Original Research

Risk Taking in First and Second Generation Afro-Caribbean Adolescents: An Emerging Challenge for School Nurses

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Abstract

School nurses are well positioned to address risk-taking behaviors for adolescents in their care. The purpose of this mixed-method exploratory study was to explore risk taking in Afro-Caribbean adolescents in South Florida, comparing first- to second-generation adolescents. Quantitative and qualitative data were collected from an immigrant group using the adolescent risk-taking instrument to evaluate risk-taking attitudes, behaviors, and self-described riskiest activities. One-hundred and six adolescents participated; 44% were first generation Afro-Caribbean. Data analysis included analysis of variance, frequencies, and content analysis. There were no differences in risk-taking attitudes; smaller percentages of first generation Afro-Caribbean adolescents reported sexual activity, substance use, and violence. Over one third of the sample, regardless of generational status, reported alcohol use, but did not note alcohol or other health-compromising behaviors as "riskiest" activities. It is important to better understand Afro-Caribbean adolescents' perspectives about risky behaviors, and school-based venues offer the best promise for reaching these adolescents.

Keywords

risk, behaviors, Afro-Caribbean, adolescents

Afro-Caribbean people comprise one of the fastest growing ethnic groups in the United States, one in five being either an immigrant or the child of an immigrant (Passel & Cohn, 2009). McCabe (2011) reported that there were 3.5 million Caribbean immigrants residing in the United States, suggesting that this group is larger than some more visible national origin groups. Afro-Caribbean immigrants tend to reside on the east coast; in fact, McCabe continued that 69% of Caribbean people, many of whom are undocumented, live in Florida and New York. Hoefer, Rytina, and Baker (2011) define undocumented immigrants as foreign-born persons who entered the United States without inspection or who were admitted temporarily and stayed, refusing to return to their country of origin on the date assigned by immigration officials.

People from the Caribbean often move to the United States because of relentless poverty and a desire to pursue a better life for themselves and their children. In the New York harbor, there is a perpetual call from America to the world with the inscription on the Statue of Liberty: "Give me your tired, your poor, your huddled masses yearning to breathe free. The wretched refuse of your teeming shore; send those, the homeless, tempest-tossed to me. I lift my lamp beside the golden door!" This message expresses sentiments that encourage immigrants with little indication of the precarious future that can await them.

For Afro-Caribbean people, some dimension of a precarious future is related to health care needs because little is known about the health habits of Afro-Caribbean people whose unique needs and unconventional treatment approaches demand attention if nurses wish to provide optimal care (Archibald, 2011). Even less is known about Afro-Caribbean adolescents who are particularly vulnerable (Portes & Rumbaut, 2005; Rumbaut, 2005). The period of adolescence is accompanied with a need to be heard which has potential to empower. Within the Afro-Caribbean population, where adolescents are often unheard (Jolly, Weiss, & Liehr, 2007), this need is crucial. School nurses are especially well positioned to hear the needs of Afro-Caribbean children because regardless of immigration status, children

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attend school when they arrive in the United States. Schools are their major source of socialization outside the family, and school nurses are often their major health care providers. Enhanced understanding of the behaviors that threaten health for this ever-increasing segment of the Afro-Caribbean population falls into the hands of school nurses.

In recent years, there has been increased focus on adolescents' risk-taking behaviors in the United States, but research that includes or identifies youth by country of origin or immigrant status is still limited. Immigrants in the United States are designated as first or second generation as a description of migrant status. Also, the literature supports that first-generation adolescent immigrants are more prone to risk-taking behaviors (Rumbaut, 2005) than their second-generation peers. Still, research studies in the United States seldom give a glimpse into the risk-taking behaviors of Afro-Caribbean adolescents as a group but consider the Afro-Caribbean component of the sample within a larger immigrant or ethnic group. For instance, Silverman, Decker, and Raj's (2007) study with female immigrant adolescents assessed disparities in experiences of physical and sexual dating violence based on immigrant status and language spoken at home. The researchers found that Black immigrant female adolescents had higher risk for experience of dating violence as compared to their Hispanic and Caucasian American counterparts.

