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Parent–Adolescent Communication About Sexual Pressure, Maternal Norms About Relationship Power, and STI/HIV Protective Behaviors of Minority Urban Girls

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Abstract

Racial/ethnic minority adolescent girls bear a disproportionate risk for HIV and face barriers to autonomous sexual decision making, but parental messages may help protect against sexual risk taking. The authors examined African American and Hispanic girls' sexually transmitted infection (STI) and HIV prevention practices, parent–adolescent communication about sexual pressure, and maternal gender norms (N = 118). Teens were more likely to practice consistent STI/HIV prevention when mothers talked about partner sexual pressure ($p = .017$) and fathers talked about resisting partner sexual pressure ($p = .034$). Sexually active girls who perceived that their mothers held egalitarian beliefs about partner decision making had more consistent condom use ($p = .029$). Given the context of increased STI/HIV risk, it is critical that parents discuss partner dynamics with daughters. Nurses play a unique role in facilitating these conversations; they provide parents with age-appropriate resources and assist in normalizing fears, which can help increase parent–child sexual-risk communication.

Keywords

parent–adolescent communication; sexual decision making; sexual pressure; partner relationships; sexual risk; adolescent females; HIV prevention

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There is an urgent need to increase effective prevention strategies to reduce the disproportionate risk for HIV experienced by minority adolescent girls, especially those living in low-income urban households. Adolescents in the United States are at high risk for contracting sexually transmitted infections (STIs) including human immunodeficiency virus (HIV). Epidemiologic data describing rates of HIV and STIs show that African American and Hispanic females are disproportionately affected (Centers for Disease Control and Prevention [CDC], 2005). HIV rates among adolescents are accelerating faster for females than males; infection is primarily acquired through heterosexual transmission. According to Healthy People 2010, responsible sexual behavior for adolescents involves abstaining from sexual intercourse or using a condom if sexually active (U.S. Department of Health and Human Service [HHS], 2000). Data from 2005 demonstrate that 46% of high school–age females have already had sexual intercourse (61% for African American and 44% for Hispanic adolescent females; CDC, 2006) Among those who have had sexual intercourse in

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the past 3 months, only 56% used condoms the most recent time they had sex (50% for African American and 62% for Hispanic adolescent females; CDC, 2006).

In a sample of African American and Hispanic adolescent girls 15 to 19 years old, primarily from lower income urban households, we examined the relationship between parent–adolescent communication about sexual pressure from peers and partners and consistent STI/HIV prevention practice (abstinence or consistent condom use during sexual intercourse). We also explored the relationship between perceived maternal gender norms about decision making in male–female relationships and consistent STI/HIV prevention practice. We hypothesized that (a) girls with greater parental communication about sexual pressure from partners would be more likely to enact STI/HIV prevention behaviors, (b) girls reporting a greater level of parental communication about sexual pressure from peers would be more likely to enact STI/HIV prevention behaviors, and (c) girls who perceived that their mothers held egalitarian gender beliefs would be more likely than their peers to enact STI/HIV prevention behaviors.

BACKGROUND AND SIGNIFICANCE

Although most sexually active girls have sex with partners who use condoms, others still face barriers to enacting sexually protective behaviors. Risk prevention among adolescent girls is enhanced when parents are active in communicating with teens their preferences, beliefs, and values (Aspy et al., 2007; Jaccard, Dittus, & Gordon, 1996; Miller, 2002), but little is known about the influence of maternal egalitarian beliefs or parent–child communication about sexual pressure. This section details the current literature in the areas of sexual pressure, parent–adolescent sexual risk communication, and maternal beliefs about gender norms.

Sexual Pressure

Sexual pressure is a continuum of influence, ranging from mild to extreme, toward having sex or having sex in a particular way (e.g., without condoms). Sexual pressure from partners can be tacit (e.g., expectations for sex in a relationship) or more overt, such as enticements (e.g., offering gifts). It may include psychological or verbal abuse and coercion in relation to sexual decision making, such as when the partner threatens to get angry or end the relationship, or it may actually include partner violence. It often occurs in a context in which the male partner has greater relationship power, meaning that his wishes hold more sway than hers (Blythe, Fortenberry, M'Hamed, Tu, & Orr, 2006). Intimate-partner violence against women occurs more often in economically disadvantaged communities, and minorities are over-represented among those living in disadvantaged urban neighborhoods (Benson & Fox, 2004).

