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Article 14

Contributing Factors to Sexual Health Among a Diverse Sample of Emerging Adult Women: Implications for Counseling

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Abstract

The current paper examines sexual health as it relates to types of intimate partner violence, self-esteem, partner support of birth control, and pressure to have sex and/or a baby among emerging adult young women ages 18–25. Differences across racial/ethnic categories as well as between pregnant/parenting and non-pregnant/non-parenting categories are considered. Results highlight differing sexual health experiences of pregnant/parenting and Hispanic/Latina young women, specifically. Pregnant/parenting young women reported higher levels of psychological aggression which has additional consequences. Hispanic/Latina young women reported lower levels of partner support for birth control and greater pressure from significant others to have a baby. Implications include a need to particularly integrate skills to recognize and combat psychological aggression into counseling prevention and intervention programming as well as culturally-specific interventions, particularly for Hispanic/Latina young women.

Keywords: domestic violence, sexuality

Based on 2010 national research completed by the Guttmacher Institute, the highest pregnancy rates are among young women ages 18–24 years old (Kost & Henshaw, 2014). While the teen pregnancy rates have been decreasing nationally to historic lows, the pregnancy rates among 18–19 year olds was 92.2 pregnancies per 1,000 (3 times that of the 15–17 year old rate (30.1 per 1,000; Kost & Henshaw, 2014). Among those young adults, 73% of pregnancies were unplanned. While it is known that pregnancy among unmarried women does not equal unplanned pregnancy, the national statistics described above indicate that a large majority are unplanned. These statistics

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beg the question: what factors contribute to the large number of unplanned pregnancies among the emerging adult age group? Are there relationship level variables that play a role? The current study examines sexual health as it relates to levels and types of intimate partner violence, self-esteem, partner support of birth control, and external pressures to have children among emerging adult young women ages 18–25.

Emerging Adults and Sexual Health

Emerging adulthood is defined as a unique stage of "development for the period from the late teens through the twenties, with a focus on ages 18–25" (Arnett, 2000, p. 469). Research has documented that emerging adults are a distinct population demographically and qualitatively and, thus, deserve specific attention in their own right (Arnett, 2000). Emerging adults are in the stage of exploring life possibilities, making new choices in the world, and defining themselves as part of a working community. These explorations also have implications for sexual health.

Specifically, emerging adults are more likely to engage in sexual behavior than their adolescent counterparts but are less likely to receive ongoing sexual health education during this transitional time (Kost & Henshaw, 2014). This may contribute to the high pregnancy rates as well as higher occurrences of sexual transmitted infections (STIs), such as the human papillomavirus (HPV), chlamydia, gonorrhea, and HIV/AIDS during this age. Nearly 50% of the 20 million new STIs diagnosed each year are among young people aged 15–25 years (Centers for Disease Control and Prevention [CDC], 2013). Based on 2012 reports by the CDC, among female chlamydia reports, the 20–24-year-old age group had the highest rate of all age groups (3,695.5 per 100,000), followed closely by the 15–19 year old age group (3,291.5 per 100,000; CDC, 2013a). This pattern was the same for female gonorrhea reports as well, with the 20–24-year-old age group having the highest rate of all female age groups (578.5 per 100,000; CDC, 2013b).

Studies examining the health indicators from adolescence to young adulthood (the period referred to as emerging adulthood) have documented that reproductive health tends to worsen with age into the emerging adulthood period (Harris, Gordon-Larsen, Chantala, & Udry, 2006). This decline was consistent across all racial and ethnic categories. However, a parallel line of research has documented that while overall reproductive health declines, certain ethnic groups have disparate rates of STIs. For example, research has documented that African Americans and those who identify as Hispanic/Latino have higher rates of chlamydia and gonorrhea in the emerging adult period compared to Caucasians (Park, Mulye, Adams, Brindis, & Irwin, 2006). Given that STIs can have serious reproductive health consequences, exploration of the sexual health practices and behaviors during the emerging adult period is essential.

Emerging Adulthood and Self-Esteem, Intimate Partner Violence, and Birth Control

Research has documented that the emerging adulthood period is linked with complex processes of development in the area of self-esteem (Schwartz, Cote, & Arnett, 2005). During this stage of life, identity issues play a prominent role. Individuals in this stage are focusing largely on developing a stable identify as an adult figure, although

without the external guidance that historically may have been provided during adolescence (Schwartz et al., 2005). The process of self-identity and the development of self-esteem can be formed by trying out new patterns of behavior. These explorative times also apply in the sexual health arena. Therefore, exploring the role of self-esteem in the context of sexual health behaviors is critical.

