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Romantic Relationships, Consent, and the Impacts of Early Sexual Force on Long-term Health

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Abstract

Romantic and sexual relationships are an integral part of human development, with implications for emotional, social, and physical well-being across the lifespan. However, what, when, and how we teach young people remain pertinent questions. Using a combination of interview data from 24 recent high-school graduates and survey data from a nationally representative United States sample, this dissertation explores young people's experiences with romantic relationships, their conceptualization of consent, and the long-term association between early sexual violence and mental and physical health in adulthood. The findings are three-fold: First, despite most teens receiving some sexuality education, what they learn is most often focused on the prevention of sexuality transmitted diseases and teen pregnancy through either abstinence or contraception. Absent from their instruction are challenges that young people themselves identify as most salient to their experience: qualities of healthy relationships, boundary-setting, consent, and balancing independence and connection. Second, young men and young women conceptualize consent in vastly different ways. While young women regard consent as something that must be ongoing, they also describe active consent as unrealistic and challenging; whereas, males conceptualize consent as something that is simple, straightforward, and obtained through a simple 'yes' or 'no'. Finally, risk of sexual assault differs for males and females across the lifecourse. Males are proportionately more likely to experience sexual force as children, whereas the risk of sexual violence increases for young women as they move through adolescence. Across all ages, young people who experience sexual force in their childhood or

adolescence are more likely to report compromised mental and physical health in adulthood. Considering these findings, this dissertation concludes by asking how we might better serve the needs of young people as they enter the world of dating and sexual activity and how we can better support young people who experience sexual violence to help them thrive as adults.

Past research on adolescence has often examined romantic relationships and sexual relationships separately, rather than considering them as part of a conjoined developmental process with overlapping and distinct components. Research on both romantic relationships and sexual relationships has focused on problematic outcomes of relationships from a clinical perspective. In this dissertation, I explore young people's challenges but take a developmental and educational perspective rather than a public health approach to romantic relationships and sexuality. Moreover, research has historically focused on challenges to young women and ignored the stories and needs of young men. The approach in this dissertation reveals the ways in which young men and women's needs both overlap and diverge regarding talking about romantic and sexual relationships.

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Chapter 1: Introduction

Romantic and sexual relationships are an integral part of lifespan development and serve as a bedrock for our social world. Such relationships fulfill important psychological and social needs, such as belonging (Baumeister & Leary, 1995) and intimacy (Erikson, 1963). Positive, emotionally nurturing relationships are associated also with strong mental and physical health (Robles, 2014).

Romantic feelings emerge in pre-adolescence, around 11 years old. In their explorations, young people begin speaking with their peers about engaging in romantic relationships and assessing those whom they are interested in dating (Connolly et al., 2013). The National Longitudinal Study of Adolescent Health (Add Health) suggests that more than half of adolescents have "some experience" in romantic relationships by age 12 and 25% of 12-year-olds reported having a "special romantic relationship" in the past 18 months. Rates of engagement in romantic relationships are relatively consistent across African-American, Hispanic, Native, and White adolescents, while Asian students are somewhat less likely to engage in romantic relationships in adolescence (Rauer et al., 2013). By the time teens are 18, 55% have had sexual intercourse (Martinez & Abma, 2015). The commonality and longevity of romantic relationships continue to expand over time, such that 84% of adults marry by the age of 40 (Copen & Mosher, 2012)

Weinstein and Rosen (1991) theorize that sexual development occurs in two stages: transitional and relational. During the transitional stage of development, early adolescents may engage in sexually related acts because it "feels good" or because they deem it to be the cultural

norm or understand it as an adult way to express affection. As adolescents age and mature, their motivations for sex change, becoming driven by intimacy or connection with their partner. Hirsch and Khan (2020) point out that sexual relationships are driven by a number of motivations, including sex as a form of comfort, as a source of social status, to have children, or for intimacy with a partner. However, they found that most young people do not have the skills or training to know how to articulate their sexual desires, and often learn about them through trial and error. It is perhaps unsurprising, then, that over half of American women describe feelings of ambivalence, confusion, or regret about their first sexual interaction (Centers for Disease Control & Prevention, 2015).