A significant proportion of adolescent girls face difficulties in navigating their sexual safety. One study found that approximately 15% to 20% of adolescent and young-adult women reported that they never feel they are entitled to make their own decisions about contraception, tell their partners they do not want to have intercourse without contraception, or inquire about their partner's history of STIs (Rickert, Sanghvi, & Wiemann, 2002). Beyond young women feeling a lack of entitlement, another barrier to contraceptive use may involve partner negotiation when a girl and her male partner disagree about whether or not to have sex or to use a condom (Champion, Shain, & Piper, 2004; Tschann, Adler, Millstein, Gurey, & Ellen, 2002). In this context, unwelcome sexual pressure from male partners may confer added risk for girls to experience unwanted sexual encounters or unprotected sex (Blythe et al., 2006).

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Unwanted sexual pressure from partners clearly places adolescent girls at increased risk for STIs/HIV; urban minority girls exposed to more intimate-partner violence are more likely to also experience more unwanted sexual pressure, and this may account for some of the disproportionate burden of illness found among urban girls experiencing economic disadvantage.

Sexual pressure from peers (who are not partners) may also confer added risk for STIs/HIV but is manifested differently. Peer sexual pressure includes tacit pressure that sexual intercourse without condoms is a common experience among peers (Crosby et al., 2000). Sexual pressure from peers may also be overt, such as being subjected to negative reactions from peers for lack of sexual activity or being encouraged into situations in which sex might occur (Teitelman & Loveland-Cherry, 2004).

Parent–Adolescent Communication

Although findings have not been consistent (Crosby & Miller, 2002), a number of studies have indicated an association between parent–adolescent communication, especially mother–daughter communication, about sexual topics (sexual initiation, condoms, and STIs) and a reduction in sexual-risk behaviors among adolescent females (Aspy et al., 2007; Crosby & Miller, 2002; DiClemente et al., 2001; Hutchinson, 2002). Adolescent girls who have discussed sex-related topics with their mothers are less likely to have initiated intercourse (DiIorio, Kelley, & Hockenberry-Eaton, 1999; Hutchinson, 2002; Jaccard et al., 1996) and more likely to have used condoms and contraception (Dutra, Miller, & Forehand, 1999; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Miller, Levin, Whitaker, & Xu, 1998).

Beyond delaying sexual initiation and increasing rates of condom use, parent–daughter communication moderates unhealthy partner and peer influence on girls' sexual behavior. Girls who communicate with their mothers are less likely to be influenced by their perceptions that sexual activity is normative among their peers (Whitaker & Miller, 2000). Furthermore, adolescent females who reported less frequent communication about sexual topics with their parents reported fewer discussions with partners about STIs, AIDS, and using condoms and also reported lower self-efficacy to negotiate safer sex or refuse an unsafe sexual encounter (DiClemente et al., 2001).

Although fewer studies have specifically examined father–daughter communication about sexual risk, no association with girls' sexual-risk behaviors has been demonstrated (Dutra et al., 1999; Hutchinson, 2002). However, fathers may play a specific role in sexual socialization of daughters in the areas of understanding men and sexual pressure from partners (DiIorio et al., 1999; Hutchinson, 2002).

Parent–child communication, specifically the communication between mothers and daughters, has proven to be influential in the reduction of sexual-risk behaviors among adolescent girls. What is known is that topic-specific dialogue (i.e., abstinence, condom use, etc.) is consistently more effective than more global forms of communication (i.e., "don't have sex"). Yet, one topic, still significantly unexplored, is if and how parent–adolescent communication about sexual pressure promotes STI/HIV protective behaviors among adolescent girls. To date, no literature has been found that specifically explores any links between parent–child communication about sexual pressure and STI/HIV prevention practices.

Maternal Beliefs About Gender Norms

Parent–adolescent sexual communication combined with teens' perception of parental beliefs (especially maternal beliefs) about sexual behavior and its consequences has a

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significant impact on adolescents' sexual experiences (Jaccard et al., 1996; Miller, 2002). Yet, the impact of other maternal beliefs, such as gender norms, on adolescent sexual-risk behaviors has not been previously explored. One gender norm—that males have greater power in sexual and contraceptive decision making than women—has been associated with unprotected sexual behaviors among adult women (Fullilove, Fullilove, Hayes, & Gross, 1990; Shearer, Hosterman, Gillen, & Lefkowitz, 2005; Villarruel, 1998). Conversely, women who perceive they have greater dominance or power within an intimate relationship have been found to have higher condom-use self-efficacy and more positive condom-use expectancies and to engage in safer sexual practices (Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Soet, Dudley, & DiIorio, 1999). Among a sample of sexually active college students, Shearer and colleagues (2005) found that gender attitudes about family roles (attributed to family values about those roles) were associated with condom-use beliefs and that more traditional gender-role attitudes were associated with riskier beliefs. Furthermore, women in that study who perceived greater barriers to condom use and had lower expectancies for sexual enjoyment when condoms were used were more likely to have traditional attitudes about marital roles.