Another factor playing a key role in the sexual health of emerging adult young women is the occurrence of intimate partner violence. Intimate partner violence is defined as "any form of physical, sexual, emotional, psychological, and/or verbal abuse between partners in an intimate relationship" (Murray & Graves, 2012, p. 14). More than one third of adolescents report having been physically, emotionally, or sexually abused in an intimate relationship (American Psychological Association, 2013). The experience of intimate partner violence often leads to a number of risky behaviors among victims. Studies have shown that physical and sexual abuse by an intimate partner is associated with substance use, unhealthy weight control behaviors, sexual risk behaviors, pregnancy, and/or suicidality (Silverman, Raj, Mucci, & Hathaway, 2001). Specifically, involvement in a verbally abusive relationship was associated with not using a condom during intercourse (Roberts, Auinger, & Klein, 2005).

Disparities not only exist in the prevalence of intimate partner violence, but they have also been found to exist in the consequences of that violence. African American female adolescents who experienced dating violence have been shown to be more likely to fear potential consequences of condom negotiation, fear talking with the partner about pregnancy prevention and thus were shown to have higher risk of STI contraction, perceive less control over their sexuality, and have unhealthy relationship norms compared to other racial/ethnic categories (Wingood, DiClemente, McCree, Harrington, & Davies, 2001).

Additionally, there are specific consequences of intimate partner violence on pregnant and/or parenting young women compared to their non-pregnant/non-parenting counterparts. Research has shown that intimate partner violence victimization and perpetration are positively associated with numbers of unintended pregnancies and pregnancy problems (O'Donnell, Agronick, Duran, Myint-U, & Stueve, 2009). Experiencing intimate partner violence following the delivery of the first child has been found to be associated with a repeat pregnancy within 24 months (Raneri & Wiemann, 2007). Specifically for pregnant women, experiencing intimate partner violence has been associated with later entry into prenatal care, low birth weight, premature labor, fetal trauma, unhealthy maternal behaviors, and attachment issues (Jasinski, 2004; Levendosky, Lannert, & Yalch, 2012; Neggers, Goldenberg, Cliver, & Hauth, 2004).

The current exploratory research builds on these links and examines more directly the sexual and reproductive behaviors of emerging adult young women and the link between intimate partner violence and sexual health disparities among that population. In addition, racial/ethnic differences in social support, pressure from significant others, and intimate partner violence as they relate to sexual and reproductive health among emerging adult women are examined.

Methods

Participants

Participants included 192 emerging adult young women in a suburban community in the southern United States. Emerging adults for the current study were defined as young women ages 18–25 years old. Participant ages ranged from 18–25 years old with the average being 21 years old (*SD* = 2.16). The majority of respondents (45.7%) identified as Black/African American, 37.1% identified as Hispanic/Latina, 11.3% identified as White, 5.2% identified as Multiracial, and 0.5% identified as Asian. Most (60%) respondents were non-pregnant/non-parenting and the remaining 40% were pregnant/parenting.

Participants were recruited in-person from community agencies such as the local health department, the department of social services, emergency rooms, teen parent mentoring programs, local university classes, and various other organizations where large numbers of emerging adults would be located. The wide variety of these recruitment locations was to ensure that we could obtain both groups of participants: pregnant/parenting and non-pregnant/non-parenting participants. Incentives were used to increase recruitment. Incentives consisted of water and snacks during completion of the paper survey and all survey participants were invited to enter a raffle to win a $50 gift card. Because the information was deemed part of a program evaluation protocol, an IRB approval request was submitted, and the project was determined to be exempt.

Both paper and electronic versions of the survey were available for completion so that the participant could select the preferred version of administration. Paper versions of the survey were available in English and Spanish, while the electronic version was only available in English. In-person recruitment consisted of paper survey completion while electronic versions were completed by disseminating the survey link via e-mail to community partners and agencies that serve or have access to young women ages 18–25 years old. Questions were identical for each survey administration format. The two groups of emerging adults were recruited to complete two variations of a survey, one for pregnant/parenting and the other for non-pregnant/non-parenting.

Measures

The survey measure consisted of 46 questions that were pulled from existing standardized scales and compiled for the current research (see the Appendix for the measure). The measure was reviewed and approved by a health literacy expert to ensure readability at a maximum of a seventh-grade reading level. The current research focuses primarily on the subscales of self-esteem, psychological aggression, and physical violence as they relate to the variables of age of sexual initiation, number of pregnancies, partner support of birth control, and pressure from significant other to have sex and have a baby.

