk behavior and/or safe sex practice (Hellerstedt et al., 2006; Marsiglia et al., 2006).

Friend or peer influence has similarly been considered a factor in adolescent risk behavior (Bryant & Zimmerman, 2002; Kim, Gebremariam, Iwashyna, Dalton, & Lee, 2011; Miranda-Diaz & Corcoran, 2012; Prinstein, Boergers, & Spirito, 2001). Little information is available on the influence that peers have on AI sexual risk behavior. Much of the research on AI and peer influence is related to substance abuse (Boyd-Ball, Vèrroneau, Dishion, & Kavanagh, 2014; Whitesell et al., 2014). Significant research is available on the role of peers in sexual risk behavior for other racial and ethnic groups. For example, friend perceptions of condom use, sexual risk, and pregnancy have all been found to influence behavior in adolescents (Buhi & Goodson, 2007; Childs et al., 2014; Kotchick, Shaffer, Forehand, & Miller, 2001; Seiving, Eisenberg, Pettingell, & Skay, 2006). Subsequently, adolescents who were sexually active were more likely to be in friendship groups with others who were sexually active (Ali & Dwyer, 2011; Kotchick et al., 2001).

Given the increasing number of AIs in urban areas and the limited research with the group, it is important for those working with urban adolescent AI girls to understand how AI girls perceive the influence of family and friends on sexual risk behavior. Additionally, this population often is overlooked in health disparity research, as evidenced by the paucity of data available, and thus often gets placed in interventions with other racial and ethnic minorities that may not share similar beliefs or historical perspective. Culturally appropriate, research-based interventions to decrease sexual risk behaviors for urban based AIs are not currently available but should be developed given the high rate of sexual risk behavior in the population.

Aim

I conducted a secondary analysis to explore the perceptions of AI adolescent girls living in an urban, Midwest area about the influence of family and friends on their sexual behavior. The secondary analysis findings I present in this article are the result of a larger grounded theory study focused on the development of a theoretical model to understand urban adolescent AI girls' sexual risk behavior (Saftner, Martyn, Momper, Loveland-Cherry, & Low, 2015).

Method

Design

In the initial project, I utilized grounded theory methodology. Glaser's (1978, 1992) method on grounded theory guided exploration of the psychosocial processes and contextual factors related to sexual risk behavior in AI adolescent girls. According to Lincoln and Guba (1985), grounded theory research is important for formulating understanding of local scenarios that would go unexplained and implicit if not researched. For the secondary

analysis, I continued to use the methods prescribed by Glaser (1978, 1992) and verified the original results by confirming the initial findings.

Questions for the talking circle and interviews were designed by the primary author, Dr. Saftner, for the initial study. Symbolic interactionism (SI) and Bronfenbrenner's (1977) ecological model guided the development of talking circle and interview questions. Mead (1934) and Blumer (1969) placed great emphasis on the importance of meaning and interpretation as essential human processes that react against behaviorism and mechanical stimulus-response psychology. SI focuses on social interaction occurring within the context of society. Sexual decisions made by the adolescent are shaped by interaction with society and these decisions, in turn, shape society. Using SI in this research facilitated understanding of the psychosocial processes of the AI adolescent girl by guiding the conduct of the interviews and talking circles and the data analysis focused on the individual psychosocial processes.

Additionally, context is necessary to consider in grounded theory work. Egan (2002) argued "the researcher must begin with an awareness of the context of the research by considering such factors as cultural, social, organizational, and interpersonal influences" (p. 282). This context must be viewed from the lens of those participating in the grounded theory study rather than through the investigator's lens (Egan, 2002). In order to organize SI in a societal context, an adaptation of Bronfenbrenner's (1977) ecological model for the AI adolescent and their environment was used to understand the broad influences affecting AI adolescent girls.

After initial development of the questions, Dr. Saftner presented the questions to two experts in qualitative research and AI research. The questions were updated based upon the recommendations of the experts and reviewed by staff members at the AI health center where recruitment primarily occurred. Staff, including medical personnel and youth group leaders, provided feedback and adjustments occurred to reflect the expertise of those working with AI youth. (For a list of talking circle questions, see Saftner et al., 2015).