Gender-role attitudes likely play a role in adolescent girls' choices to both engage in sexual behavior and implement safer sex behaviors once sexually active. However, as seen by the limited literature presented on this topic, few studies have explored the role of parent–child communication about resisting sexual pressure or how familial gender norms influence these STI/HIV prevention practices. Thus, this investigation contributes to our understanding of the role of communication from parents (both mothers and fathers) to daughters about resistance of sexual pressure as well as furthers our understanding of maternal gender norms on abstinence or condom use.

CONCEPTUAL FRAMEWORK

The conceptual framework for the study draws from the theory of gender and power (Wingood & DiClemente, 2000), social learning theory (Bandura, 1986), and the theory of planned behavior (Ajzen, 2002; Madden, Ellen, & Ajzen, 1992). As indicated by the theory of gender and power, imbalance in power and control in interpersonal relationships is one means that restricts females' capability to negotiate safer sex (Wingood & DiClemente, 2000). This imbalance of power in relationships can be further reinforced by gender norms and economic inequalities (Wingood & DiClemente, 2000). This power differential places women at increased risk of inconsistent condom use.

The TPB focuses on processes that underlie attitudes (reflection of behavioral beliefs about the consequences of performing the behavior), subjective norms (reflection of normative beliefs about whether important others would approve or disapprove of the behavior), and perceived behavioral control (beliefs about barriers, resources, and opportunities; Madden et al., 1992). The concept of perceived behavioral control emerges from Bandura's (1986) work on self-efficacy. Self-efficacy is defined as the belief that one can successfully accomplish a behavior required to perform an act (Bandura, 1998), a definition that is consistent with the definition for perceived behavioral control, which refers to an individual's belief in his or her capability to organize and execute a behavior (Ajzen, 2002).

These theories guided the identification of modifiable determinants of risk-associated behaviors. In this study model, predictors of STI/HIV prevention were modeled as gender norms (theory of gender and power) influencing attitudes and beliefs about abstinence or condom use (TPB) and those norms' affecting actual practice of abstinence or consistent condom use.

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METHODS

In this cross-sectional survey study, we examined parent factors associated with adolescent girls' risk for STIs/HIV among African American and Hispanic females ages 15 to 19 years. Given the importance of exploring adolescent girls' sexual behavior as influenced by their parents and partner, in this study we chose to examine parental communication about sexual pressure and perceived maternal beliefs about the decision-making process in adolescent girls' male–female relationships.

Setting

Participants were recruited from health clinics and community sites in medium-sized urban areas in Michigan. The clinic sites provided reproductive health care to adolescents (family planning, STI screening, and prenatal care). The community sites provided teens an opportunity to participate in after-school or extracurricular activities. We recruited from a variety of sites to maximize the likelihood that the sample would include sexually experienced and non–sexually experienced girls. In addition, these recruitment sites were purposively selected because they were used primarily but not exclusively by low-income African American and Hispanic teens, which was the population of interest.

Procedures

Interviews were conducted between October 2004 and July 2005. Participants were recruited using flyers and snowball technique (participant referral) and through small-group presentations at the community sites. Girls who expressed an interest in participating were screened for eligibility either in person or on the telephone. Eligibility criteria were the following: (a) being 15 to 19 years of age, (b) self-identifying as African American or Hispanic, (c) not having previously given birth, and (d) being fluent in English. Adolescents who were 18 or 19 years of age provided written informed consent. For adolescents ages 15 to 17 years, written informed consent was obtained from a parent or guardian and assent from the participant. Institutional review board approval was obtained from both Michigan State University and the Michigan Department of Community Health. Research assistants conducted each face-to-face individual interview (approximately 1 hour) in a private room. Participants received $20 as compensation for their time and effort.