Parker, Sussman, Crippens, Elder, and Scholl's (1998) study on ethnic identification and cigarette smoking grouped Afro-American and Afro-Caribbean adolescents together. They found that 34% of the adolescents tried smoking and 4% were current smokers. In addition, African American/Afro-Caribbean adolescents, who perceived themselves as being "liked" by other ethnic groups, were more likely themselves to smoke. The weakness in that study was the blurring of ethnic/racial distinctions across the group of Afro participants.

Hunt and colleagues (2002) suggest the urgency to understand that immigrant adolescent risk-taking behavior is magnified because "migration" is associated with a host of challenges such as loss of familiar environment, culture, and lack of financial and family stability which often compound usual adolescent angst. While Afro-Caribbean adolescents, like other adolescents, often initiate risk-taking behaviors at early ages (Blum et al., 2003), the added impact of migration on risk taking is unknown. The use of research instruments to measure the complexities of risk-taking behaviors related to culture and ethnicity is overdue as one size does not fit all. For instance, the comprehensive 2005 National Youth Risk Behavior Survey (Eaton et al., 2006) does not recognize heterogeneity within the African American group.

Blum and colleagues (2003) reported that sexual debut in the Caribbean occurred in children as early as 10 years old, and Afro-Caribbean youth are significantly more likely to be simultaneously involved in other risk behaviors such as substance abuse and violence. This insight demands attention because of far-reaching implications that threaten well-being as risk behaviors such as unsafe sexual practices and substance abuse potentiate each other thereby escalating incidence of HIV/AIDS and/or substance dependence. Adolescent conduct and risk-taking behavior has profound impact on health outcomes in adult life (Herrenkohl et al., 2010), which also provides relevance and urgency for this study.

Purpose

The purpose of this study was to explore risk-taking behaviors of Afro-Caribbean adolescents living in the United States. As a first step in considering the impact of migration, the study was designed to compare first- and second-generation adolescents. This study determined "generational status" through birthplace of adolescents and their parents. First-generation adolescents are those young people who were born in the Caribbean with at least one of their parents being Caribbean-born; second-generation adolescents are those young people who were born in the United States with at least one Caribbean-born parent. This approach to operationalizing generational status has been used by other researchers when studying this population (Portes & Rumbaut, 2005; Vazonyi, Trejos-Castillo, & Huang, 2006). The adolescent risk-taking behavior instrument (ARTI), which is estimated at the fourth-grade reading level, was used to address the following research questions:

1. What are the differences in risk-taking attitudes for first- and second-generation Afro-Caribbean adolescents?
2. What percentages of first- and second-generation Afro-Caribbean adolescents report sexual activity, substance use, and violent behaviors?
3. What do Afro-Caribbean adolescents describe as the riskiest activity they have ever undertaken?

Method

Design

This was a mixed-methods exploratory study. The mixed-methods approach was selected because it provides objective and subjective description that promises to contribute to fundamental understanding of unique ethnic/cultural groups such as the Afro-Caribbean population. After obtaining approval from the University Institutional Review Board (IRB), convenience sampling was used to select adolescents by recruiting from community centers with a large representation of Afro-Caribbean adolescents. Invitation flyers were distributed at the centers and the nurse-researcher spoke with assembled groups to introduce the study and answer questions. All parental information was available in English and Creole. Inclusion criteria required participants to be 7th through 12th-grade students of Afro-Caribbean heritage

(Afro-Caribbean themselves or at least one parent was Afro-Caribbean). Both parents and teens consented and agreed on a time and place that was convenient for data collection. Data were collected in a conference room at one of the local community centers. Confidentiality and anonymity were assured and no identifying information was collected. Parents were not present so that adolescents could respond as honestly as possible without fear of retribution. The ARTI was distributed. After completing the questionnaires, each adolescent was thanked and each received a $5 gift card incentive.

