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Perceptions of Sexual Assertiveness among Adolescent Girls: Initiation, Refusal, and Use of Protective Behaviors

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Abstract

Study Objective: We describe adolescent girls' perceptions of sexual assertiveness and examine the relationship of these perceptions with developmental and interpersonal variables.

Design: Cross-sectional analysis

Setting: Participants were recruited from a school-based health clinic, local colleges, and through snowballing to participate in a 6-month study examining microbicide acceptability.

Participants: 106 sexually experienced girls (ages 14 through 21 years).

Methods: Girls described their demographics, sexual history, and romantic relationships and completed the Sexual Assertiveness Scale for Women (SAS-W), which assesses perceptions of sexual assertiveness: Initiation of Sex, Refusal of Unwanted Sex, and Pregnancy-STD Prevention.

Results: Girls perceived themselves as asserting themselves between 50 and 75% of the time with their current or most recent partner. The Initiation subscale was not related to the other two subscales. In final models, girls with a prior pregnancy perceived themselves as initiating sex more than girls without a prior pregnancy. Having a greater number of lifetime partners was related to perceptions of less refusal and greater number of partners, being sexually experienced longer, and engaging in more unprotected sex were related to perceptions of less implementation of preventive methods. None of the relationship variables were related to scores on any subscale.

Conclusions: Most of these girls perceived themselves as sexually assertive. Given that sexual experience not relationship factors were related to perceptions of sexual assertiveness, the design of counseling messages should incorporate sexual experience. These messages should find effective ways to help girls communicate both their sexual desires and enhance their ability to protect themselves.

Keywords

adolescents; female; sexual assertiveness; initiation of sex; refusal of sex; implementation of STD preventive methods

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Introduction

One of the main goals of adolescence is to develop a healthy sense of sexuality, which includes feeling good about one's body and sexual desires and protecting oneself from sexually transmitted diseases (STDs) and unwanted pregnancy. Yet, some young women do not acknowledge their sexual feelings,¹ do not advocate to have their sexual needs met,² and are not able to refuse unwanted sexual activities.^{2, 3} It has been suggested that young women with low sexual assertiveness skills may be particularly likely to not use birth control/condoms consistently and to be coerced in their sexual relationships,⁴⁻⁶ thereby placing them at risk for the negative outcomes of adolescent sexual behavior. Certainly, adolescents continue to have unacceptably high rates of STDs and unwanted pregnancies.^{7, 8}

Not surprisingly, aspects of sexual assertiveness are included in many behavioral interventions designed to promote healthy sexual decision-making. Almost all programs teach adolescents how to refuse unwanted sexual activity, and abstinence plus safer sex programs also teach them how to use and negotiate protective methods.⁹ In contrast to the amount of education or messages girls receive about preventing the negative outcomes of sex, very little, if any, information is provided to girls about how to acknowledge their sexual desires and successfully negotiate those feelings with partners in a healthy positive way.^{1, 10}

Development of a healthy sense of sexuality occurs within a cultural context and could be influenced by a number of factors. Previous research indicates that perceived appropriateness of being sexually assertive changes based on age and education and varies among young women from differing ethnic backgrounds.² While there is some evidence to suggest that partner communication is an important predictor of sexual assertiveness,³ little is known about how the adolescent's previous experiences with the adverse outcomes of sexual behavior (e.g., STD history) and how characteristics of her romantic relationship influence her perceptions of her sexual assertiveness skills. Thus, it is important to examine how the experiences of an adolescent girl relate to her perceptions of sexual assertiveness across a variety of domains. In that regard, the aims of the present study are:

- a. To describe adolescent girls' sexual assertiveness across three domains: Initiation of sexual activity, refusal of unwanted sexual activity, and implementation of STD preventive behaviors.
- b. To examine the relationship of demographics, sexual history, and relationship characteristics on girls' current perceptions of their level of sexual assertiveness in each of the three domains.

Materials and Methods

Sample and Procedure

Two hundred and eight sexually experienced adolescent girls, ages 14 through 21 years, were recruited from school-based teen clinics and local colleges, and through snowball sampling (i.e., participants referred other girls to the study) to participate in a 6-month study examining the acceptability and use of a microbicide surrogate. Girls completed face-to-face interviews at baseline for which they received \$30 and were screened for pregnancy and STDs.