Sample and Setting

Participants were primarily recruited from a Title V AI health center in an urban city in the Midwest, United States and from the community via word of mouth and community member referral. The urban health center receives the majority of its funding from the Indian Health Service and the US Department of Health and Human Services. Approval for the study was given by the director of the AI health center and the University's institutional review board. Given the sensitive nature of the questions asked of the youth participants in the study, a certificate of confidentiality was obtained from the National Institute for Nursing Research. Although primarily funded by the Indian Health Service, it is important to note that the AI health center uses the University as the IRB of record and this relationship was approved by the Indian Health Service. Additionally, given the variety of tribes represented in the study, the location of the study in an urban area away from traditional tribal lands and government, and the fact that participants were asked of their tribal affiliation and not membership, individual tribal approval was not appropriate.

Participants were recruited via posted flyers throughout the AI health center, referrals from the youth group and medical staff, and word of mouth. Participants included twenty 15-19 year old girls, who self-identified as AI and lived in an urban or suburban area. Those recruited identified English as their primary language and if less than 18 years old had parental consent to participate. Sexual orientation was not used as a recruiting criterion. Nineteen of the 20 girls identified as heterosexual and one girl identified as bisexual during the talking circles and interviews. The terms ‘American Indian’ and ‘girl’ are used to describe the participants as these are the terms the participants used to describe themselves and others.

Data Collection

Prior to beginning data collection, participant consent/assent and parental consent (of those under age 18) was obtained. Participants and family members who were present during the consent process were offered a meal and given \$5 to cover transportation costs. Participants also received a \$30 gift card to a local retail store for participation in the initial study and an additional \$20 gift card for participation in a follow up interview. Participants were asked to complete a demographic form, an event history calendar (Martyn & Belli, 2002; Martyn et al., 2013), and participate in a talking circle or individual interview.

Event history calendars (EHCs), developed by Martyn (2009), allow youth to self-report past behavior over a 3 year period and reflect on goals for the upcoming year. This calendar is used in both research and clinical practice to assess and analyze patterns of behavior (including sexual behavior, substance use, and positive/negative life events) (Martyn et al., 2013; Martyn, Saftner, Darling-Fisher, & Schell, 2011; Munro, Martyn, Fava, & Helman, 2014). The EHC is designed as a grid with time units (columns) of years. For each year, the following adolescent data is recorded: the participant’s current age, grade in school, who they lived with, who they considered to be their support system, activities they participated in, positive events, negative events, sexual activity (including the number of partners, the duration of the relationship, the type of sex engaged in, and whether or not birth control was used), and any drug, alcohol, or tobacco use. The first three time unit columns included the current year, and the two previous years. The final column was intended for the future year. In this column, the adolescents were to write down what they expected to occur and any goals they might have (e.g. go to college, get a 4.0, stay with their current boyfriend, etc.). The calendars serve as an auto-biographical memory cue that enhances understanding of how events within a person’s life are related. Previous research noted that EHCs “promote sequential and parallel retrieval within the autobiographical memory network” (Belli, 1998, p. 383) and elicit high quality retrospective reports (Belli, Shay & Stafford 2001; Belli, Shay, Alwin, 2009). The calendars supplemented the talking circle/interview data and demographic information with additional information about birth control use, number of sexual partners, substance use history, and other contextual factors that may influence sexual behavior. They provided an important piece of historical context to situate data analysis in.

Participants were given the choice of participating in a talking circle or an individual semi-structured interview. Talking circles are a traditional method of group communication in AI culture and have been used in both urban and rural settings among young and elderly AI

participants (Becker, Affonso, & Beard, 2006; Haozous, Eschiti, Lauderdale, Hill, & Amos, 2010; Hodge, Frederick, & Rodriguez, 1996; Patten et al., 2013; Picou, 2000; Strickland, 1999). Although similar to focus groups, talking circles offer the additional benefit of allowing everyone in the group a voice. It is customary to pass an item around the circle and the person with the item speaks without interruption from other members. In this study, I used a shell that was used at the AI health center for other talking circle groups. After speaking, the person holding the shell passed it on to the next person and the next person would talk. Eleven AI girls chose to participate in individual interviews and nine participated in talking circles. Recruitment ended when data saturation or redundancy was achieved (Lincoln & Guba, 1985). In this study, data saturation occurred after 20 participants.