In an effort to give back to the community, after all data were collected, at a separately scheduled meeting, the researcher, a nurse practitioner who routinely works with adolescents in a school-based clinic, conducted an information session. She provided an opportunity for questions about risk-taking behaviors and health-related consequences during adolescence. All adolescents at the community center, whether or not they participated in the study, were invited to participate in the information session. In this way, the adolescents could learn essential health information and simultaneously, community capacity could be enhanced through this process of teaching/learning to empower adolescents to make informed health decisions. This process is consistent with the recommendations from Wallerstein and Duran (2006), who describe best practices for community-based research, particularly when working with communities who endure health disparities.

Measures

The ARTI was used to evaluate risk-taking attitudes and behaviors, and also to describe riskiest activities. This scale is a two-part measure including quantitative and qualitative data.

The ARTI has most often been used with African American adolescents (Busen & Kouzekanani, 2000). The instrument was originally developed in 1990 to measure high-risk adolescents' perceptions of risk behavior using the social adaptation and the risk-taking subscale (Busen & Kouzekanani, 2000). Part 1 of the ARTI contains 44 four-point (*strongly agree* to *strongly disagree*) items purported to measure two dimensions, social adaptation and risk taking (Busen, Marcus, & Von Sternberg, 2006). The risk-taking dimension includes risks associated with substance use, sexual activity, and violence. The social adaptation dimension of the ARTI captures social attitudes related to risk-taking behaviors. Reliability for Part 1 of the ARTI, estimated with Cronbach's coefficient α, was documented as .77 and .80 for the social adaptation and risk-taking scales, respectively (Busen & Kouzekanani, 2000). Part 1 of the ARTI was used as it was originally developed. Part 2 of the ARTI contains descriptive variables including demographics and risk-behavior questions. The demographics include age, sex, ethnicity, and birthplace of parents and adolescents. There are 19 questions addressing demographics, and the majority of the questions (79%) were introduced in this research to ascertain specific Afro-Caribbean heritage and generational status. There are 22 questions addressing risk behaviors (sexual activity, violence, substance use) and the majority of these questions (68%) were in the original ARTI. Questions added for this research were developed to capture meaningful Afro-Caribbean descriptors of risky behaviors. For instance, a question regarding blunts/blacks (a commonly available street cigarette laced with addictive substances) was added to the question about smoking. There are 41 questions in Part 2 of the ARTI.

In this study, the quantitative component of the ARTI was used to address the first and second research questions. The first question queried attitudes regarding risk taking. Higher scores indicated attitudes that were consistent with higher risk-taking activity. Risk-taking behaviors reported in Part 2 of the ARTI were used to address the second research question. The qualitative component of the ARTI, containing open-ended questions where the participant wrote about their riskiest activity, was used to address the third research question.

Sample

One hundred and six adolescents participated, resulting in a small (.2) to medium (.5) effect size (Cohen, 1992). The nurse-researcher, who is Afro-Caribbean, personally solicited participants for this convenience sample. She spoke with assembled groups at the community centers to introduce the study and answer questions. Both male ($n = 49$) and female ($n = 57$) adolescents were included; 44% of the adolescents were first-generation and 56% were second-generation Afro-Caribbeans. The mean age for both generational groups was 16 ($\pm$ 1.8) years. Fifty-nine percent of the first-generation and 98% of the second-generation adolescents had lived in the United States for over 5 years. Nearly 60% of the first generation adolescents did not have a Social Security number, a descriptor suggesting undocumented status. Thirty-one percent of the sample was of Haitian descent, and 69% represented a range of Caribbean countries including the Bahamas, Jamaica, and Turks and Caicos Islands. Forty percent of the adolescents lived with single mothers, and sexual debut occurred at an average of 11.5 ($SD = 3.3$) years.

Analysis

The first research question, which queried differences in attitudes about risk taking, was addressed with one-way analysis of variance. The second question was addressed with frequencies to describe risk-taking behaviors associated with sexual activity, violence, and substance use. For the third research question, data were analyzed using conventional content analysis (Hsieh & Shannon, 2005) distinguishing the responses of first- and second-generation adolescents. Two

Table 1. Risk-Taking Behaviors for First- and Second-Generation Afro-Caribbean Adolescents.