The study was approved by the Institutional Review Board at the University of Texas Medical Branch in Galveston. For those under the age of 18, parental consent and adolescent assent were obtained, and for those over 18, self-consent was obtained.

The Sexual Assertiveness Scale for Women (SAS-W)¹¹ was added to this ongoing study, and thus, the last 109 girls of the 208 girls enrolled in the study completed the SAS-W. At the time

of the baseline interview, 28 of the 109 girls reported not being in a relationship, 78 reported having a boyfriend, and 3 reported having a same-sex romantic partner. The focus of this study was on sexual assertiveness in heterosexual relationships, given that sexual assertiveness could differ between same sex and heterosexual relationships. Thus, the three participants in same sex relationships were not included in the analyses, yielding a sample of 106 for the analyses.

Measures

The baseline interview consisted of questions about demographics, sexual history and behaviors, sexually transmitted diseases (STDs) and pregnancy, health beliefs, and relationship status and characteristics.

Demographics—Age and race/ethnicity were obtained. Race/ethnicity was classified into four categories: Non-Hispanic white, African-American, Hispanic, and Other.

Sexual history/behaviors—The following variables were collected for purposes of descriptive and/or predictive analyses: Age of first vaginal intercourse, number of lifetime partners, number of non-condom protected sexual episodes in the past three months, and STD and pregnancy histories.

Relationship characteristics—Participants were asked to report whether they were in a romantic relationship. Those who reported having a current boyfriend were asked how long they had been in the relationship and to describe their current satisfaction with that relationship on a 4-point Likert scale ranging from *not at all satisfied* to *very satisfied*. Exclusivity of the dating relationship was dichotomized (i.e., non-monogamous versus mutually monogamous). A participant was considered to be in a mutually monogamous relationship if she reported that neither she nor her partner had been with anyone else outside their relationship. A girl who reported being unsure about whether her partner had been with anyone else outside their relationship was considered to be in a non-monogamous relationship.

Girls also completed the Mutual Psychological Development Questionnaire (MPDQ),¹² which is a 22-item questionnaire measuring six conceptually-driven aspects (i.e., empathy, engagement, authenticity, zest, diversity, and empowerment) of mutuality in intimate relationships. A subset of 11 items assesses participants' perceptions of how they would rate the relationship from their perspective and another subset of 11 items measures participants' perceptions of how they would rate the relationship from their partners' perspectives. Participants were given two stems (i.e., “When we talk about things that matter to [other person], I am likely to ...;” and “When we talk about things that matter to me, [other person] is likely to ...”) followed by 11 phrases each (e.g., *pick up on my partner's feelings, get impatient*), which they rated on a six-point Likert-type scale ranging from *never to all the time*. Some items were reversed scored. Mean scores of the 22 items were calculated. Higher mean scores are indicative of a higher degree of mutuality within the relationship. Genero et al.¹² reported high internal consistency, good test-retest reliability, and good construct validity.

Sexual Assertiveness—The SAS-W¹¹ is an 18-item scale that assesses perceived levels of sexual assertiveness on three dimensions: *Initiation*, *Refusal*, and *PregnancySTD prevention*. The first subscale, *Initiation*, assesses a woman's perceptions of the degree to which she initiates sex (6 items; e.g., “I begin sex with my partner if I want to” and “I wait for my partner to touch my breasts instead of letting my partner know that's what I want”). The *Refusal* subscale measures a woman's perceptions of the degree to which she rejects unwanted sexual advances (6 items; e.g., “I refuse to let my partner touch my breast if I don't want that, even if my partner insists” and “I put my mouth on my partner's genitals if my partner wants me to, even if I don't want to”). The *Pregnancy-STD Prevention* subscale assesses a woman's

perceptions of the degree to which she insists on the use of birth control and STD prevention methods with her partner (6 items, e.g., “I make sure my partner and I use a condom or latex barrier when we have sex” and “I have sex without a condom or latex barrier if my partner doesn't like them, even if I want to use one”). The instructions for the SAS-W were: “Think about a person you usually have sex with or someone you used to have sex with regularly. Think about what you would do even if you have not done some of these things.” Items are scored on a 5-point Likert scale ranging from *never* to *always*, with some items being reversed scored. Mean subscale scores were calculated. Higher mean scores are indicative of greater perceived levels of sexual assertiveness. The SAS-W¹¹ has demonstrated good internal consistency, test-retest reliability, and construct validity in a sample of women from university and community settings.