Additionally, eight individual semi-structured follow-up interviews were conducted with the original 20 participants for member checking, clarification, and further exploration of data and peer validation of the data analysis. Participants were chosen based upon their expressed interest in more time with the researcher or their responses. Participants whose ideas and responses resonated with the themes that emerged or voiced unique beliefs during the talking circles or interview were asked to return for a follow up interview.

Data from the talking circles, individual interviews, and follow up interviews consisted of transcripts of the audio-recorded sessions as well as debriefing notes and memos recorded by the PI. Transcription occurred within 96 hours of the session by an independent company located in New York with experience transcribing health science research data. No identifying information was used on the audio recordings to protect the identity and privacy of participants.

A total of 478 pages of talking circle and individual interview data were coded and analyzed. In addition to the 478 pages, an additional 74 pages of memos from the PI and an AI research assistant supplemented the audio recorded transcripts. The memos by the PI were created during the data analysis process. Memos were used as a means for the PI to collect additional personal, theoretical, methodological impressions, thoughts, and research ideas. The PI included notes about the participants in the memos including who accompanied her to the talking circle/interview, dynamics between family members and other participants, and general impressions of the participant. Additionally, an AI research assistant familiar with community center and the surrounding urban community was hired to review the talking circle and interview data from an AI perspective (as the PI was not AI). The research assistant had a bachelor's degree and was previously involved with health research data collection while an undergraduate student. The research assistant was considered a "traditional" American Indian man by his colleagues and peers at the community center. In addition, because he was raised by women and was considered more traditional, his perspective can be seen as leaning towards feminist thought. The research assistant wrote memos for each transcript regarding his perspective on the themes that emerged in each talking circle and interview. The impressions from the research assistant were integrated with the other memos and used for further confirmation of codes and to determine if the PI was recognizing all themes, particularly those that might be more evident to someone within the culture.

Data collection dynamics—The dynamics of the data collection process varied from talking circle to talking circle and interview to interview. Talking circles and interviews varied in length. The shortest talking circle (with only two participants) was approximately 25 minutes; the longest (with four participants) was approximately 90 minutes. Interviews varied from twenty minutes to 90 minutes. As the PI, I was known by many of the girls who participated because of my presence and volunteer work at the community center. Some of the participants who were unknown to me were referred by staff members or friends who reassured them of my intentions for the project during the referral. This referral process provided me a level of credibility as a researcher that most likely contributed to personal disclosure of sensitive information. I also provided a comprehensive introduction to participants that included my experience as a clinician specializing in sexual health.

For those who chose to participate in talking circles, the participants typically joined a group with friends or known peers. In these groups, the girls that knew each other well were more likely to open up about their sexual history (or lack of sexual history) in the first few minutes of the talking circle. Those who did not know the others well (usually one girl) generally opened up about halfway through the talking circle and disclosed their full sexual history by the end of the talking circle. Because the girls completed the EHCs prior to the groups and interviews, they understood the topics that would be discussed and this seemed to act as an “ice-breaker” for further discussion. For those participating in individual interviews, disclosure varied. The majority of adolescents who participated in individual interviews disclosed their sexual history quickly and all the participants disclosed their history by halfway through the interview.

Data Analysis

As with the initial analysis, the secondary analysis first reviewed the event history calendars for information not obtained in talking circles/interviews regarding the participants’ life history and behaviors. Constant comparative method was utilized to determine specific characteristics of the population (Glaser & Strauss, 1967). Impressions regarding the adolescent’s life history and behaviors were noted. Then, the EHCs were laid out side by side in rows of four and analyzed once again individually and then as a group. The researcher noted similarities and differences as well as changes over time (Cresswell, 2003). Specific counts were made of the type and of family living situations, goals, risk behaviors, negative events, and sexual behaviors. As a part of counting specific incidents, constant comparative method was used to determine patterns among individual participants and the larger group. These patterns were noted and became a part of the larger data analysis of talking circle/interview transcripts. The EHC data facilitated understanding of the participants’ social context.

Glaser’s (1978; 1992; 1998) constant comparative method was used for data analysis using three levels of increasingly theoretical coding. Open coding of the data (Level I) began data analysis. Level I coding involved line by line analysis of the transcribed data from the talking circles and individual interviews in order to identify the processes and contextual factors in the data (Glaser, 1978). During the primary project and again during the secondary analysis, these processes/contextual factors or substantive codes were compared with other

data, including the completed EHC data, and assigned to categories (Level II). Categories were then composed of coded data that appeared to form patterns or exhibit similar information. The categories were compared to other categories to ensure that they were mutually exclusive (Glaser, 1978).