	First generation		Second generation	
	($n = 47$)	%	($n = 59$)	%
Sexual activity				
Ever had sex	($n = 17$)	38	($n = 34$)	58
Use birth control if sexually active	($n = 5$)	29	($n = 11$)	33
Never talk to parents about sex	($n = 22$)	47	($n = 34$)	58
Substance use				
Street drugs	($n = 4$)	9	($n = 6$)	10
Black/blunts	($n = 6$)	13	($n = 13$)	22
Alcohol	($n = 16$)	34	($n = 21$)	36
Violence				
Kicked out of school for fighting	($n = 6$)	13	($n = 7$)	12
Arrested	($n = 3$)	6	($n = 10$)	17
Witnessed shooting or stabbing	($n = 14$)	30	($n = 22$)	37

independent researchers grouped similar adolescent responses within each generational status category. The separate analyses were compared for consistency. The agreed-upon grouped responses were identified with researcher-generated themes.

Results

Research Question #1: What is the difference in risk-taking attitudes for first- and second-generation Afro-Caribbean adolescents living in the United States? There was not a significant difference in risk-taking attitudes ($p = .06$) between the groups (first generation; second generation). However, the data indicate that second generation adolescents had higher scores ($2.1 \pm .47$) on the risk-taking attitudes component of the ARTI compared to first generation adolescents ($1.9 \pm .43$).

Research Question #2: What percentage of first and second generation Afro-Caribbean adolescents report sexual activity, violence, and substance use behaviors? Three items on the scale addressed each risk-taking behavior (Table 1). Fifty-eight percent of the second generation and 38% of the first generation teens reported sexual activity and no more than one third reported using birth control. Also, 48% and 58% of first and second generation, respectively, reported that they never talk to their parents about sex. Regarding substance use, blacks/blunts (a commonly available street cigarette laced with addictive substances) were used by 22% of second-generation adolescents and 13% of first-generation adolescents (Table 1). More than one third of the adolescents in each group reported alcohol use. The questions addressing violence included "exposure to" violence (witnessing) and "engagement in" violence (fighting; arrests). A higher percentage of second-generation adolescents (37% vs. 30%) witnessed violence and these adolescents reported nearly 3 times the frequency of arrests as the first-generation adolescents.

Research Question #3: What do Afro-Caribbean adolescents describe as the riskiest activity they have ever undertaken? Table 2 identifies the major content themes including the number of adolescents by generational status. The table also provides examples of excerpts from participants' responses. In addition to the reported sexual activity, violence, and substance use, themes of "thrill-seeking," "stealing/lying," and "challenging authority" emerged. Consistent with the other components of the ARTI, a higher number of second-generation adolescents described riskiest activities in each category except in the category of "challenging authority."

Discussion

The main objective of this study was to explore the risk-taking behaviors and attitudes of Afro-Caribbean adolescents in the United States, a population that is on the rise and that often relies on school nurses for health care services. The data were collected in an area of South Florida with a dense population of Caribbean Americans. Being cognizant of the high rate of immigration to this region, this study is significant at many levels as the majority of first-generation participants were undocumented, suggesting life experience that was compounded by the issues associated with immigration, acculturation, and access to health care in America. This study also sheds a light on first- to second-generation distinctions in attitudes and behaviors. It suggests that first-generation Afro-Caribbean adolescents are at lower risk of engaging in sexual activity, violence, and substance use than those Afro-Caribbean adolescents born in the United States. This finding is consistent with some studies (Bagley, 1972; Portes & Rumbaut, 1996), while it is divergent from others such as Kao (1999). Since findings are

Table 2. Riskiest Behaviors Reported by First and Second Generation Afro-Caribbean Adolescents.

Riskiest behaviors	# of 1st/2nd generation	Example excerpts
Sexual activity	3/5	Having sex so young
		Having sex with a man I do not know
Substance use	1/4	Drink from my uncle's liquor
		Trying blacks
Aggression	2/10	Beating up a grown man
		Hitting my little sister till she bleed
Exposure to threatening environment	2/4	Being with people—shooting/stabbing
		Being in an all White place, listening to White kids discriminate against Blacks
Thrill seeking	4/8	Driving and running a red light
		Jumping off a bus while in motion
Stealing/lying	5/11	Forging my mom's signature
		Stealing from Wal-mart
Challenging authority	10/6	Running from the police
		Going out without my parents knowing