Measures

The study survey assessed a variety of parent factors as well as gathering background and health information. For these analyses, we used questions on demographic characteristics, parental sexual-risk communication, maternal gender norms about relationship power, and girls' sexually protective behaviors. Maternal gender norms about relationship power were operationalized as mothers' beliefs (as perceived by the adolescent) about whether male partners should have greater decision-making influence in the relationship. Demographic information included family composition, age, race/ethnicity, and socioeconomic status. Mother's education and receiving any Medicaid and/or any other assistance were used as a proxy for socioeconomic status, as our only source of information was the adolescent, which made accurate assessments of parental income less feasible. For questions pertaining to the mother, teens referenced their mother or other primary female parenting adult (mother figure). For questions pertaining to father, teens referenced their father or other primary male parenting adult (father figure).

Parent–teen sexual risk communication—The Parent–Teen Sexual Risk Communication Scale, Version 3 (PTSRC; Hutchinson, 2007) was used to collect data on general parent–adolescent communication about sexual risk in seven areas (original scale includes eight variables; the last variable was modified to create the four sexual-pressure

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items). In this study, alpha for unchanged scale items was α = .91 for mothers and α = .92 for fathers, consistent with the reliability of the original scale (α = .93 and .88 for mothers and fathers, respectively; Hutchinson, 2007). The overall scale, including the unchanged and modified scale items, was also shown to have excellent internal reliability (mothers, α = .94, and fathers, α = .95).

Parent–adolescent communication about sexual pressure—Parent–adolescent communication was defined as mothers' and fathers' verbal conveyance of information about sexual pressure. This was assessed using four questions with a response set as follows: 1 = *none (not at all)*; 2 = *very little*; 3 = *some*; 4 = *a lot*; and 5 = *everything (extensively)*. Each question was asked with regard to mother (or mother figure) and father (or father figure) separately. Questions were (a) How much did s(he) tell you about sexual pressure from dating partners? (b) How much did s(he) tell you about peer pressure in relation to sex? (c) How much did s(he) tell you about how to resist pressure about sex from dating partners? and (d) How much did s(he) tell you about how to resist pressure from other peers about sex? These four questions were based on one item pertaining to sexual pressure from peers or dating partners from the PTSRC-III (Hutchinson, 2002, 2007; Hutchinson & Cooney, 1998). Reliability of changed items was assessed and remained high (α = .900 and α = .933 for mothers and fathers, respectively).

Maternal beliefs about relationship power (gender norms)—Maternal belief about relationship power was defined as the adolescent's perception of her mother's belief about whether male partners should have more influence in decision making. It was assessed using two questions created by the first author based on previous research (Pulerwitz, Gortmaker, & DeJong, 2000; Teitelman & Loveland-Cherry, 2004). The questions were pilot tested with African American and Hispanic adolescent girls for meaning and comprehension, and the questions were reworded according to the girls' feedback and suggestions. The reworded questions were then deemed appropriate through a group discussion between research team members and four girls who pilot tested the questions. The two questions pertaining to mother's beliefs regarding relationship power, as perceived by the daughter, were (a) she believes a young woman should place the young man's need before her own and (b) she believes a young man should have more influence than a young woman over important decisions that affect them both. The response format for these two items was a 4-point Likert scale, with responses categorized as no (*definitely or probably no*) and yes (*definitely or probably yes*).

STI/HIV prevention practice—STI/HIV prevention practice was defined as sexual behaviors that reduce the risk of acquiring STIs/HIV (abstinence or consistent condom use during sexual intercourse). Other researchers have used measures of adolescent sexual risk taking that have combined sexual activity as well as consistent condom use (Dutra et al., 1999). Our measure of sexually protective behaviors was based on the Healthy People 2010 definition of responsible sexual behavior, which is defined as either abstaining from sexual intercourse or using condoms if sexually active (U.S. HHS, 2000). The three items that composed the variable were an answer of *yes* to either the question (a) have never had sex or (b) have always used condoms during sex and (c) used a condom at last sex. For the purposes of this study, sex was defined as penile-vaginal intercourse.

DATA MANAGEMENT AND ANALYSIS

All data were double entered into the database. Subsequently, they were thoroughly checked, including careful review for out-of-bound data points and for consistency between the data entered and survey skip patterns. Frequencies and percentages were calculated for all items. The relationships between items and consistent STI/HIV prevention practice were

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first tested using Fisher's exact tests and chisquare tests. Demographic factors (Table 1), number and gender of parental figures, closeness and comfort variables, and partner variables of "partner gets his way" and "partner has more influence" were assessed as potential covariates. None of these variables were significant once the communication variables were accounted for, and hence, they are not included in the tables or discussion. Logistic regression analyses were then performed to evaluate the relative importance of the various items, having adjusted for important demographic variables such as age, race, and socioeconomic status (as measured by receipt of Medicaid).