Statistical methods

Data were double entered into a Microsoft Excel spreadsheet and then imported into SAS for analyses. For the 106 girls in heterosexual relationships, descriptive analyses were performed on demographics, sexual history/behavior variables, relationship characteristics, and SAS-W subscales scores.

Correlation coefficients were used to determine the relations among the predictors and each SAS-W subscale. Categorical variables with more than two levels were examined in independent general linear models to predict each SAS-W subscales. Variables that were significant at $p < .10$ were entered together into general linear models (GLM) for each outcome (i.e., each SAS-W subscale). A backward elimination strategy was used until only statistically significant predictors ($p < .05$) remained in the final models.

Results

Descriptive Analyses

Demographics—The mean age of the 106 girls was 18.07 years ($SD = 1.89$). Twenty-two percent ($n = 23$) were Non-Hispanic white, 53% ($n = 56$) were African American, 22% ($n = 23$) were Hispanic, and 3% ($n = 4$) were “Other”. For purposes of the analyses, the “Other” category and Non-Hispanic white categories were collapsed into one category.

Sexual history/behaviors—The mean length of sexual experience was 3.20 years ($SD = 1.84$), with the mean age of first sexual vaginal intercourse being 14.88 years ($SD = 1.56$). The median number of lifetime partners was 4.0 (range of 1 to 40). Girls' reports of the frequency of vaginal sexual episodes in the 3 months preceding intake ranged from 0 to 600 with a mode of 0 and median of 9. The range of episodes that girls reported not using a condom was also 0 to 600, with a mode of 0 and a median of 1. Thirty-nine percent ($n = 41$) of the girls had a history of at least one prior pregnancy and 29% ($n = 30$) had a history of an STD. Girls who were not in a current heterosexual relationship did not differ significantly on any of the sexual experience variables from girls who were in a current heterosexual relationship.

Relationship characteristics—The number of days that girls reported to be in their current romantic relationship ranged from 14 to 2190, with a mean of 635.22 ($SD = 538.84$). In terms of satisfaction with their current partners, 12% reported being *somewhat satisfied*, 35% reported being *satisfied*, and 54% reported being *very satisfied*; no one reported being *not at all satisfied*. Fifty-one percent ($n = 40$) of girls in a heterosexual relationship were *mutually monogamous* in that relationship. The mean score on the MPDQ was 4.82 ($SD = .60$). Scores of “4” on this subscale indicated that girls perceived that they and their partner experienced mutuality in their relationship *more often than not* and scores of “5” indicated that girls and their partner experienced mutuality *most of the time*.

Sexual assertiveness—SAS-W mean scores were 3.35 (SD = .81) for *Initiation*, 4.05 (SD = .77) for *Refusal*, and 3.81 (SD = .93) for *Pregnancy-STD Prevention*. Scores of “3” equated to perceptions of assertiveness in each of the domains for *half the time*, while scores of “4” equated to *usually or 75% of the time*. The *Refusal* subscale significantly correlated with the *Pregnancy-STD Prevention* subscale ($r = .39, p < .01$), but the *Initiation* subscale did not significantly correlate with either of the other two subscales.

Predictive Analyses

Initiation—In bivariate models, length of time sexually experienced ($r = .17, p = .08$), number of lifetime partners ($r = .17, p = .09$), and a history of pregnancy ($r = .19, p = .05$) were correlated with the SAS-W *Initiation* subscale. Demographics, the other sexual experience variables, and relationship characteristics were not related to the *Initiation* subscale. When the three significant predictors ($p < .10$) were entered together into a GLM using a backwards elimination procedure, only history of pregnancy remained as an independent predictor ($F(1, 104) = 4.08, p < .05$). Girls who had previously been pregnant reported perceiving themselves as initiating sexual behaviors more than those who had never been pregnant ($\bar{x} = 3.55, SD = .72$ vs. $\bar{x} = 3.23, SD = .85$).

Refusal—Length of time sexually experienced ($r = -.16, p < .10$) and the number of lifetime partners ($r = -.26, p < .01$) were inversely related to the SAS-W *Refusal* subscale. Demographics and relationship characteristics were not correlated with SAS-W *Refusal* mean scores. When the two significant sexual history variables were entered together into a multiple regression using backwards elimination, the number of lifetime partners remained as a significant predictor ($F(1, 103) = 7.45, p < .01$). A greater number of lifetime partners was associated with reporting of less frequent refusal behaviors.

