Is Lack of Sexual Assertiveness Among Adolescent And Young Adult Women a Cause for Concern?

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CONTEXT: *Understanding young women's sexual assertiveness is critical to developing effective interventions to promote sexual health and reduce sexual risk-taking and violence. Young women's perception of their sexual rights may vary according to demographic characteristics, sexual health behaviors and victimization history.*

METHODS: *Data were collected from 904 sexually active 14–26-year-old clients of two family planning clinics in Texas, reflecting their perceptions of their right to communicate expectations about or control aspects of their sexual encounters. Logistic regression analysis was used to assess which characteristics were independently associated with believing that one never has each specified sexual right.*

RESULTS: *Almost 20% of women believed that they never have the right to make their own decisions about contraception, regardless of their partner's wishes; to tell their partner that they do not want to have intercourse without birth control, that they want to make love differently or that their partner is being too rough; and to stop foreplay at any time, including at the point of intercourse. Poor grades in school, sexual inexperience, inconsistent contraceptive use and minority ethnicity were independently associated with lacking sexual assertiveness.*

CONCLUSIONS: *Many sexually active young women perceive that they do not have the right to communicate about or control aspects of their sexual behavior. Interventions to prevent sexually transmitted diseases, unwanted pregnancy and coercive sexual behaviors should include strategies to evaluate and address these perceptions.*

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An important part of adolescence is the development of sexuality and the achievement of good sexual health. Sexual development is characterized by the acquisition of skills used to control feelings of sexual arousal and to manage the consequences of sexual behavior, as well as by the development of new forms of sexual intimacy.[1] Despite the complexity of this process, researchers and others concerned with adolescent sexuality tend to focus only on whether teenagers have had sexual intercourse and on whether they have been involved in an unintended pregnancy.[2] Consequently, research has examined outcomes of sexual behavior, such as precocious sexual activity or unintended pregnancy, and little is known about the social interactions that accompany these behaviors.[3] An important component of intimate social interactions is one's repertoire of strategies for promoting or discouraging sexual contact.[4] Given the elevated risk of dating violence among adolescents[5] and the concomitant threats of unintended pregnancy and sexually transmitted diseases (STDs), increased understanding of factors that promote effective communication about sexual contact is of considerable value.

A young woman's ability to effectively communicate her sexual beliefs and desires is a necessary step toward her development of healthy sexual intimacy, and is critical if she is to adequately protect herself against unwanted or unsafe sexual activities.[6] In the current cultural context, where traditional gender roles establish the expectation that men will initiate sexual activity and women will respond with permission or denial,[7] it is critical that young women be able to clearly communicate their sexual beliefs and desires. Failure to do so may place them at risk for unintended pregnancy, STDs, sexual coercion, violence and other negative sexual experiences.[8]

The construct of sexual assertiveness has been developed to further the understanding of women's communication strategies to protect their sexual health and autonomy, and is predicated on the assumption that women have rights over their bodies and to behavioral expressions of their sexuality.[9] For example, a young woman's ability to engage in safe sexual practices is dependent on her partner's willingness to take measures to avoid unintended pregnancy and STDs. If a young woman does not believe that she has the right to assert her desire for effective protection, she increases her risk of pregnancy and infection, regardless of whether she experiences any overt sexual coercion. Another adolescent may not feel that she has the right to refuse sexual intercourse once she has had sex with a partner. Thus, cognitive-behavioral interventions to promote sexual health, as well as to reduce sexual risk-taking and unwanted sexual experiences, should be grounded in an understanding of adolescent and young adult women's perceived sexual assertiveness.

Research examining beliefs and attitudes about sexual behaviors among adolescent females is limited. However,

a study conducted among a large sample of young adult women found that the anticipation of negative reactions from male partners was significantly associated with decreased abilities to refuse unwanted sex and to effectively engage in pregnancy and STD prevention; another important finding was that previous sexual experience was associated with an increased ability to initiate intimate behavior.[10] It is less clear, however, if beliefs about sexuality vary by demographic characteristics, such as race and ethnicity, or by sexual behaviors, such as having multiple sexual partners. This article examines how perceived sexual assertiveness varies according to women's demographic characteristics, sexual health behaviors and history of violence.