RESULTS

A total of 118 participants were included in the analyses (entire survey study sample). Demographic characteristics of the sample are given in Table 1. Overall, the average participant was 15 to 17 years old (71%, mean 16.38 years ± 1.33), self-identified as African American (64%), and currently had a boyfriend (90%). The majority of adolescents' mothers had at least some college education (59%).

Forty-four percent ($n = 52$) of the girls reported never having had sexual intercourse; of the girls who reported being sexually active ($n = 66$), 42% ($n = 28$) stated they used condoms consistently and at last sex. Thus, 80 girls (68%) practiced consistent STI/HIV prevention either through abstinence or consistent condom use during sexual intercourse.

Parent–Adolescent Sexual-Risk Communication

Items from the PTSRC-III (Hutchinson, 2007) were assessed to provide an understanding of parent–adolescent communication about sexual risk among this sample. Seven of the eight items in this scale were kept as is; the last, communication about sexual pressure from partners and peers, was modified from one item to four items (as explained above). Of the original items, only mother's talking about waiting to have sex was significantly related to STI/HIV prevention practices; girls were three times more likely to practice consistent STI/HIV prevention practices when mothers talked at least very often about waiting to have sex (OR = 2.81; $p = .036$).

Communication About Sexual Pressure

Analyses revealed that there were differences in the amount of communication about sexual pressure that teens reported receiving from their mothers as compared to fathers. More than half of the mothers talked about each of the four sexual-pressure items (sexual pressure from dating partners, peer pressure in relation to sex, resisting pressure about sex from dating partners, and resisting pressure from other peers about sex) at least very often, as compared to only a third of fathers (sexual pressure from dating partners [$p = .005$]; peer pressure in relation to sex [$p = .001$]; resisting pressure about sex from dating partners [$p = .006$]; and resisting pressure from other peers about sex [$p = .055$]).

In unadjusted analyses (see Table 2), we found that adolescent reports of communication about sexual pressure with mothers did influence consistent STI/HIV prevention practice. Teens were twice as likely to practice abstinence or consistent condom use during sexual intercourse (STI/HIV prevention practice) if they reported greater communication with their mother about sexual pressure from dating partners (OR = 2.25; $p = .050$) or resisting sexual pressure from dating partners (OR = 2.12; $p = .049$). Maternal communication about sexual pressure from dating partners remained significant after adjusting for demographic information (age, race, and socioeconomic status as measured by receiving any Medicaid and/or any other assistance; OR = 3.95, $p = .017$; Table 2); however, resisting sexual pressure from dating partners was no longer significant. One unexpected outcome was that

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teens who reported less communication with mothers about resisting sexual pressure from peers were three times more likely to practice consistent STI/HIV prevention practice (OR = 3.39, $p = .045$). This outcome was the same for girls who practiced safe sex as well as those who were abstinent.

Paternal communication had no significant influence on STI/HIV prevention practice in unadjusted analyses (Table 2); however, adjusted analyses revealed that teens who reported greater communication from fathers about resisting pressure about sex from dating partners were five times more likely to practice consistent abstinence or condom use during sexual intercourse (OR = 4.95, $p = .034$).

Thus, among this study sample, both mothers' and fathers' communication about sexual pressure from dating partners was significantly correlated with adolescent reports of either abstinence or consistent condom use. Differences by parent gender, however, were found in relation to which sexual-pressure variable influenced the outcome variable (consistent practice of STI/HIV prevention); mothers' general communication about sexual pressure and fathers' specific communication about how to resist sexual pressure were associated with abstinence or consistent condom use during sexual intercourse.

Maternal Gender Norms

Very few girls (8%, $n = 10$) perceived that their mothers believed a young woman should place the young man's needs before her own; these small numbers were insufficient for conducting adjusted analyses. Unadjusted analyses did reveal, however, that teens were 11 times more likely to practice consistent STI/HIV prevention if they perceived that their mother believed that men's needs are *not* more important than women's (OR = 11.5, $p = .029$). Close to one third (31%, $n = 36$) of the girls perceived that their mothers believed a young man should have more influence than a young woman over important decisions that affect them both. However, this belief did not have any significant influence on consistent STI/HIV prevention practices ($p = .930$).

Sexually active group—Additional analyses (not shown) were conducted on the group of adolescent girls who reported being sexually active ($n = 66$); the same sexual-pressure variables proved important in this smaller group. Furthermore, in this group, the maternal norm that young men should have more influence about important decisions in the relationship maintained a statistically significantly association with less consistent STI/HIV prevention practice even in adjusted analyses (OR = 6.6, 95% confidence interval = 1.1, 38.5).