Pregnancy-STD prevention—Race/ethnicity significantly predicted the SAS-W *Pregnancy-STD Prevention* subscale ($F(2, 103) = 3.75, p = .03$), with African American girls ($\bar{x} = 3.99, SD = .87$) reporting a greater percentage of time in which they insist on use of preventive methods than that of non-Hispanic whites/other ($\bar{x} = 3.40, SD = 1.03$). There were no other significant differences between race/ethnic categories. Length of time sexually experienced ($r = -.31, p < .01$), number of lifetime partners ($r = -.36, p < .01$), frequency of non-condom protected intercourse ($r = -.27, p < .01$), a history of pregnancy ($r = -.17, p = .08$), and a history of an STD ($r = -.18, p = .07$) were inversely related to SAS-W *Pregnancy-STD Prevention*. Age and relationship characteristics were not correlated with SAS-W *Pregnancy-STD Prevention* subscale scores. When the six significant variables were entered into a GLM using a backwards elimination procedure, length of time sexually experienced, number of lifetime partners, and frequency of non-condom protected intercourse remained in the final model at ($F(3, 101) = 11.08, p < .01$). Being sexually experienced longer, having a greater number of partners, and engaging in more unprotected sex in the three months preceding intake were associated with reports of less frequent pregnancy-STD preventive behaviors.

Discussion

Many of the adolescent girls in this study reported that they communicated their sexual needs with their partners, were able to refuse unwanted sexual advances, and insist upon pregnancy-STD preventive methods, which are all parts of a healthy sense of sexual self. Sexual behaviors are private behaviors and it is possible that girls overestimated their ability to refuse sexual intercourse and to implement protective behaviors. However, their perceptions and behaviors were consistent with each other, suggesting that girls were at least relatively accurate in their reports about their perceptions of sexual assertiveness. For instance, girls who had more partners perceived themselves as refusing sexual behaviors less often, and girls who had more

unprotected intercourse and an STD/pregnancy history reported perceiving themselves as implementing pregnancy-STD preventive behaviors less frequently.

Of concern is that 15% of girls in our study perceived themselves as only communicating their sexual desires to their partner about 25% of the time. It could be that these girls are very satisfied in their sexual relationships and that most of their sexual needs are already being met without them having to request them. However, Rickert et al.² found a similar percentage of the women in their study that perceived they “never” have the right to request sex or to ask to have sex in a different manner. Other qualitative research suggests that girls may silence their sexual desires, because of the fear of physical violence or bad reputation.¹ Thus, those girls in our study who did not perceive themselves as frequently communicating their sexual needs likely did not feel they had the right to express their needs and subsequently could be at risk for adverse sexual outcomes.

Interestingly, there was no relationship between girls perceiving that they could communicate their sexual needs and their perception that they could refuse unwanted sex or insist on STD protection. This suggests that if we are to support girls to both protect themselves against risk and to develop a healthy sense of sexual self, then it will be important to inquire about all three aspects of sexual assertiveness when assessing and counseling patients. Historically, we have focused on the timing of girls' sexual behaviors and the ability to refuse unwanted sex and practice safe-sex behaviors. However, the work of Tolman and Fine^{1, 10, 13} has pointed out the potentially deleterious impact of failing to examine girls' sexual desires and feelings and their perceptions of their body during sexual experiences. In order to promote healthy sexual development, adolescent girls need to be able to acknowledge that they have sexual desires and be aware that these desires may influence their sexual decision-making. With a holistic view of their sexuality, girls may be better equipped and ready to develop effective ways to communicate their sexual desires while at the same time protect themselves.

Our findings indicated that sexual assertiveness related to prior sexual experiences. Those girls who had been sexually active longer and had more partners felt more able to initiate sex, but less able to refuse sex and insist on pregnancy-STD preventive methods. Thus, increased sexual experience is associated with greater sexual risk behaviors. Given the cross-sectional nature of the study, we could not determine the directionality of the relationship between sexual experience and perceptions of sexual assertiveness. It is possible that as girls become sexually experienced, they begin to perceive themselves as less assertive. However, it could also be that girls' sexual perceptions develop prior to their sexual experiences and that these perceptions shape their future sexual behaviors. Recent longitudinal research suggests that other types of sexual cognitions, such as abstinence attitudes and sexual self-esteem, precede sexual experiences.¹⁴ The same could be true for the relationship between perceptions of sexual assertiveness and sexual experiences. Further research that examines how girls' sexual assertiveness changes over time is needed, especially given that such information could aid in the development of intervention studies designed to promote healthy sexuality.