Pregnancy status. The pregnancy/parenting status of the participants was determined in two ways. The online, electronic version of the survey asked if the participant was currently pregnant or if they had children. For the hard copy versions, there were two different versions created, one for pregnant/parenting young women and one for those who were non-pregnant/non-parenting. Participants completing hard copies were directly asked in person if they were currently pregnant and/or if they had children

to determine which version the participant would complete. On both versions of the survey, three open-ended questions were asked at the beginning of the survey to determine pregnancy/parenting status and experiences. Participants were asked to indicate the number of pregnancies, number of miscarriages, and number of abortions they had experienced. The pregnant/parenting version of the survey additionally asked participants to indicate the number of children they had, ages of children, and whether the father was involved in the raising of the child/children.

Self-esteem. Participants were asked five questions from the Rosenburg Self Esteem Scale (Rosenberg, 1965) to understand self-esteem, yet keep the overall survey battery short to facilitate participation and avoid survey fatigue. Questions included "I like myself," "I feel I do not have much to be proud of," and "I take a positive attitude toward myself." Participants responded on a 4-point Likert scale, with 1 = Strongly Disagree and 4 = Strongly Agree. Scale scores ranged from 5–20, with higher scores indicating higher levels of self-esteem. Subscale reliability for the five items demonstrated moderate internal consistency ($\alpha = 0.68$).

Psychological aggression. Four questions were used from the Revised Conflict Tactics Scale Psychological Aggression subscale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) to measure psychological victimization by one's partner. These questions were selected to understand psychological aggression, yet keep the overall survey battery short to facilitate participation and avoid survey fatigue. Respondents were asked to report how often these behaviors occurred in the past year as well as if the behaviors occurred in previous years. Scale scores ranged from 4–32, with higher scores more experiences of psychological aggression. Subscale reliability for these items demonstrated high internal consistency ($\alpha = 0.91$).

Physical violence. Participants were asked a series of questions to assess the frequency of non-sexual physical violence by one's partner. Five questions were used from the Revised Conflict Tactics Scale Physical Assault subscale (Straus et al., 1996). These questions were selected to understand physical violence, yet keep the overall survey battery short to facilitate participation and avoid survey fatigue. Respondents were asked to report how often these behaviors occurred on a 3-point scale, 1 indicating 'never,' 2 indicating '1 to 3 times,' and 3 indicating 'more than 3 times.' Scale scores ranged from 5–15, with higher scores indicating more experiences of physical violence. Subscale reliability for these items demonstrated high internal consistency ($\alpha = 0.81$).

Partner support of birth control. Participants were asked to report on how supportive their partner was of their use of birth control. Response options were on a 5-point Likert scale, with 1 = unsupportive and 5 = supportive.

Pressure from significant other. Participants were asked to rate two statements about feeling pressure from their significant others: one asking about pressure to have sex, one about pressure to have a baby. Response options were on a 5-point Likert scale, with 1 = strongly disagree and 5 = strongly agree.

Analytic Approach

Analyses were conducted using SPSS Version 21 (IBM, 2012). Responses to the questions within each scale were provided a numerical score and summed to create total scale scores. Analyses included descriptive statistics of the scale scores. Data were assessed for differences between pregnant/parenting and non-pregnant/non-parenting

emerging adults using *t*-tests and chi square tests where appropriate. Differences in responses by ethnicity also were analyzed.

Results

Preliminary descriptive, frequency, and correlational analyses were conducted across ethnic groups and parenting status. Averages are summarized in Tables 1 and 2. The majority of respondents (91.1%) reported "yes" to having ever had vaginal sex and 83.7% reported being sexually active vaginally at the time of survey completion. The average respondent reported having sex for the first time at age 16, with ages of sexual initiation ranging from 7 to 21 years old. Pregnant/parenting respondents, on average, engaged in sex almost a year earlier (M = 15.65, SD = 2.20) than their non-pregnant/non-parenting counterparts (M = 16.41, SD = 2.00). There was a marginally significant difference in race/ethnic group, with African American women (M = 15.81, SD = 2.08) reporting earlier age of first sexual intercourse than Hispanic/Latina (M = 16.41, SD = 1.95) or White women (M = 16.83, SD = 1.95). The majority of respondents (72.5%) reported "yes" to having ever engaged in oral sex, with 57.8% reported being sexually