After ensuring that each category was mutually exclusive, the categories were then reduced by comparing them to each other to determine how they fit in a higher order category. Reduction of the numerous 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

The influence of family and friends on sexual behavior emerged during the secondary analysis. Three themes for family influence and two themes for friend influence are presented in this section. It is important to note that many of the girls in the study considered their family members (e.g. cousins, sisters, etc.) as a part of their friend group. It is often difficult to draw clear lines between the AI family's sphere of influence and the peer group's sphere of influence. It is necessary when considering the spheres of influence to understand that family and peers are often not mutually exclusive in AI families.

Participants' age ranged from 15-19 with the average age of 17 years with over half (N = 13) of the girls' enrolled in Medicaid (See supplemental file for additional demographic information). Table 1 details the participants' risk behaviors (sexual and non-sexual) as reported on the event history calendar.

Family

American Indian families continue to change as populations move from and between reservations and traditional lands to areas with non-AI populations. According to Red Horse, Lewis, Feit and Decker (1976) and Light and Martin (1996) urban AI families are different than other families and may extend beyond the traditional nuclear and extended family. Light and Martin (1996) maintain that AI families do not conform to the "rigid structure" of Western families and relationships but instead support and care for all members of the community. Red Horse (1997) contends family, kinship and relationship patterns greatly impact individuals and families. However, according to Harper (2011), urban AI families continue to evolve as they surround themselves with the dominant White culture and Eurocentric views.

Participants described examples of people they considered family including parents, siblings, grandparents, cousins, aunts, uncles, and legal guardians. Urban adolescent AI girls cited family as the primary influence on sexual behavior. The girls in this study acknowledged the importance of their families' opinion related to decisions about sexual behavior. Three themes emerged related to family influence: 1) networks of family influences; 2) the ability to talk about sex with family members, primarily female family members; and 3) receiving varied messages about sexual behavior from family members.

Networks of family—Fathers, mothers, grandmothers, and sisters were described as having a strong protective influence on the girls' sexual behavior. Participants stated, "My dad definitely influences me not to have sex," "My mom was 16 when she had me," and "My mom and her mom were on my head about safe sex....they don't want us to get pregnant or have diseases." A 17 year old sexually active participant stated:

[My mom] just doesn't want me to have sex at all...She told me to wait until I'm ready...I talk about sex with my mom and sister on a daily basis...sometimes my sister hides condoms everywhere I can find it. She's just saying to be safe.

Another participant, age 18, explained that her parents influenced her decisions about sex because she was concerned about their opinion of her. She explained, "I think my family has influenced me some to not have sex because I don't like disappointing them."

Talking about sex—Having a family member to talk with openly about sex was identified as an asset and a protective influence on sexual behavior for the girls in this study. Girls described a network of family including parents, siblings, aunts, grandmothers, and cousins who they could talk to about sex. All of the girls in the study had at least one family member they could discuss sex with openly. A 17 year old non-sexually active participant explained how she could talk to both the older and younger people in her family about sex. The conversations varied depending on who she talked to in the family, but she still felt comfortable talking to family members about sex. She stated:

I can talk about sex with my grandparents or like I said the older women in my family, but it's more of a just don't have sex kind of conversation. My older cousins, they talk about sex openly and safe sex and I learned from their mistakes.

Another 19 year old participant who was not sexually active said, "I'll talk to my cousins and all but my parents it's still like nonexistent...They don't talk about it but they do expect me to wait until I'm married." In this case, even though the 19 year old did not openly discuss sex with her parents, she still understood her family's expectations about sexual behavior and had other family members who she could talk to about sex. A 16 year old agreed and stated "I'm not really open with my mom and dad....but I have an older sister and she's the only one I can go to and tell everything to."