inconsistent in the literature, much remains unknown. What is known, however, is that there are complex interactions related to generational status that affect health and behavior for immigrant children (Hamilton, Noh, & Adlaf, 2009). The majority of the first-generation participants lived in the United States 6 or more years, suggesting potential for assimilating into the American culture. As new immigrants spend more time in the host country they become more exposed to open discussions about sexual behaviors (Portes & Rumbaut, 2005) and might become more comfortable reporting and/or engaging in risk-taking behaviors. Future studies using the ARTI, and following adolescents longitudinally through the immigration process are warranted as this program of research advances.

In spite of the researcher's efforts to assure anonymity, differences in reported behaviors may be related to fear of repercussion for providing an honest self-report. Caribbean children are taught "not to disclose" by their parents who fear that information might circle the community and eventually "get back home" (Archibald, 2010). That might be one reason the first generation Afro-Caribbean teens' reports of risky behaviors were lower than their second generation peers' reports. Disobeying parental rules about disclosure could result in beating or flogging, a disciplinary action that has widespread support in the Caribbean. For some Caribbean families, "corporal punishment" has long been accepted as a successful approach for eliciting desired behavior and children's fear of being beaten influences behavior and engenders silence regarding behavior that would not be endorsed by parents.

Threats of deportation seem to be omnipresent among undocumented immigrants. This insecurity is another factor that most likely influenced reports of behaviors for first-generation adolescents. In this context, health care providers, teachers, and neighbors may be considered authorities. In fact, anyone who is documented is perceived as a threat to hopes of living in the United States. The insecurity associated with being undocumented might contribute to the lower percentages of adolescents reporting high-risk behavior for the first-generation segment of this sample. Threatening the hope for realizing the coveted American dream compounds the identity challenges faced by these immigrant adolescents. As Achkar and Macklin (2009) eloquently brought to view, immigrant families may be wary of data gatherers at this time in the United States when illegal immigrants are the focus of much contentious political discussion.

The use of alcohol by at least one third of the sample is particularly troubling although it converges with previous work with immigrant adolescents (Epstein, Botvin, Baker, & Diaz, 1998). Afro-Caribbean adolescents might have a high risk of developing alcohol use because of unsupervised free time and an unstable social environment (Archibald, 2007), where parents are eager to and have the opportunity to hold multiple jobs—a phenomenon that is unheard of in many third-world countries. In the Caribbean, family structures thrive on the support of extended family living in the community (Archibald, 2007; Blum et al., 2003), which is not always present in the United States. Still, parental absence may be perceived by the adolescent as neglect or rejection (Epstein et al., 1998), thereby contributing to risk-taking behaviors.

Questions related to social–emotional challenges such as these need further study in which adolescent voice is queried during one-on-one dialogue by nurse-researchers who can access these adolescents in school-based settings. No studies of this nature were traced in the literature. Rumbaut (2005) provides a relevant perspective regarding social–emotional challenge for immigrant adolescents. He identified two turning points that can curtail adolescents' progress toward educational and occupational opportunities: incarceration and childbearing for males and females, respectively.

Neither group viewed unprotected sex as a "riskiest" activity. Understanding the mismatch between reported

frequencies of risk-taking behavior (Table 1) and the qualitative data (Table 2) is critical and demands further study, where nurse-researchers could query Afro-Caribbean adolescents about their perspectives regarding sexuality including introduction to sexual activity, safe sex practices, and consequences of unprotected sexual activity. There is evidence that it is possible to affect changes in adolescents' risky sexual behavior (Kirby et al., 2004), but researchers have generally not incorporated unique cultural nuances which influence decisions about behavior. For instance, Hayter and colleagues (2012) from the United Kingdom advocate for school-based sexual health clinics, which incorporate strong stakeholder voice, including the voice of adolescents. Translation of this sort of programming to the United States with attention to distinct cultural groups, like Afro-Caribbean adolescents, is warranted.