Table 1

Racial/Ethnic Variations in Key Variables

	Overall		African American		Caucasian		Hispanic	
Measure	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Sexually Active (Vaginal)	1.15	.36	1.20	.41	1.06	.24	1.10	.31
Age of First Sex	16.16	2.03	15.81	2.08	16.83	1.95	16.41	1.95
Sexually Active (Oral)	1.44	.50	1.54	.50	1.24	.44	1.37	.49
Pregnancy Status	1.61	.49	1.64	.48	1.81	.40	1.52	.50
# of Pregnancies	.89	1.03	.77	.89	.25	.72	1.22	1.15
# of Miscarriages	.13	.39	.10	.38	.05	.22	.19	.43
# of Abortions	.15	.51	.26	.67	.05	.22	.06	.29
Self-Esteem	17.92	2.16	18.27	2.00	18.17	1.81	16.6	2.41
Psych Aggression	7.38	6.87	6.29	4.73	5.10	2.19	9.34	9.14
Physical Violence	5.62	1.32	5.59	1.19	5.31	.70	5.74	1.57
Partner Support for BC	2.75	.62	2.84	.45	3.00	.00	2.57	.80

active orally at the time of the survey. About one in five (21%) respondents reported "yes" to having ever engaged in anal sex with only 10.1% reporting being sexually active anally at the time of survey completion.

Respondents were asked about prior pregnancies, miscarriages, abortions, and births. The average respondent reported having had one (0.89) pregnancy with responses ranging from none to four pregnancies. The average respondent reported having had 0.13 miscarriages with responses ranging from none to two miscarriages. Regarding abortions, the average respondent reported having had 0.15, with responses ranging from none to four abortions. Respondents on average reported having one (1.26) child with responses ranging from none to four children. Significant differences were found between respondents who were pregnant/parenting versus those who were not.

Table 2

Pregnancy Status and Contribution Factors

	Pregnant/Parenting		Non-Pregnant/Non-Parenting	
Measure	*M*	*SD*	*M*	*SD*
Age of First Sexual Intercourse	16.65	2.19	16.41	1.99
Self-Esteem	17.28	2.49	18.22	2.03
Psychological Aggression	8.37	7.69	6.49	5.83
Physical Violence	5.81	1.79	5.57	1.14
Partner Support for Birth Control	2.54	.76	2.86	.46

Preliminary correlation analyses indicated a negative correlation between self-esteem and psychological aggression (r = -.29, $p < .001$), with self-esteem increasing as psychological aggression decreased. There also was a positive correlation between physical violence and psychological aggression (r = .52, $p < .001$), with physical violence increasing as psychological aggression increased. Although correlations did not indicate a significant relationship between self-esteem and the number of pregnancies experienced by participants, there were significant correlations in several other constructs. As the number of pregnancies increased, experiences of psychological aggression were more frequent (r = 0.18, n = 171, p = .02), and experiences of physical violence increased (r= 0.20, n = 170, p = .01).

Hypothesis Testing

To examine whether there were racial/ethnic differences in parenting status, a chi-square analysis was conducted by Race (Hispanic/Latina, African American, White) X Parenting Status (Yes, No). This analysis was significant, $\chi(2, N = 174) = 6.01$, $p < .05$, indicating that a higher number of Hispanic/Latina women indicated "Yes" to being a parent compared to the other ethnic groups. Because of this variation, all subsequent analyses will be conducted using both Race/Ethnicity and Parenting Status.

To examine whether parenting status and racial/ethnic group influenced the target sexual health related variables (self-esteem, psychological aggression, and physical violence), a 2 X 3 multivariate ANOVA was conducted with Parenting Status X Racial/Ethnic Category across the target constructs.

Self-esteem. The 2 X 3 analyses indicated a significant difference in levels of self-esteem across race/ethnicity only, $F(2,119) = 25.39$, $p < .01$. Tukey post-hoc analysis indicated that Hispanic/Latina young women reported lower self-esteem ($M = 16.64$, $SD = 2.41$) than both White/Non-Latina ($M = 18.17$, $SD = 1.81$) and Black/African American ($M = 18.27$, $SD = 2.00$) young women, $t\ (120) = 16.64$, $p < .01$. There was not a two-way interaction between Parenting Status X Race/Ethnicity, and the relationship between self-esteem and Parenting Status was no longer significant after factoring in Race/Ethnicity.