In general the girls appreciated having someone to talk to within their family, but they often chose to talk to younger members of their family like siblings and cousins rather than the older generations. One girl cited her cousins understanding of what she deals with on a daily basis as her rationale for consulting with them rather than with her mom. Others stated that their parents and grandparents were staunchly opposed to adolescents having sex, even if they were practicing safe sex. Therefore, conversations with the older generation were often uncomfortable. One 17 year old explained, "My grandma thinks nobody should have sex until you're married. But I don't ever really talk to like my mom or anything about it." This particular participant had older sisters and relied on their advice regarding safe sex and also learned from their mistakes. Although sexually active, she used birth control 100% of the time and said, "I don't want to have kids like my sisters...I don't want to be like them."

All of the participants in this study stated that they had at least one family member who was available to discuss sexual questions and behavior. Most of the participants cited female family members as the person they would choose to talk to. In fact, of the 20 participants, only two cited a male family member (in both cases their father) as a primary person they would communicate with about sexual behavior and safe sex. However, both of these girls also cited their sister as another primary person who they would communicate with about sex. This female relationship is important as a method for young urban AI girls to engage others about the questions all adolescents generate about sexual behavior and activity.

Varied messages about sex—Family messages regarding sex were important to the adolescents. Yet messages varied between those messages that discouraged sexual risk behavior and messages that encouraged sexual risk behavior. Girls in this study believed that the messages they received from family members about sex had an influence on their sexual initiation, safe sex practices, and decisions to abstain from sex.

Messages discouraging sexual risk behavior: Participants in this study believed that family members who discouraged sexual risk behaviors and promoted safe sex behaviors influenced their decisions about sex. A 17 year old participant stated that she and her mother frequently discussed birth control methods. She said, “My mom knows I get the depo shot because she made me get it.” Others were even more open about birth control options and safe sex. A 17 year old had an open relationship about sex with her mother. She believed that her mom helped her stay safe. She explained:

My mom just basically told me I had to be safe and stuff. She told me that basically if I was going to do that I should be safe about it and play it smart and, you know, get on birth control and things like that if I wanted to have sex...They [my family] would rather I have safe sex...I should always be safe...She'll [my mom] take me to my appointments at Planned Parenthood and sometimes she'll even schedule them for me.

Others got similar messages from their family members. One 15 year old said her mom constantly lectures her about safe sex. She said one of her mom's favorite sayings is, “If you think you are grown enough to have sex, then you are grown enough to have safe sex. Always use a condom.”

Messages encouraging sex: Yet, although many participants had family members who were encouraging safe sex or abstinence, others felt that their decisions to become sexually active were also influenced by their family members. Not all family influence was positive and did not routinely promote abstinence or safe sex if the decision was made to become sexually active. For some, the desire to be accepted by their older siblings and cousins was a primary influence in becoming sexually active. In fact, upon reflection these girls often stated that they wished they had waited, but at the time felt that being sexually active would garner their older family members' favor and offer them access to a new social group.

One of the most striking examples emerged from a 15 year old's account of why she chose to become sexually active. The 15 year old had a desire to be like her older cousins. She stated, “My two cousins...no three of my cousins are all older than me. They are like 16.

Two of them tell me I should have sex and one of them tells me I shouldn't." When probed about safe sex communication, the participant responded that "sometimes" she received information from her cousins about safe sex, but they primarily discussed sexual activity and not safety. The two cousins who encouraged sex were the cousins that the participant had contact with on a regular basis and she valued their opinions. For this participant, and for the other participants in this study, family was the strongest influence in the girls' lives.

As the previous example illustrates, participants often got mixed messages from family members. A sexually active 19 year old felt that having family members to talk to about sex was helpful, particularly after her mother died. However, she felt that there were often mixed messages from different family members. She described her own experience with discussing sex with family and said:

After my mom died, everybody on my mom's side tried to give me sex talks...I got really mixed messages from people. Some of my aunts think if you're ready, go for it; and some people were like 'no' don't do anything."

Similarly, participants often received mixed messages from different familial generations. Participants most often cited their grandparents and parents as family members who discouraged sexual risk behavior and promoted safe sex and younger family members (e.g., siblings and cousins) as the family members who encouraged sexual activity.

Each participant in this study felt that their family helped influence their behavior about sex, although many received mixed messages about sexual behavior. They all felt a strong connection with their family members, valued their family's input about their behavior, and had at least one family member who they could openly ask questions about sex.