Sexual consent remains both tangential and integral to the formation of healthy relationships. The 2015 Youth Risk Behavior Surveillance Survey reports that 10.6% of students (15.6% of females and 5.4% of males) who had dated in the past year had been forced by their partner to engage in unwanted sexual activity (Kann et al., 2016), although these numbers are thought to be underreported. Sexual violence and consent are issues typically introduced to young people in college as part of orientation seminars; however, given that more than half of young people will have had sexual intercourse by the time they are 18, it is important to understand how high-school students conceptualize consent and learn how to obtain consent in sexual interactions.

Sexual violence can be perpetrated outside the context of romantic relationships by acquaintances and strangers. When young people are most at risk of sexual assault, and how early experiences of sexual assault impact long-term health and well-being, add further

considerations about the timing and type of information and support young people need access to prior to adulthood.

Despite the integral nature of these relationships, the frequency of negative outcomes, and the significant impacts that relationships challenges can pose for health and development across a person's lifespan, how, when, and what we teach young people about romantic and sexual relationships continue to be sources of debate. Although some proponents of comprehensive sexuality education may wish to venture further into conversations about the potential benefits or pleasures of sex and sexuality as an aspect of identity, the topic firmly remains a public talking point rooted in teenage sex as a public health issue and motivated by a desire to reduce teen pregnancies and sexually transmitted diseases (Fine & McClelland, 2006; Hirsch & Khan, 2020). Although 95% of students will receive some form of sexuality education by the time they graduate, most students will receive only basic contraceptive instruction; healthy relationship skills, including sexual agency and consent, are absent from the sexuality education curriculum for most youth (Albury et al., 2017; Coyle et al., 2016; Hirsch & Khan, 2020).

The alignment of sexuality education curriculum to the developmental and social needs of young people as they enter the dating world has been understudied, prompting us to ask: What are the challenges that young people grapple with as they begin to form romantic connections to others? What are the questions young people pose about healthy relationships, and to what extent do their educational experiences both inside and outside the classroom equip them with the tools to resolve these questions?

This dissertation uses a combination of interview and survey data to investigate how young people learn about and make sense of romantic and sexual relationships in high school, how they conceptualize consent, and how sexual force prior to adulthood impacts long-term physical and emotional health and well-being. The findings are limited in their generalizability to other young adult populations because of the relatively small sample size and the skew of the population toward more achievement-driven samples. Nonetheless, the findings provide novel evidence about how gendered power dynamics, consent, and long-term physical and mental health may be related. As such, the findings inform the public conversation and educational policy about the critical role that healthy emotional and relationship dynamics and consent in youth romantic and sexual relationships play in adult health.

In Chapter 1, I describe young people's conceptualization of dating relationships as more intensified versions of friendships, requiring greater time and emotional investments. These investments create challenges related to power, boundaries, and conflict resolution that are unique to these romantic pairings. Rather than receiving support with these challenges from parents and educators, most young people are left to their own devices: being told to refrain from dating in favor of academic pursuits, receiving lessons that depict extreme examples of relationship challenges, or told nothing at all. Instead, young people are turning to internet searches and popular media to learn how to navigate their challenges.

In Chapter 2, I highlight the gap between how females and males imagine consent conversations. In particular, I note the ways in which young women highlight the importance of ongoing consent in their definitions of sexual consent, yet they describe ongoing consent as

unrealistic in the context of both idealized romantic encounters and more practical power dynamics in which they become reactors to sexual advances rather than partners in their creation. Males, conversely, define and consider consent to be straightforward "yes" or "no," leaving consensual sexual interactions uncomplicated. Together, these frameworks create a significant gap that young people must overcome to communicate about sexual needs and to form mutually pleasurable, desired sexual interactions.

Finally, in Chapter 3, I explore the long-term outcomes on psychological and physical health for young people who experience sexual force in their childhood or adolescence. I begin by outlining the differences between males and females when they first become at risk of sexual violence, finding that men are at higher risk for earlier assaults, while females become increasingly at risk over the course of their adolescence. I then explore the role that age at time of first assault has on long-term outcomes of depression, stress, and both self-reported and biological measures of physical health.

Using a combination of in-depth interview data and longitudinal survey data, this dissertation examines in depth the lived experiences of 24 recent high-school graduates and broadly considers how experiences with sexual violence manifest into mental and physical health challenges between early adolescence and adulthood in a nationally representative sample of youth in the United States (US). Together, these chapters reveal a need to meet young people at their developmental level to provide support, education, and insight into how to navigate romantic and sexual relationships, as well as the importance of providing prevention, education,

and treatment for survivors of sexual violence to stem the potential long-term impacts of sexual force.