DATA AND METHODS

Sample

Female clients of two Title X–funded, community-based family planning clinics operated by the University of Texas Medical Branch at Galveston were recruited by a bilingual research assistant between April and November of 1997. All sexually active women aged 14–26 who identified themselves as being white, black or Hispanic, who were not currently pregnant or were less than six weeks postpartum, and who did not demonstrate any obvious cognitive or mental impairment were eligible to participate in the study. (Although we attempted to consecutively recruit participants, it is likely that we missed some eligible women because of clinic traffic patterns or scheduling.) The research assistant outlined study requirements and eligibility criteria in Spanish or in English. After giving oral informed consent, each woman completed an anonymous self-administered questionnaire in English or Spanish; participants received five dollars as compensation for their time and effort. The methods used to recruit participants and the study procedures, including the questionnaire, have been described in more detail elsewhere.[11]

Of 990 potential participants, 904 agreed to take part in the study and completed the questionnaire. (Fifty-four women refused to participate because of time constraints; 32 agreed to participate but did not complete the questionnaire.) The only difference noted between those who completed the questionnaire and those who refused or did not finish was that women who refused or did not finish were more likely than those who completed the questionnaire to speak only Spanish. Therefore, our results may not be representative of young women attending these family planning clinics who speak only Spanish.

Questionnaire

We pilot-tested the questionnaire on a sample of 25 women to ensure readability, ease of understanding and reasonable completion time. The final 12-page instrument contained five sections: demographic characteristics (e.g., age, race and ethnicity), reproductive characteristics (e.g., parity, gravidity and age at menarche), contraceptive use and high-risk sexual behaviors (e.g., number of sexual partners, use of drugs prior to sex), lifetime history of physical or sexual violence, and perceived sexual assertiveness. The last section consisted of 13 items starting with the phrase "I have the right to"; participants indicated whether they felt that they never, sometimes or always have the right to engage in each behavior.[12]

Statistical Analyses

Participants were categorized as being in one of three age groups: 14–17, 18–21, or 22 or older. Each women was asked what letter grades she typically received in her last year of school; answers were coded into three categories: B average or higher, C average, or less than a C average. Sexual experience was based on the participants' lifetime number of sexual partners: 1–2, 3–5, or six or more. Participants who reported using birth control sometimes, about half of the time or most of time in the last year were defined as inconsistent contraceptive users; women who reported using some form of contraception at each act of intercourse were defined as consistent users. We classified a woman as having a history of physical violence if she affirmed that someone (a parent, sibling, boyfriend, friend or stranger) had ever hit, slapped, kicked or otherwise physically hurt her enough to cause bruising or bleeding; we considered a woman to have experienced sexual assault if she indicated that she had ever been touched without her permission, forced to touch someone or forced to have intercourse.

We conducted logistic regression analyses to assess which characteristics were independently associated with believing that one never has each specified sexual right. All analyses controlled for the effects of age, race and ethnicity, sexual experience, academic grade average, parity, consistent contraceptive use in the last year and lifetime history of physical and sexual assault.

RESULTS

Overall, 27% of respondents were aged 14–17 years, 43% were 18–21 and 30% were 22–26. The sample was almost equally divided among white, black and Hispanic women. Approximately half (54%) of respondents reported using birth control at every sexual encounter in the last year; 44% had one or more children. Of the total sample, 13% reported early menarche (age 10 or younger), 32% had had six or more sexual partners, 34% had a history of physical assault and 21% had a history of sexual assault.

The proportion of respondents who reported believing that they never have specific sexual rights ranged from 8% to 49% (Table 1, page 180). Specifically, 8–9% believed that they never have the right to make their own decisions about sexual activity, regardless of their partners' wishes, or to tell their partners when they are or are not interested in sex, or when they want to be hugged or cuddled without having sex. Larger proportions (15–19%) believed that they never have the right to make decisions about contraception regardless of their partners' wishes; to tell their partner that they do not want to have intercourse without birth control, that they want to make love differently or that he is being too rough; to ask their partner if he has been ex-

TABLE 1. Percentage distribution of family planning clinic clients aged 14–26, by how frequently they believe they can assert various sexual rights

Sexual right and perceived frequency of assertiveness	% (N=904)
To make own decisions about sexual activity, regardless of partner's wishes	
Never	9
Sometimes	13
Always	78
To make own decision about birth control, regardless of partner's wishes	
Never	17
Sometimes	15
Always	69
To tell partner "I want to make love"	
Never	9
Sometimes	30
Always	61
To tell partner "I do not want to make love"	
Never	8
Sometimes	30
Always	62
To tell partner "I won't have sex without birth control"	
Never	16
Sometimes	18
Always	66
To tell partner "I want to make love differently"	
Never	16
Sometimes	34
Always	50
To masturbate to orgasm	
Never	49
Sometimes	18
Always	33
To tell partner he is being too rough	
Never	19
Sometimes	28
Always	53
To tell partner "I want to be hugged or cuddled without sex"	
Never	8
Sometimes	30
Always	62
To tell relative "I am not comfortable being hugged or kissed in certain ways"	
Never	27
Sometimes	15
Always	57
To ask partner if he has been examined for STDs	
Never	15
Sometimes	13
Always	72
To stop foreplay at any time, including at the point of intercourse	
Never	18
Sometimes	27
Always	55
To refuse to have sex even if she has enjoyed it with this partner before	
Never	17
Sometimes	28
Always	55
Total	100

amined for STDs; to stop foreplay at anytime, including at the point of intercourse; and to refuse to have intercourse, even though they may have had sex with that partner before and enjoyed it. However, 27% felt that they never have the right to tell a relative that they are uncomfortable being hugged or kissed in certain ways, and 49% reported that they never have the right to masturbate to orgasm.