Although small, the number of reported arrests in this immigrant group, as with any other group, is troubling. Kposowa, Adams, and Tsunokai (2010) reported that sometimes the crimes that immigrants commit are solely for survival and might be unsubstantiated yet serve as evidence for stereotyping. Stereotyping biases may feed into political perspectives and even media ratings (Rumbaut, Gonzales, Komaie, Morgan, & Tafoya-Estrada, 2006) at the expense of a people seeking a better life. In reality, studies find few connections between increased immigration and a rise in crime (Martinez, Lee, & Nielsen, 2004) and there is suggestion that immigration might be a way to stabilize and revitalize deteriorated communities (Martinez, 2006). This is clearly an area of study that warrants attention as our immigrant population continues to grow.

Limitations and Recommendations

Several factors limit generalizability of study results. The use of convenience sampling contributed to potential for biased findings with self-selection by those who chose to volunteer. The Afro-Caribbean adolescents were recruited from community centers representative of five Caribbean islands. A broader representation would be available in schools and a next step would be to engage with school nurses to extend this work. The overall sample size in this study was relatively small, limiting the ability to determine a significant difference between the generational groups and contributing to the potential for a Type II error. Further research is needed with a larger sample of Afro-Caribbean adolescents in school settings. One advantage of conducting the research in school rather than community center settings might be that fear of repercussion is minimized. As larger numbers of students are recruited across grade levels, it would be less likely that reported behaviors could be linked to specific communities or individual adolescents.

In order to shed further light on the issue of risk-taking behavior in Afro-Caribbean adolescents, more scrutiny is needed regarding differences within the immigrant population, with particular consideration for the variation in length of time of residing in the United States as well as other relevant factors that impact acculturation and assimilation. For instance, Kenyon and colleagues (2010) found that factors like having the same sexual partner and communication between partners significantly influenced use of birth control for ethnically diverse adolescent girls. If nurses wish to promote health with this population, further study discerning details of immigrant status are essential.

There is a need for an evidence base documenting effective approaches for reducing risky behaviors and adolescent voice may best inform identification of effective approaches. Qualitative study with this population is an important next step to sort through complex issues left unresolved in this exploratory study, such as adolescent definitions of risk taking, co-occurrence of risky behaviors, understanding of health consequences associated with risk taking, and factors that contribute to risk protection behaviors.

Implication for School Nursing

The ever-increasing number of immigrant families, such as those of Afro-Caribbean descent, creates both a challenge and an opportunity for school nurses. School nurses are in a unique position to influence adolescent choices regarding risk-taking behaviors. It is important for school nurses to acknowledge immigrant populations as unique and become advocates in the development and implementation of risk reduction and health promotion programs. These programs must be nonthreatening and delivered in an adolescent-friendly environment, where youth can feel free to discuss personal issues that matter to them. A nonjudgmental attitude focused on valuing the adolescent best positions the nurse to give voice to adolescent concerns. Using this nonjudgmental approach, immigrant adolescents' personal responsibility for their health care can be strengthened, and risk-taking behaviors may be reduced or prevented. In addition, conducting research among Afro-Caribbean people and other immigrants is crucial to informing health care providers and policy makers about the complex issues surrounding immigrant populations. The absence of reliable research increases the likelihood that policies and programs will be dismissive rather than inclusive and effective.

Conclusion

This study contributes foundational information for understanding risk-taking behaviors for Afro-Caribbean adolescents, a steadily growing segment of the U.S. population. Although focused on one distinct cultural group, the study highlights the importance of coming to know adolescents who tend to be silenced. Practicing nurses, especially school nurses, are called to pay attention to adolescent voice by

considering the risk-taking behavior of immigrant adolescents in their care.

The study suggests that Afro-Caribbean adolescents have a number of behavioral health risks. These risks can have significant and lasting health consequences. Since most immigrant and Afro-Caribbean adolescents attend public school (Hernandez, 2004), school nurses are the major health care providers for this population. Implementing culturally sensitive health care and education programs in school settings will increase access to care for this population. It is critical that environments be created where these adolescents, regardless of legal or generational status, can express themselves to caring school nurse listeners, enabling authentic assessment of their health risks. School nurses are best positioned to provide culturally appropriate guidance that empowers these youth to achieve optimal health.

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