Thus, among this sample, maternal gender-norm beliefs outcomes were mixed. Although girls' perceptions of their mother's beliefs that men's needs were more important than women's needs were not significantly correlated with STI/HIV prevention practices, beliefs that influence important decisions did reveal significant results.

DISCUSSION

Findings from this study support prior literature that shows a correlation between parent–child communication about sexual risk, specifically talk about postponing sexual debut, and STI/HIV prevention practices (DiIorio et al., 1999; Dutra et al., 1999; Hutchinson, 2002; Hutchinson et al., 2003; Jaccard et al., 1996; Miller et al., 1998). The outcomes of this study extend these earlier findings. Teens whose mothers had communicated about sexual pressure from dating partners or resisting sexual pressure from dating partners were more than two times more likely than their counterparts to report abstinence or consistent condom use during sexual intercourse. Furthermore, girls who reported father communication about

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resisting sexual pressure were five times more likely to practice consistent STI/HIV prevention.

These analyses moved beyond examining just sexual risk communication to include two variables related to maternal gender norms about male–female relationships. Adolescents who perceived that their mothers believed that men's needs were *not* more important than those of women were 11 times more likely to practice abstinence or use condoms consistently during sexual intercourse. This is a critical finding in that messages from mothers about relevant women's feelings and beliefs related to relationship roles empowered adolescents to consistently enact STI/HIV prevention behaviors.

Within this sample, findings about parent–daughter communication and perceived maternal gender norms were particularly important, given that 56% of the girls were sexually active, higher than the national rate of 46% (CDC, 2006). The significance of these findings may be even greater among a more representative sample, given that only 68% of the girls practiced either abstinence or consistent condom use during sexual intercourse, 17% lower than the 85% of adolescents who reported abstinence or used condoms in the 1999 Youth Risk Behavior Survey (YRBS; U.S. HHS, 2000).

Sexual Pressure Communication

The findings indicate that maternal communication about partner pressure and paternal communication about resisting partner pressure were associated with girls' STI/HIV prevention behaviors compared to among girls with less communication, which supports part of our first hypothesis.

Contrary to this first hypothesis, less maternal talk about peer pressure was associated with decreased STI/HIV risk behaviors among girls. It may be that peer norms and not sexual-risk communication influence this variable. Although there was an association, the direction of causality can not be determined. We also do not know if mother–daughter discussions are taking place before or after sexual-risk behaviors are initiated. Whitaker and Miller (2000) suggest that lack of communication with parents may cause teens to turn to their peers, who then influence behavior, through peer norms, toward having sex or having sex without condoms. Perhaps maternal conversations about sexual topics need to begin early to prevent undue peer influence initially and continue through adolescence tailored to girls' developmental needs.

The second hypothesis, that girls who perceived that their mothers held egalitarian gender beliefs would be more likely than their peers to enact STI/HIV prevention practices, was supported. Among sexually active girls, those who perceived that their mothers held egalitarian gender beliefs were more likely to practice abstinence or consistent condom use, and consequently, were at lower risk for STIs/HIV than girls with mothers who did not hold such beliefs.

Discussions with mothers that include the topic of sexual pressure from partners may increase girls' awareness of potentially risky situations and provide them with the ability to avoid these situations to the extent that they have control. This association might also indicate that girls are less likely to engage in sexual risk behaviors when their mothers communicate better and more frequently about sexual topics.

Although found less frequently than conversations with moms, father–daughter conversations may be especially salient for helping girls resist pressure from male partners. Hutchinson (2002) reported that many daughters would like more discussions with fathers about understanding men and resisting pressure from men to have sex. Thus, a father's

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providing information about how to resist pressure may increase an adolescent girl's conviction that she can execute the behaviors required (self-efficacy) to avoid being pressured to have sex in situations in which she and her partner disagree.

Our findings do lend support for the importance of distinguishing sexual pressure from partners and peer sexual pressure in parent–daughter conversations. Because these two processes are manifested differently (Crosby et al., 2000), it is important for parental conversations to review the specific strategies needed to address each form of sexual pressure separately. Ideally, these discussions are part of an ongoing dialogue between parents and daughters about the teens' actual social experiences. Further research could explore the timing of parent–adolescent discussions about the distinct topics of sexual pressure from peers and partners and identify patterns most optimal for STI/HIV prevention.