Friends

Friend influence was also described by participants as influencing their sexual risk behavior. However, friend influence was identified after family influence as an impact on sexual behavior. Two themes emerged related to friend influence: 1) friends discourage sexual risk behavior; and 2) friends encourage sex. Similar to studies with other racial groups in urban areas, AI adolescents who were sexually active were more likely to be friends with others who were sexually active.

Friends who discourage sexual risk behavior—Participants in this study cited their friends as influencing their decisions about sex, particularly abstinence. This was particularly true in the group of girls who had never engaged in sexual activity. A 16 year old who was not sexually active stated "I don't really talk to them [the girls at school who are having sex]." She explained that she felt no pressure from her boyfriend to have sex because none of his friends were having sex either. Therefore, she felt comfortable continuing to abstain and did not feel like her relationships would suffer because of her decision.

Similarly, an 18 year old college student who was not sexually active felt that her friends were similar to her. She stated, "my best friend just recently started having sex, but most of my close friends haven't really." She noted that her friends' common bond of not having sex

“probably impacts why we connect.” This participant felt that her friends were there to help her make good decisions and that she would feel like she disappointed them if she did not adhere to the groups’ norms. She said, “There would be some judgment from some of my friends if I just found someone and just started having sex.” However, she felt that if she found a partner and was in a committed relationship, her friends would support her decision to have sex. But, she believed that her friends would expect her to practice safe sex.

Another participant, a 19 year old who also was not sexually active explained that her friends were supportive of her religious convictions to abstain until marriage. She stated that when the topic of sex came up within the group her friends always spoke about safe sex or no sex. It was important for this participant to maintain her friendship group and feel respected for her religious decisions for remaining abstinent. She aligned herself with other girls who understood and respected her belief system. Because of this purposeful choice of friends, the participant limited peer pressure to have sex.

Girls in this study reported their friends as influences on their sexual behavior. Those who had friends who discouraged sex or promoted safe sex felt supported in their decisions to avoid sexual risk behavior. Participants, particularly those who were not sexually active, allied themselves with others who respected their desire to abstain and felt that these friendships helped them ignore peer pressure from others.

Friends who encourage sex—Multiple girls in this study felt pressure to have sex from their female friends, peers, and boyfriends. Participants who were sexually active cited peer pressure from friends as part of the reason they initiated sexual activity in adolescence. An 18 year old with four total sexual partners in her lifetime stated that her friends were all sexually active and encouraged her to be sexually active. She said, “I just wanted to leave out [go out] with my friends a lot and like stay away from the house...I kind of got exposed to having sex and a lot of people make it seem like it’s alright.” This participant explained that none of her friends ever spoke about safe sex or birth control. She felt lucky that she never got pregnant but she did contract a sexually transmitted infection. She described catching chlamydia, “I ended up catching an STD and it like changed everything...so, I really don’t want to go through that again.”

A 16 year old sexually active participant with nine partners in three years believed that her friends influenced her to have sex. She stated “about 60% of my friends are having sex” and felt constant pressure from friends and partners to engage in sexual intercourse. Different messages were received from girlfriends and boyfriends, with more protective influences from girlfriends and more risk influences from boyfriends. She and her girlfriends were very open with one another about their disapproval of their sexual decisions, although they continued to have sex. This participant felt that her female friends helped “keep me straight” but that boyfriends are often the ones who pressure girls to have sex. “Sometimes it’ll be the person I’m with because they’ll say like oh, it’s all right, but I don’t know. Sometimes I’ll just go along with it even though I know it’s not right.”

Similarly, other participants felt that their friends encouraged them to have sex regardless of whether it was safe sex or not. Two participants who were friends, ages 17 and 18, both

stated that “all our friends are having sex.” The 17 year old had eight sexual partners in three years and had an abortion and a miscarriage in a two year time period. The 18 year old had seven sexual partners in a three year period and had one abortion. They both stated that they talked about sex with one another “all the time” as well as with their larger friendship group and that sex was a normal part of any adolescent relationship. Both believed that safe sex was important but reported infrequent contraceptive use and denied conversations with friends about safe sex. In fact, those who were sexually active were less likely to report discussions about safe sex with their friends compared to those who were not sexually active.