On the other hand, roughly 50–60% of women believed that they always have the right to tell their partner that they want to make love differently and that he is being too rough; to tell a relative that they are not comfortable being hugged or kissed in certain ways; to stop foreplay at anytime; and to refuse to have sex even though they may have had sex with that partner before and enjoyed it. More than 60% reported that they always have the right to make their own decisions about sex and contraception regardless of their partner's wishes; to tell their partner when they are interested or not interested in sex, that they refuse to have sex without birth control or that they want to hug or cuddle without sex; and to ask their partner is he has been examined for STDs

Results of the logistic regression analyses show that a young woman's background characteristics, sexual and reproductive history, and history of abuse are important predictors of her level of sexual assertiveness (Table 2). In comparison with white women, black and Hispanic women have significantly higher odds of perceiving that they never have 11 of the 13 sexual rights studied (odds ratios, 1.6–3.1), including rights that would help them prevent acquiring an STD or becoming pregnant unintentionally. Women with poor grades in school had elevated odds of sharing seven of these perceptions; for example, those with less than a C average were more likely than those with better grades to indicate that they can never stop foreplay or deny intercourse to a familiar partner (1.8 for each). Age has few effects on sexual assertiveness; most important, perhaps, women aged 18–21 had higher odds than older women of considering themselves unable to ask a partner if he has had an STD test (1.7)

Of the factors related to a woman's sexual and reproductive history, lifetime number of sexual partners emerged as the most consistent predictor of her sexual assertiveness: Women who had had only one or two partners were more likely than those who had had six or more to believe that they never have 10 of the 13 rights (odds ratios, 1.7–3.3). Inconsistent contraceptive use was associated with about half of the rights examined (1.5–1.9), and most of these can affect a woman's risk of having an unintended pregnancy. Women who had had one or more births were more likely than those who had never given birth to feel that they never have the right to masturbate to orgasm or to stop foreplay at any time (1.6–1.7).

Finally, physical or sexual victimization was associated with four beliefs about sexual rights. For example, women who had never been physically assaulted had elevated odds of never feeling they have the right to refuse intercourse with a familiar partner (odds ratio, 1.7), and those who re-

TABLE 2. *Adjusted odds ratios (and 95% confidence intervals) from logistic regression analyses assessing the effects of selected characteristics on women's belief that they never have certain sexual rights*