Psychological aggression. The 2 X 3 analyses indicated a significant difference in levels of psychological aggression across Parenting Status only, $F(2,119) = 3.76$, $p < .05$. Parenting women reported significantly higher levels of psychological aggression compared to non-parenting women. There was not a two-way interaction between Parenting Status X Race/Ethnicity.

Physical violence. The 2 X 3 analyses did not indicate any differences in levels of physical aggression based on Race/Ethnic Group or Parenting Status, $F(2,167) = .93$, *ns*.

Partner support of birth control. The 2 X 3 analyses indicated a significant difference in levels of partner support of birth control across race/ethnicity only, $F(2,119) = 3.46$, $p < .05$. Tukey post-hoc analysis indicated that Hispanic/Latina young women reported lower levels of partner support for birth control ($M = 2.57$, $SD = .08$) than both White/Non-Latino ($M = 3.00$, $SD = .19$) and Black/African American ($M = 2.81$, $SD = .08$) young women, $t\ (120) = 2.84$, $p < .05$. There was not a two-way interaction between Parenting Status X Race/Ethnicity, and the relationship between partner support for birth control and Parenting Status was no longer significant after factoring in Race/Ethnicity.

Pressure from significant other. The 2 X 3 analyses indicated a significant difference in perceived pressure from significant other to have a baby across Race/Ethnicity, $F(2,119) = 8.29$, $p < .001$, as well as by Parenting Status, $F(2,119) = 6.40$, $p < .01$. Tukey post-hoc analysis indicated that Parenting women reported more pressure from their significant other to have a baby than non-parenting women. Furthermore, Hispanic/Latina women reported greater pressure from their significant other to have a baby than both African American and White/Non-Latino women. There was not a two-way interaction between Parenting Status X Race/Ethnicity. Interestingly, the 2 X 3 analysis examining perceived pressure from significant others to have sex did not indicate any significant differences. Therefore, the significant differences found indicate that the pressure seems to stem mainly around having a baby rather than around having sex per se.

Understanding contributors to birth control support. A follow-up regression analysis was conducted to examine the relationship between perceived support to use birth control and the other target constructs. A stepwise linear regression was conducted with Parenting Status and Race/Ethnicity controlled in Step One and psychological aggression, physical violence, and pressure to have a baby in step two. Results indicated that after controlling for Parenting Status and Race/Ethnicity, psychological aggression significantly predicted levels of birth control support, $b = -.31$, $t\ (101) = -2.41$, $p < .05$, with women who perceive higher levels of psychological aggression reporting lower levels of birth control support. No other variables were significant.

Summary of Findings

In summary, there were several key findings from these analyses. Parenting women reported engaging in sex at an earlier age and reported higher levels of psychological aggression. Psychological aggression was linked to a decrease in self-esteem, a decrease in partner support for birth control, and an increase in physical violence. Hispanic/Latina women reported a significantly different pattern of sexual health experiences compared to African American and White/Non-Latina women. Specifically, Hispanic/Latina women were more likely to be parents, had lower levels of self-esteem, reported lower levels of partner support for birth control, and reported greater pressure from their significant other to have a baby. Important to note, there were no differences across Racial/Ethnic group or Parenting Status around pressure to have sex. Rather, the differences were mainly around pressure to have a baby.

Discussion

The current research findings provide us with a helpful narrative of how sexual reproductive health behaviors are related to a variety of relationship factors such as intimate partner violence, self-esteem, partner support for birth control, and pressure to have sex or have a baby among emerging adult young women. The current findings can be utilized by counselors, pregnancy prevention and intervention professionals, as well as medical professionals to improve outcomes for emerging adult young women. For example, given that parenting in early adulthood was linked to an earlier age of sexual initiation, efforts should continue to focus on reaching young people earlier to prevent pregnancy as well as to educate them about healthy relationships and sexual health. This is consistent with previous research showing that conversations about sexuality should begin early and occur often (National Campaign to Prevent Teen and Unplanned Pregnancy, n.d.).

Given the links among psychological aggression and a host of associated sexual health factors such as self-esteem, physical violence, and partner support for birth control, prevention and intervention curricula would benefit from an intentional inclusion of information about psychological aggression. This should include a general understanding of psychological aggression as a form of intimate partner violence that should be taken seriously, as well as skill building strategies to equip young people with combating it. We proclaim that an intentional inclusion of information and skills around psychological aggression are essential within curricula for both males and females. Closely connected to this content, counselors and other professionals are encouraged to challenge underlying gender norms supporting psychological aggression, discuss ways to identify it, and provide practical ways for young people to get out of relationships where it may be happening using gender-sensitive, culturally-informed strategies and activities for learning. Prevention and intervention efforts also should specifically discuss the importance of partner support of birth control to safe sexual practices and healthy relationships.