However, despite some participants feeling that there was significant encouragement from their friends to have sex, some still chose to remain abstinent. A 19 year old who was not sexually active believed that her friends thought she was abnormal because she wasn’t having sex. She stated that her friends “influence me to have sex. They say I should because I’m 19 and they say I’m too old to be a virgin.” She continued by saying “some girls haven’t had sex and some girls have had sex. They [the ones who have sex] don’t want to be your friends if you don’t.” However, she decided to abstain from sexual activity in spite of constant peer pressure because “friends come and go and family is forever.” Encouragement to have sex did not necessarily mean that an adolescent will be sexually active. Those who received messages from other sources, particularly their family members, often chose to follow the expectations from the other sources, rather than their friends.

Sexual initiation: Friends encouraging friends to have sex was a common theme reported by participants. Many of the participants believed that their own decision to initiate sexual activity was influenced by their friends. In particular, losing one’s virginity at a young age was a theme reported by those who were sexually active. A 15 year old participant with five sexual partners lost her virginity in the 8th grade when she was 14 years old. She said, “I guess it was just because all of my friends had done it...and I felt like at 14 I was like yea, I’m a virgin still.” She believed that most of her friends were losing their virginity around the age of 11 which made her abnormal compared to her peers.

Another 15 year old participant also lost her virginity in the 8th grade at age 14. She had two sexual partners in two years and never used contraception. She stated, “Everyone was talking about it [sex]. So I was like, well, let me just get it over with. So I did.” An 18 year old, who lost her virginity when she was 15, believed that losing one’s virginity in early adolescence was normal behavior. She said, “I think most of my friends lost their virginity when they were 15 or younger.” She believed that when she lost her virginity she was older than average, particularly since her best friend had lost her virginity at age 13.

Early sexual initiation was often influenced by friends. Girls often cited their friends as a reason for initiating sexual activity. Fitting in with the group was a common explanation for why participants chose to have sex in early adolescence. The girls wanted to fit in with their friends and felt that if they were not having sex, they were not the same as their friends.

Pressure from boys: Participants also cited pressure from boys as another factor influencing their sexual behavior. Pressure from boys was often directed at girls who were already

sexually active and often bordered on harassment. For example, a 15 year old who was sexually active felt immense pressure from the boys at school to have sex. The participant stated that boys focus on the girls they think they could have sex with and ignore the large number of girls in her school who were from a conservative religious group. Another participant, age 16 had similar experiences with the boys in her school. Once the boys in her school found out she had sex with her boyfriend of over a year, they targeted her and harassed her. She felt constant pressure from her male classmates to have sex.

Boys were often considered predatory towards girls that were sexually active. A 17 year old participant remarked that in her neighborhood, the boys began to make sexual comments at girls as soon as they hit puberty. The girls described constant cat-calls and sexually derogatory comments from boys directed towards them as well as occasional incidents of groping on the street. Participants believed that boys in their school and neighborhoods were constantly harassing girls to have sex. They felt constant pressure to give in to the demands for sex and when girls found themselves in situations where they were alone with boys and pressured, they often gave in to the demands of the boys.

Discussion

In this study, all the participants believed that the messages they received from family members had the greatest influence on their sexual risk behavior. Family members (defined by the participants) included both immediate family (siblings, parents) and extended family (grandparents, aunts/uncles, cousins). Although the family's influence on adolescents in other racial and ethnic groups has been previously documented (Grossman et al., 2013; Kao et al., 2012), this is the first study that has documented the same association for the AI adolescent population living in an urban area within the United States. This similarity may be important for those working with the population in various settings including schools, health care systems, and community organizations. It may be possible to tailor interventions that are proven to be effective with other racial and ethnic groups to fit the AI population. For example, the "Be Proud! Be Responsible!" intervention with African American populations was used as a guide for the "¡Cuidate!" intervention with Latino youth (Jemmott, Jemmott, Fong, & McCaffree, 1999; Villarruel, Jemmott, & Jemmott, 2006). Similar outcomes may be possible with urban AI populations if programs are tailored to the unique historical and cultural needs of AI youth.

Girls in this study reported that having a network of family members, particularly a female family member to talk to about sex, influenced their sexual behavior. A review of the literature found no studies from the United States that point to one female family member as critical to sexual knowledge and behavior. It is possible that this relationship is present in other racial and ethnic groups or possibly in Native people outside the United States. However, this is the first study to identify the connection and thus it may be unique to the urban AI family. Having a female family member to discuss sexual beliefs and practices with could impact an adolescent's decision making related to sexual behavior. This unique finding for the population could be useful in developing interventions or tailoring existing interventions to decrease sexual risk behaviors.