Maternal Gender Norms

The maternal gender norm (as perceived by the daughter) that young men should have more influence about important decisions in the relationship was associated with less consistent STI/HIV prevention practice among sexually active girls in this study. This suggests that maternal norms about relationship power (that echo an imbalance in decision making favoring males) place sexually active girls at a disadvantage in using condoms consistently. The finding is consistent with previous work, which found that greater relationship power was associated with more condom use (Pulerwitz et al., 2000, 2002). The current study is the first to link girls' perceptions of maternal beliefs about relationship power and increased condom use in daughters. For young women—in particular, those who are also experiencing multiple challenging social exposures such as poverty—the influence of traditional gender norms may place them at greater sexual risk (Amaro & Raj, 2000; Fullilove et al., 1990; Gomez & Marin, 1996; Wingood & DiClemente, 2000), and therefore, addressing the influence of gender-role beliefs becomes imperative.

These findings build on and extend the work of others whose research indicates that increased parent–adolescent communication about sexual topics is associated with reduced sexual risk among adolescent females (Crosby & Miller, 2002; DiClemente et al., 2001). In particular, the findings indicate that both mother's and father's communication, specifically regarding sexual pressure with partners, is associated with the daughter's sexually protective behaviors. This is in contrast to other studies that indicate only mother's (not father's) sexual-risk communication is associated with less frequent sexual-risk behaviors (DiIorio et al., 1999; Dutra et al., 1999). Given that girls' perceptions of maternal beliefs are influential to girls' sexual decision making (Jaccard et al., 1996; Miller, 2002), these results highlight the importance of addressing gender norms about decision making in future family-based interventions designed to reduce adolescent girls' risk for STIs/HIV.

Limitations

There were a number of limitations to this study that are important to identity. Although we assessed whether discussion about sexual pressure and how to resist it took place between parents and adolescents, we do not know the specific content or quality of these discussions. It would be important in future studies to examine the nature of the discussion to better determine the most effective risk-reduction strategies. Furthermore, the use of dichotomous outcome (yes/no) measures in this initial analysis means that only strong associations between the variables were able to be detected. However, because this study was conducted with hard-to-reach minority teens, it is these strong associations that are of most interest for directing future research.

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Because this was a cross-sectional study, we have identified associations but cannot assess temporal order or direction of causality. Longitudinal studies with larger sample sizes are needed to more fully understand these associations. Also, because this sample comprised African American and Hispanic girls, primarily from low-income households in the midwestern United States, we do not know to what extent these findings may apply to other populations.

We have made the assumption that greater teen awareness of sexual situations involving pressure and how to resist them will increase their ability to prevent being pressured into sexual situations they do not want. Although this may be the case some of the time, there may be situations in which girls are aware of sexual pressures and knowledgeable of how to resist them but are not able to prevent a sequence of events that puts them at greater sexual risk. Further research is needed to identify environmental exposures that increase risk of sexual pressure by partners, and these findings can be used to develop appropriate, comprehensive prevention interventions that address both the individual risks as well as social exposures.

Implications

Given the context of increased STI/HIV risk faced by minority urban girls, it is especially critical that parents discuss partner dynamics with their daughters. In particular, conversations about sexual pressure with available mother and father figures may bolster girls' STI/HIV protective behaviors, as would mothers' support for egalitarian decision making in partner relationships. However, additional research is needed about the content and timing of parent–adolescent discussions of sexual pressure and about the different forms of sexual pressure girls experience and strategies for safety to further develop appropriate interventions.

Nurses in practice with youth and their families play a unique role in facilitating these types of conversations. Parents may not feel comfortable expressing their values about abstinence or safer sex or have the information or skills to do so. In these instances, nurses can provide parents with age-appropriate recommendations and resources for initiating communication and providing accurate information to their children (see *Guidelines for Comprehensive Sexuality Education* (3rd ed.), National Guidelines Task Force [2004]; Innovative Approaches to Increase Parent-Child Communication About Sexuality: Their Impact and Examples From the Field, Sexuality Information and Education Council of the United States [2002]; and Raising Sexually Healthy Youth: Rights. Respect. Responsibility. & Parent-Child Communication, Advocates for Youth [2002]). Furthermore, nurses can assist in normalizing the fears and stresses that communication about abstinence and/or safer sex may place on a parent. This support to parents may prove a catalyst in increasing parent–child communication about STI/HIV prevention practices. Practitioners can also provide guidance and support to youths who are challenged with decisions about abstinence and consistent condom use. Last, endorsement of communication with parents and techniques to assist youths in increasing their skills (i.e., using role play) can provide the tools for promotion of sexual-risk communication, a proven method of increasing abstinence and safer sex practices.