Sexual health is a key component of overall health, particularly among the emerging adult population given the spike in sexual activity during this time. Therefore, brief intimate partner violence screenings should be completed in as many general health settings as possible, including with all primary care physicians and other medical

professionals. More specifically, agencies already using such screenings should be sure to include (if they are not already) a question inquiring about partner support of birth control. While we do not necessarily know the cause-effect nature between psychological aggression and partner support, the current research shows that partner support of birth control is a form of control that is being exerted over young women and is leading to an increased likelihood of reporting being pregnant or a parent during early adulthood.

An overarching theme of the current findings is the need for additional research to develop culturally relevant interventions among the Hispanic population. The current findings demonstrate that this population of emerging adult women may have unique needs, specifically around partner support of birth control and pressure from significant others to have a baby. Although research has been conducted in this area, there remain a relatively few number of prevention and intervention programs specifically targeting this population that are regularly utilized in community-based or school settings. Research indicates that a knowledge and awareness of Hispanic culture is essential for this population, particularly given that the implicit program goals of education and self-sufficiency can sometimes be at odds with Hispanic culture (Russell & Lee, 2004). Future developments in curricula need to ensure recognition of these cultural components while also balancing information and skill building that is designed to address the unique needs of the Hispanic population, particularly around pressure to have a baby, psychological aggression, and unplanned pregnancy.

Limitations

As discussed previously, surveys were administered to emerging adults aged 18–25 who were pregnant and/or parenting or non-pregnant/non-parenting. As with any survey research, there is a delicate balance between depth and breadth of questions to be asked and maintaining a desirable survey length. While the surveys used in the current study were successful in obtaining information of interest for the current assessment, there were limitations.

First, regarding the intimate partner violence scales focused on in the current research (psychological aggression, physical violence), only subscales or portions of entire measures were used to maintain brevity of the survey. Therefore, not all facets of psychological aggression and physical violence were examined in the current research. Further, the questions asked if these experiences had ever taken place and did not provide key time points (e.g., before or after pregnancy) by which to reference when the experiences took place. Findings should be interpreted with these limitations in mind. The current research provides an excellent starting point for future research examining intimate partner violence experiences among this specific population.

Second, a shifting in the wording of some questions is needed in future research. It became apparent that emerging adults were confused by terms such as “peers” and “contraception” in the surveys. In future assessments, one should consider using the term “friends” rather than “peers” so as to limit the confusion of survey respondents.

Third, in terms of sexual and reproductive health practices, the majority of the survey questions were geared toward heterosexual relationships. A better understanding of the sexual and reproductive health attitudes and behaviors of emerging adult same-sex couples is needed, specifically as it relates to intimate partner violence. Fourth, the survey questions did not consider all potential risk (e.g., parental substance use, parental

incarceration, trauma history) and protective (e.g., spirituality, religion, parental monitoring) factors related to intimate partner violence and sexual behavior. Given that these variables provide important contextual information for sexual behavior and pregnancy, understanding these contextual factors and what role they play in their sexual and reproductive health attitudes and behaviors would be a relevant topic for future research. Finally, the lack of availability of electronic surveys in Spanish was also a limitation.

Summary

This study examined the contributing factors to sexual health among emerging adult women. Our findings replicate previous research and recommendations that counselors should continue to focus on reaching young people earlier to prevent pregnancy as well as to educate them about healthy relationships and sexual health. In addition, this research highlights a need to intentionally integrate information and skills into counseling practices that focus on recognizing and combating psychological aggression. Psychological aggression such as intimidating, threatening, and verbally berating another person can be very harmful within an intimate relationship. Thus, counselors and interventionists should explore the presence of psychological aggression as an important component of sexual health and integrate skill-building and assertiveness training to combat psychological aggression. Sexual health assertiveness training that incorporates assertively communicating relationship desires, including condom negotiation, can be an important step to reducing unplanned pregnancies. Given related research that highlighted that verbally abusive relationships were associated with not using a condom during intercourse (Roberts et al., 2005), helping young people "find their voice" and assertively communicate their needs could be an effective strategy for treatment.