Despite the AI participants having family members to speak to about sex, they often receive mixed messages. Given the nature of the messages, educating the entire family rather than the individual may be important for further reduction of sexual risk behavior. Consistent with The National Campaign to Prevent Teen and Unplanned Pregnancy, family support is imperative in preventing adolescents from engaging in sexual activity and parents should never underestimate their influence or their child's desire for their parents' guidance, approval, and support (Albert, 2009; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2008). In the case of the AI adolescent, we must look beyond the parents and include extended family members into our efforts to decrease sexual risk behavior. Interventions should target not only the youth but the female family member that the youth identifies as a critical informant.

Although family was cited as the primary influence on sexual behavior, friends also emerged as a consistent influence with varied messages. Those AI girls who were sexually active and/or did not practice safe sex believed that having friends who were having sex as well as feeling pressure from boys influenced their sexual behavior. Similarly, those who abstained from sex or were consistently practicing safe sex cited their friends as encouraging abstinence, respectful of their beliefs, or promoting safe sex behavior. Given this information, current interventions aimed at reducing peer pressure and creating a respectful environment among males and females could be used with AI youth.

Additionally, it is important for those working with AI youth to clarify who they are receiving their messages from and the content of those messages. From the discussions with the participants, it was clear that many girls receive false information about sexual activity, pregnancy, and sexually transmitted infections as well as pressure to engage in sexual activity. It would be important to clarify information about sex and risky behaviors for AI youth to ensure that they are making safe choices. In addition, interventions could focus on both knowledge about risky sexual behavior and autonomy/confidence to spurn pressure for sex.

Finally, it is important to remember that it is often difficult to draw clear lines between the AI family's sphere of influence and the peer group's sphere of influence because there is often considerable overlap in the two groups. It is important when considering the spheres of influence to understand that family and peers are often not mutually exclusive and therefore, must be understood as relationships that can take upon different forms and yet exert similar influence. Given this overlap, those working with AI girls should consider the influence of friends and family and encourage events where friends and family members can obtain health promotion education together.

Limitations

There were two limitations to this study. The first limitation was the inability to generalize the results from this study to the larger urban AI adolescent girl population. Data for this study was collected in one Midwestern state. Most of the participants reported being affiliated with a Three Fires tribe, tribes traditionally located within the Midwestern region of the United States. Therefore, it is unclear whether the results from this study can be generalized to other urban populations in areas outside of the Midwestern United States.

The second limitation to this study was related to recruitment of participants. The majority of the participants were connected with and recruited from their area's AI community center. Therefore, it is unclear whether these results would be applicable to AI adolescent girls who are not involved in their community AI center or have minimal connection to their cultural heritage.

Future Research Recommendations

Urban AI girls have unique family patterns including a network of trusted family members that should be investigated further. Given the fact that all the girls in this study cited a female family member as a trusted confidant on sexual behavior, future work should include those family members into developed interventions. Researchers should also consider the overlap between friends and family members and target those relationships to reduce sexual risk behavior. Additionally, given the similarities noted between AI urban girls and non-AI urban girls related to family and friend influence, researchers may consider modifying existing interventions to fit the needs of the AI girls. Finally, although this study focused on adolescent girls, it would be important to further study AI adolescent boys given the girls' mention of the pressure they received from their male counterparts.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1**Risk Behaviors**

Variables	Girls (N=20)
Lifetime Sexual partners	
0 partners	9 (45.0%)
1-2 partners	5 (25.0%)
3-5 partners	3 (15.0%)
6-10 partners	3 (15.0%)
Cigarette use	6 (30.0%)
Alcohol use	12 (60.0%)
Marijuana use	7 (35.0%)
Other drug use *	2 (10.0%)
Fighting	1 (5.0%)
Cutting	6 (30.0%)
Eating disorders	2 (10.0%)
Total risk behaviors	
0 risk behaviors	1 (5.0%)
1 risk behavior	3 (15.0%)
2 risk behaviors	7 (35.0%)
3 risk behaviors	6 (30.0%)
4 risk behaviors	2 (10.0%)
5 risk behaviors	1 (5.0%)

* Includes acid and ecstasy.