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TABLE 1

Demographic Characteristics of the Teens

Characteristic; *n* (%)	All Teens (*N* = 118)	Consistent STI/HIV Prevention Practice: Yes (*n* = 80)	Consistent STI/HIV Prevention Practice: No (*n* = 38)
Age			
15–17	84 (71.2)	66 (82.5)	18 (47.4)
18–19	34 (28.8)	14 (17.5)	20 (52.6)
Race			
African American	76 (64.4)	51 (63.8)	25 (65.8)
Other	42 (35.6)	29 (36.3)	13 (34.2)
Primary race/ethnicity			
African American	76 (64.4)	51 (63.8)	25 (65.8)
Hispanic/Latino	20 (16.9)	14 (17.5)	6 (15.8)
Multiracial	21 (17.8)	14 (17.5)	7 (18.4)
Other	1 (0.8)	1 (1.3)	0 (0.0)
Currentlhiy dating	106 (89.8)	68 (85.0)	38 (100.0)
Mother's education			
High school / GED	44 (40.7)	25 (34.2)	19 (54.3)
Some college	64 (59.3)	48 (65.8)	16 (45.7)
Parental figure or teen receiving assistance	67 (56.8)	46 (57.5)	21 (55.3)

Note. STI = sexually transmitted illness, GED = general equivalency diploma.

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TABLE 2

Relationships Between Maternal Gender Norms About Relationship Power, Mother/Father Communication, and Teen Consistent STI/HIV Prevention Practices

Item; *n* (%)	Consistent STI/HIV Prevention Practice		Unadjusted Odds Ratio[a]	Adjusted Odds Ratio[b] (95% CI)
	Yes (n = 80)	No (n = 38)		
Mother communication:[c]				
Sexual pressure from dating partners			2.25*	
Less	32 (40.0)	23 (60.5)		(ref)
More	47 (58.8)	15 (39.5)		3.95* (1.28–12.21)
Peer pressure in relation to sex			0.83	
Less	37 (46.3)	16 (42.1)		3.39* (1.03 - 11.18)
More	42 (52.5)	22 (57.9)		(ref)
Resisting pressure about sex from dating partners			2.25*	n/s
Less	30 (37.5)	22 (57.9)		
More	49 (61.3)	16 (42.1)		
Resisting peer pressure about sex			1.85	n/s
Less	38 (47.5)	24 (63.2)		
More	41 (51.3)	14 (36.8)		
Father talks about:[d]				
Sexual pressure from dating partners			1.39	n/s
Less	45 (56.3)	24 (63.2)		
More	26 (32.5)	10 (26.3)		
Peer pressure in relation to sex			0.82	n/s
Less	49 (61.3)	22 (57.9)		
More	22 (27.5)	12 (31.6)		
Resisting pressure about sex from dating partners			2.03	
Less	41 (51.3)	25 (65.8)		(ref)
More	30 (37.5)	9 (23.7)		4.95* (1.13–21.74)
Resisting peer pressure about sex			2.12	n/s

Item; *n* (%)	Consistent STI/HIV Prevention Practice		Unadjusted Odds Ratio[a]	Adjusted Odds Ratio[b] (95% CI)
	Yes (n = 80)	No (n = 38)		
Less	43 (53.8)	26 (68.4)		
More	28 (35.0)	8 (21.1)		
Teen's perception that mother believes:				
Men's needs should be placed before own			0.087*	n/s
No	70 (87.5)	38 (100)		
Yes	10 (12.5)	0 (0.0)		
Men should have more influence in decisions[e]			1.04	n/s
No	54 (67.5)	26 (68.4)		
Yes	24 (30.0)	12 (31.6)		

Note: Unadjusted (bivariate) and adjusted odds of consistent practice are given. Separate adjusted models were generated for mother and father communication variables. n/s = not significant, ref = reference group in the analyses, STI = sexually transmitted illness, CI = confidence interval.

[a]Unadjusted odds of consistent practice with yes/more versus no/less.

[b]Final logistic regression models for teen consistent STI/HIV prevention practices, having adjusted for age, race, and socioeconomic status.

[c]Three teens missing mother communication variables as n/a or don't know (n = 115).

[d]Thirteen teens missing father communication variables as n/a or don't know (n = 105).

[e]Two teens missing as n/a or don't know.

*p .05

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