Furthermore, the current research suggests that culturally-sensitive interventions may be particularly important for the Hispanic population given the stronger links of violence factors, pressure to have a baby, and lower support for birth control reported among this population. These findings highlight that a "one size fits all" approach to intervention often is not ideal, as the cultural context of the individuals involved impacts the sexual health relationship as well. The results of this study encourage counselors to always consider cultural context in interventions and to be keenly aware of the ways in which culture impacts sexual health choices, particularly among the Hispanic population.

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Appendix – Sample of the Survey

Young Women & Sexual and/or Reproductive Health Survey

1. **Have you ever, by your choice, had:**
   - **a.** Vaginal sex ☐Yes ☐No
   - **b.** Oral sex ☐Yes ☐No
   - **c.** Anal sex ☐Yes ☐No
2. **Are you currently sexually active?**
   - **a.** Vaginal sex ☐Yes ☐No
   - **b.** Oral sex ☐Yes ☐No
   - **c.** Anal sex ☐Yes ☐No
   - **d.** I'm not having sex right now

****From this point forward, we are only asking about vaginal sex or sexual intercourse.****

3. **When was the first time you had sex (age in years)? _____**
4. **Number of pregnancies? _____** ☐ Does not apply
5. **Number of miscarriages? _____** ☐ Does not apply
6. **Number of children? _____**
   - **a. Ages of children (in years)? _____**
   - **b. Is the father involved in raising the child(ren)?**
     ☐Yes
     ☐No
7. **Number of abortions? _____** ☐ Does not apply
8. **Do you use any method of birth control?**
   ☐Yes
   ☐No

   - **a. IF YES, what type(s) of birth control do you use (check all that apply)?**

☐ Condoms
☐ Birth Control Pills
☐ Depo Provera (injection birth control)
☐ Emergency Contraception (Plan B)
☐ Lunelle (injection birth control)
☐ Implanon (implant birth control)
☐ Nuvaring (the hormonal ring)
☐ Ortho-Evra (the hormonal patch)
☐ Female Condoms
☐ Cervical Cap
☐ Sex Dams/Dental Dams
☐ Diaphragm
☐ IUD (intrauterine device)
☐ Other, please specify_____
_____

   - **b. IF YES, how much do you pay for birth control monthly?**

☐ $0-10
☐ $11-20
☐ $21-30
☐ $31-40
☐ $41-50
☐ $50-100
☐ $100+

c. IF YES, how easy is birth control to get?

○ Very difficult ○ Difficult ○ Neutral ○ Easy ○ Very easy

d. IF NO, why are you not using a method of birth control?

- ☐ Too messy
- ☐ Inconvenient
- ☐ Uncomfortable
- ☐ Too expensive
- ☐ Not applicable
- ☐ Other, please specify _____

9. How often do you use birth control?

- ☐ Every time you have sex
- ☐ Occasionally
- ☐ Never

10. Did you use contraception last time you had sex?

- ☐ Yes
- ☐ No

11. Do you have health insurance?

- ☐ Yes
- ☐ No

12. Do you go to the doctor yearly for your pap smear?

- ☐ Yes
- ☐ No

13. Do you have access to prenatal or child health care?

- ☐ Yes
- ☐ No

14. Choose the response that best reflects you:

- ☐ "I really don't want to have a baby now."
- ☐ "I go back and forth"
- ☐ "I really want to have a baby now."

15. I have access to (please check all that apply):

- ☐ Birth control
- ☐ Family planning
- ☐ STD/STI testing
- ☐ Counseling
- ☐ Emergency contraception (Plan B)

16. Are you currently in school?

- ☐ Yes
- ☐ No

a. IF YES, what grade/year are you in?

- ☐ 11th grade
- ☐ 12th grade
- ☐ 1st year of college
- ☐ 2nd year of college
- ☐ 3rd year of college
- ☐ 4th year of college
- ☐ Graduate School

b. IF YES, what type of school are you in?

- ☐ GED program
- ☐ High School
- ☐ Early College Program (i.e., middle college)
- ☐ Community College/Technical School
- ☐ University
- ☐ Other _____

c. IF YES, what type of grades do you make?