The finding that sexual experience was related and relationship characteristics were not related to girls' perceptions of sexual assertiveness could suggest that sexual assertiveness is shaped more by individual-specific factors than relationship-specific factors. Thus, a girl who is unable to assert herself in one relationship may be less likely to do so in her next relationship. However, it also could be that key relationship factors were not assessed. For instance, abuse within a relationship and age difference between partners have been found to relate to at least one aspect of sexual assertiveness - the implementation of condoms.^{5, 15} In addition, the girls in this study were a unique group of girls in that they were participating in a larger study wherein they were asked to report on their use of a microbicide surrogate during intercourse. Thus, it is likely that most of these girls were at least somewhat comfortable with their sexuality and with expressing

their sexual needs. Therefore, it is possible that relationship characteristics were less salient to them than for other adolescent girls.

These findings suggest that educational messages targeting girls' perceptions of sexual assertiveness should take into account girls' levels of sexual experience. Over time, a girl's perceptions may vary with her sexual experiences, and she may require a very different educational message about assertiveness than she did at her previous experience level. Thus, health care providers and parents will need to have multiple conversations with girls throughout their adolescent and young adult years to help them be able to better communicate their sexual needs with partners and protect themselves in their sexual relationships.

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References

1. Tolman DL. Doing desire: Adolescent girls' struggles for/with sexuality. *Gender & Society* 1994;8:324.
2. Rickert VI, Sanghvi RV, Wiemann CM. Is lack of sexual assertiveness among adolescent and young adult women a cause for concern? *Perspect Sex Reprod Health* 2002;34:178. [PubMed: 12214907]
3. Salazar LF, DiClemente RJ, Wingood GM, et al. Self-Concept and adolescents' refusal of unprotected sex: A test of mediating mechanisms among African American girls. *Prev Sci* 2004;5:137. [PubMed: 15470935]
4. Rickert VI, Neal WP, Wiemann CM, et al. Prevalence and predictors of low sexual assertiveness. *J Pediatr Adolesc Gynecol* 2000;13:88.
5. Kalichman SC, Williams EA, Cherry C, et al. Sexual coercion, domestic violence, and negotiating condom use among low-income African American Women. *J Womens Health* 1998;7:371. [PubMed: 9580917]
6. Rosenthal SL, Cohen SS. Primary prevention of sexually transmitted disease: Self-efficacy in the context of sexual coercion. *Adolesc Pediatr Gynecol* 1994;7:63.
7. Weinstock H, Berman S, Cates W. Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000. *Perspect Sex Reprod Health* 2004;36:6. [PubMed: 14982671]
8. Abma J, Martinez GM, Mosher WD, et al. Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2002. *Vital Health Stat* 2004;23:1.Series 23
9. Kirby D. Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *J Sex Res* 2002;39:51. [PubMed: 12476257]
10. Fine M. Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review* 1988;58:29.
11. Morokoff PJ, Quina K, Harlow L, et al. Sexual Assertiveness Scale (SAS) for Women: Development and validation. *J Pers Soc Psychol* 1997;73:790. [PubMed: 9325594]
12. Genero, NP.; Miller, JB.; Surrey, J. The mutual psychological development questionnaire. Wellesley College; Wellesley: 1992. p. 1-5.
13. Tolman DL. Femininity as a barrier to positive sexual health for adolescent girls. *J Am Med Womens Assoc* 1999;54:133. [PubMed: 10441919]
14. O'Sullivan LF, Brooks-Gunn J. The timing of changes in girls' sexual cognitions and behaviors in early adolescence: A prospective, cohort study. *J Adolesc Health* 2005;37:211. [PubMed: 16109340]

15. DiClemente R, Wingood GM, Crosby RA, et al. Sexual risk behaviors associated with having older sex partners: A study of black adolescent females. *Sex Transm Dis* 2002;29:20–24. [PubMed: 11773874]