Characteristic	Odds ratio
To make own decisions about sexual activity, regardless of partner's wishes	
1–2 lifetime partners*	2.48 (1.33–4.62)
History of sexual assault	1.96 (1.07–3.57)
To make own decision about birth control, regardless of partner's wishes	
1–2 lifetime partners*	1.96 (1.01–2.57)
To tell partner "I want to make love"	
Black†	2.14 (1.10–4.16)
Hispanic†	2.04 (1.07–4.04)
1–2 lifetime partners*	3.26 (1.64–6.68)
To tell partner "I do not want to make love"	
Black†	2.18 (1.12–4.25)
C average‡	2.09 (1.18–3.72)
<C average‡	2.81 (1.28–6.14)
1–2 lifetime partners*	2.63 (1.31–5.26)
Inconsistent contraceptive use	1.72 (1.03–2.87)
No history of physical assault	2.05 (1.08–3.89)
To tell partner "I won't have sex without birth control"	
Black†	1.97 (1.22–3.17)
Hispanic†	1.82 (1.10–2.99)
<C average‡	1.86 (1.06–3.27)
Inconsistent contraceptive use	1.93 (1.32–2.81)
To tell partner "I want to make love differently"	
14–17§	2.25 (1.31–2.87)
Black†	2.45 (1.48–4.07)
Hispanic†	2.58 (1.54–4.25)
<C average‡	1.85 (1.05–3.27)
1–2 lifetime partners*	2.46 (1.50–4.03)
To masturbate to orgasm	
14–17§	2.06 (1.37–3.11)
18–21§	1.43 (1.01–2.01)
Black†	1.69 (1.20–2.37)
Hispanic†	2.48 (1.73–3.57)
C average‡	1.36 (1.01–1.85)
<C average‡	2.34 (1.43–3.83)
To masturbate to orgasm (cont'd.)	
1–2 lifetime partners*	1.66 (1.15–2.40)
≥1 birth	1.59 (1.17–2.16)
To tell partner he is being too rough	
Black†	1.71 (1.08–2.70)
Hispanic†	1.90 (1.19–3.05)
1–2 lifetime partners*	1.81 (1.14–2.89)
No history of physical assault	1.60 (1.05–2.41)
To tell partner "I want to be hugged or cuddled without sex"	
Black†	3.09 (1.46–6.54)
Hispanic†	2.58 (1.20–5.63)
<C average‡	2.06 (1.01–4.23)
1–2 lifetime partners*	2.85 (1.36–5.99)
Inconsistent contraceptive use	1.85 (1.10–3.12)
To tell relative "I am not comfortable being hugged or kissed in certain ways"	
Hispanic†	1.58 (1.07–2.33)
To ask partner if he has been examined for STDs	
18–21§	1.66 (1.02–2.71)
Hispanic†	1.67 (1.02–2.72)
Inconsistent contraceptive use	1.50 (1.02–2.21)
To stop foreplay at any time, including at the point of intercourse	
Black†	1.75 (1.10–2.79)
Hispanic†	1.65 (1.02–2.68)
<C average‡	1.75 (1.01–3.07)
1–2 lifetime partners*	1.98 (1.22–3.21)
Inconsistent contraceptive use	1.49 (1.04–2.14)
≥1 birth	1.66 (1.13–2.45)
To refuse to have sex even if she has enjoyed it with this partner before	
Hispanic†	1.91 (1.18–3.07)
<C average‡	1.81 (1.03–3.19)
1–2 lifetime partners*	1.88 (1.16–3.04)
Inconsistent contraceptive use	1.52 (1.05–2.19)
No history of physical assault	1.65 (1.08–2.53)

*Reference group is six or more lifetime partners. †Reference group is white. ‡Reference group is B average or higher. §Reference group is is 22–26-year-olds. *Notes:* Consistency of contraceptive use reflects clients' use in the past year. Results are presented only for associations that are significant at p<.05.

ported a history of sexual assault had a higher likelihood than others of feeling that they can never make their own decisions about sexual activity (2.0).

DISCUSSION

Sexually assertive beliefs, behaviors and practices—including acquiring knowledge about preventing pregnancy and STDs; adopting health-promoting values, attitudes and norms; and building proficiency in risk-reduction skills—are important components in the development of sexual health during adolescence.[13] Although we found that many adolescent and young adult women reported having sexually assertive beliefs, almost 20% perceived that they never have the right to refuse to have sexual intercourse, to ask their partner if he has been examined for STDs or to say when their partner is being too rough. These data are of concern, as they represent the beliefs of a sexually experienced group who may be vulnerable to unsafe sexual practices. Thus, it is erroneous to assume that young women who attend Title X clinics are more assertive about their own sexuality because they are seeking reproductive health care. Our findings highlight the importance of understanding how adolescents develop strategies and skills to negotiate sexual behaviors within the context of romantic relationships, so that effective programs for preventing STDs, pregnancy and relationship violence may be developed.

Self-reported minority race or ethnicity and younger age were associated with a relatively low level of sexual assertiveness. Black and Hispanic women were more likely than white women to report believing that they never have most of the sexual rights examined, including the right to tell a partner "I won't have intercourse without birth control." Younger women were more likely than older women to report believing that they never have the right to ask a partner if he has been examined for STDs. These findings may help to explain why adolescents are more likely than adults to acquire STDs,[14] and why minority adolescents are at greatest risk.[15] Previous research among young adult women has

found that peers, the social culture and the interaction of peers and the culture are important influences on managing sexual relationships and behaviors.[16] Thus, effective programs to promote safer sexual behaviors among minority young women need to assess the specific subculture's beliefs and attitudes before addressing skill development.

Another important variable that contributed to young women's belief that they never have various sexual rights was academic performance. Of critical concern is the finding that young women with poor grades often felt that they could not stop foreplay or refuse to have intercourse with a familiar partner. Thus, in addition to encouraging adolescents to stay in school, it is equally important to focus on their school performance to facilitate sexual health among this vulnerable population. Teenagers who achieve better grades may feel more connected to school, which may in turn be protective against a broad range of risky behaviors.[17] Alternatively, youth who have greater sexual assertiveness may have a higher level of self-confidence, which enables them to perform well in a variety of settings, including school.