- ☐ Mostly A's
- ☐ Mostly B's
- ☐ Mostly C's
- ☐ Mostly D's
- ☐ Mostly F's

17. Are you currently employed?

- ☐ Yes
- ☐ No

a. IF YES, what is your job title?_____

18. How much do you think being pregnant or being a mother impacts your work goals?

- ☐ Not at all
- ☐ A little
- ☐ A lot

19. How much do you think being pregnant or being a mother impacts your education goals?

- ☐ Not at all
- ☐ A little
- ☐ A lot

20. How supportive is your partner when you want to use birth control?

○ Unsupportive ○Somewhat unsupportive ○Somewhat supportive ○Supportive ○Does not apply

21. I talk to my FRIENDS about:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Sex	○	○	○	○	○
Birth Control	○	○	○	○	○
Relationships	○	○	○	○	○

22. I talk to my FAMILY about:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Sex	○	○	○	○	○
Birth Control	○	○	○	○	○
Relationships	○	○	○	○	○

23. I talk to my SIGNIFICANT OTHER about:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Sex	○	○	○	○	○
Birth Control	○	○	○	○	○
Relationships	○	○	○	○	○

24. I talk to OTHER about:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Sex	○	○	○	○	○
Birth Control	○	○	○	○	○
Relationships	○	○	○	○	○

Please specify OTHER: _____

25. I feel pressure from my FAMILY/PARENTS:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
To have sex	○	○	○	○	○
To have a baby	○	○	○	○	○

26. I feel pressure from my COMMUNITY:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
To have sex	○	○	○	○	○
To have a baby	○	○	○	○	○

27. I feel pressure from my PEERS:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
To have sex	○	○	○	○	○
To have a baby	○	○	○	○	○

28. I feel pressure from my SIGNIFICANT OTHER:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
To have sex	○	○	○	○	○
To have a baby	○	○	○	○	○

29. I feel pressure from OTHER:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
To have sex	○	○	○	○	○
To have a baby	○	○	○	○	○

Please specify OTHER: _____

30. Most young adults (18–25 years old) are having:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Vaginal sex (sexual intercourse)	○	○	○	○	○
Oral sex	○	○	○	○	○
Anal sex	○	○	○	○	○

31. Substance use (alcohol, marijuana, and other drugs) influences the decisions young adults make about:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Having sex	○	○	○	○	○
Using contraception	○	○	○	○	○

32. I like myself.
○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

33. I feel that I have a number of good qualities.
○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

34. I feel I do not have much to be proud of.
○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

35. I wish I could have more respect for myself.
○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

36. I take a positive attitude toward myself.

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

37. Have you ever had sexual intercourse even thought you didn't really want to because he/she threatened to end your relationship otherwise?

☐ Yes
☐ No

38. Have you ever been forced to have sex?

☐ Yes
☐ No

39. Have you ever been forced to do other sexual things that you did not want to do?

☐ Yes
☐ No

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please indicate how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, please select that answer.

40. How often did this happen?

	This has never happened	Once in the past year	Twice in the past year	3-5 times in the past year	6-10 times in the past year	11-20 times in the past year	More than 20 times in the past year	Not in the past year, but it did happen before
My partner called me fat or ugly	☐	☐	☐	☐	☐	☐	☐	☐
My partner destroyed something belonging to me	☐	☐	☐	☐	☐	☐	☐	☐
My partner accused me of being a lousy lover	☐	☐	☐	☐	☐	☐	☐	☐
My partner threatened to hit or throw something at me	☐	☐	☐	☐	☐	☐	☐	☐

41. How many times has anyone that you have been on a date with done the following things to you? Only include when they did it to you first. In other words, don't count if they did it to you in self-defense.

	Never	1 to 3 times	More than 3 times
Threw something at you	○	○	○
Pushed/shoved you	○	○	○
Slapped you	○	○	○
Kicked/punched you	○	○	○
Used a gun/knife on you	○	○	○

Demographic Information

42. Age (in years)? _____

43. Race/ethnicity:

- ☐ Asian
- ☐ Black/African-American
- ☐ Biracial/Multiracial
- ☐ Latino/Hispanic
- ☐ Native American/American Indian
- ☐ White/Non-Latino
- ☐ Other, please specify _____

44. What is the zip code for the area that you live? _____

45. Do you consider yourself:

- ☐ Heterosexual (attracted to men)
- ☐ Lesbian (attracted to women)
- ☐ Bisexual (attracted to both men and women)

46. What best describes your current living situation?

- ☐ Living with Family
- ☐ Living with a Friend
- ☐ Living with Boyfriend/Girlfriend
- ☐ Living with Spouse
- ☐ Living Alone
- ☐ Other, please specify _____

47. Does your child attend daycare?

- ☐ Yes – Half day (4 hours or less)
- ☐ Yes – Full day (more than 4 hours)
- ☐ Family member takes care of my child
- ☐ No