Young women who reported having had one or two lifetime sexual partners held fewer sexually assertive beliefs than those who were more sexually experienced. In addition, women who reported inconsistent contraceptive use in the last year believed that they did not have many sexual rights. These data are consistent with prior research associating sexual assertiveness with sexual experience[18] and with contraceptive use.[19] In contrast, few differences emerged between the beliefs of young women who had and had not borne children; the differences found suggest that parous women may be more sexually passive and more concerned about their partner's feelings and desires than about their own.[20]

A young woman's physical and sexual victimization history is also relevant to her sexual assertiveness. In a previous study, black adolescent females with a history of dating violence were almost three times more likely than others to have an STD; these young women were also more likely to fear the perceived consequences of negotiating condom use, to fear talking with their partner about pregnancy prevention, to believe that they were at risk of acquiring an STD, to believe that they have little control over their sexuality and to have peer norms that were not supportive of using condoms and of having a healthy relationship.[21] Our data suggest that young women without a history of physical assault were more likely than those who had been physically assaulted to believe that they could never tell their partner that he was being too rough or that they could never deny intercourse to a familiar partner. These findings are inconsistent with other work that has found victimization related to sexual assertiveness,[22] which perhaps is a function of resilience, and should be further studied. Our data suggest that among women who have been assaulted, sexual assertiveness, particularly in regard to refusal of intercourse, is increased, perhaps as a function of this victimization. Thus, a greater understanding of the processes that occur after assault may help improve programs designed to prevent sexual assault.

Three important limitations of our study deserve comment. First, responses to our survey questions do not necessarily represent young women's behavior or their ability to engage in requisite behaviors to prevent unintended pregnancy, disease or victimization; rather, they reflect young women's perception of their sexual rights. Further research exploring sexual assertiveness needs to illuminate the relationships among perceived beliefs, intended behavior and actual behavior. Second, we examined the beliefs only of sexually active adolescents and young adult women; the perceptions of women who are not sexually active may be quite different. Finally, we surveyed women seeking reproductive health care from a federally funded program, who were predominately from lower socioeconomic levels. It is unclear whether these results are generalizable to women of higher socioeconomic levels or to those who live in other locations.

Our data suggest that a significant proportion of young women who are seeking reproductive health care have limited beliefs that they can control their own sexuality. Providing sexual health promotion programs within the school setting represents an effective public health strategy to enhance the sexual assertiveness of young women.[23] Although many adolescents report obtaining information on sexual health through schools, the content of these interventions is not uniform[24] and may lack important features to enhance skill acquisition. Thus, sexual health programs should not be confined to schools. Interventions to improve sexual health (including sexual assertiveness) should be extended to other community settings, such as reproductive health clinics; ideally, such programs should be tailored to targeted groups to increase their relevance and effectiveness.

Interventions that target clients of Title X–supported clinics provide services to a high-risk population and, thus, may have widespread benefits. For example, offering assertiveness counseling to young women with newly diagnosed STDs may help reduce the likelihood of reinfection. Brief individual counseling programs within clinics have been shown to reduce sexual risk behaviors and decrease rates of STD reinfection.[25] In addition, clinic programs provide care to mothers of female children and adolescents, and mothers are important in reducing adolescents' sexual risk-taking, since they are generally the primary communicators on sex-related topics.[26] Furthermore, adolescent females' confidence in their ability to negotiate condom use or to refuse sex rises as the frequency with which they discuss sexual topics with their mother rises.[27]

Clinic staff can encourage and support parent-adolescent communication about sexuality, including by providing information on the importance of sexual beliefs that lead to safer-sex practices. For example, clinicians could ask parents if they talk with their daughters about sex-related topics, and when dealing with adolescents, clinicians could inquire about their ability to discuss sexuality with their parents, especially their mother. Sexual health programs,

especially those in a clinical setting, can teach and facilitate parental skills, so that mothers and daughters are able to communicate about these issues; this, in turn, increases the ability of young women to carry on these conversations with their partners.[28]

To date, research examining adolescent sexual behavior has been motivated largely by the health and social problems that result when young people engage in intercourse, such as sexual assault, unwanted pregnancy and STDs.[29] Previous research has focused mainly on examining the correlates of early sexual initiation and condom use, rather than on understanding the sexual health and the antecedents of sexual behavior.[30] Secrecy that continues to surround sexual behavior in our society has hindered open communication about sexuality. In addition, sexuality is conceptualized in a negative and problematic context.[31] Thus, our understanding of the development of adolescent sexuality is limited and must improve to speed progress toward meeting the nation's public health objectives of decreasing unintended pregnancy, STDs and sexual violence.[32]

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