Chapter 2: Left to Their Devices: Adolescents & Sexuality Education

When should we talk to children about dating? What about sex? Who should educate them? What should they say? These questions continue to haunt parents, educators, and policymakers alike. Pitted between a debate about morality and public health, questions about sexuality education have narrowed into measurable outcomes: How do we reduce teen pregnancy and sexually transmitted diseases? Lost in these discussions are questions about the developmental needs of young people as they begin to explore romantic and sexual relationships. What challenges and struggles do young people identify as salient to their experiences and to what extent do their interactions with adults and peers address their challenges?

Background

Romantic relationships in adolescence provide a platform for young people to explore important psychosocial tasks related to developing a sense of psychological and sexual identity, intimacy, and belonging (Collins, 2003; Connolly & McIsaac, 2009). These tasks offer opportunities to develop social and emotional skills, including conflict management, differentiating one's own emotions from those of others,[1] and emotional regulation through both the positive and painful elements of relationships (Larson et al., 1999). Healthy mutual relationships in adolescence are associated with strong levels of support, enhanced self-esteem, social acceptance, and feelings of self-worth and self-confidence (Collibee & Furman, 2015; Joyner & Udry, 2000). Positive romantic relationships in adolescence have also been associated

[1] Licensed marriage psychologist David Schnarch defines differentiation as "the process by which we become more uniquely ourselves by maintaining ourselves in relationship with those we love" (Schnarch, 2009)

with more successful adult relationships (Connolly et al., 2013), which have strong associations with emotional well-being, life-satisfaction, and long-term health (Robles, 2014).

Conversely, relationship challenges are associated with higher levels of familial tension, poorer academic outcomes, and depression for teens (Rogers et al., 2018). A study of 98 adolescent couples found that daily levels of conflict in a relationship corresponded with an overall fluctuation in mood and well-being (Rogers et al., 2018). These emotions can stem from several potential relationship challenges, including high levels of interpersonal conflict, relational instability, difficulties establishing boundaries , pressure to engage in unwanted sexual acts, public break-ups, and disclosure of sexual images (Joyner & Udry, 2000; Lippman & Campbell, 2014; Thomas, 2017; E. C. Weinstein & Selman, 2014). Adolescent relationships also mark the onset of intimate partner violence (IPV), which may include emotional, physical, and sexual coercion and violence. More than 25% of adolescents involved in romantic relationships experience some form of dating violence (Wolfe & Feiring, 2000). The 2015 survey on Youth Risk Behavior Surveillance found that 9.6% of the students in dating relationships had been intentionally hurt in the previous 12 months, and 15.6% of young women reported being forced to engage in unwanted physical sexual behavior in the previous 12 months (Kann et al., 2016).

Sexuality Education and Sources for Information about Relationships and Sex

How do we support young people to guide them toward the more positive outcomes associated with relationships? Public education now usually includes some sexuality education, either as a standalone class or as part of a general health course. By the time they graduate school, more than 95% of US teens will have some formal sexuality education through a school

or community program (Kost et al., 2010). The most frequent outcome of interest for measuring the efficacy of these programs is a reduction in teen pregnancy and sexually transmitted infections (STIs) (Coyle et al., 2016; Rohrbach et al., 2015), although gender inequality and IPV have been increasingly recognized as relevant and significant elements of the sexuality curriculum (Haberland & Rogow, 2015).

Curricula range from abstinence-only education, which encourages young people to wait until after marriage to have sex (often called Risk Avoidant curricula); to abstinence plus education (also called Risk Reduction curricula), which encourages abstinence but also provides basic information about condoms; and comprehensive sexuality education, which includes information about condom use and safer sex practices (Coyle et al., 2016).

Efforts by comprehensive sexuality education proponents have aimed to make sexuality education more developmentally appropriate for young people, matching the content to the cognitive, physical, and sexual development of young people (see SIECUS.org for example). However, limited research has explored the extent to which sexuality curricula align with the questions and needs young people raise about romantic and sexual relationships. The research that does exist suggests a significant gap between the needs of students and the content of the courses they receive. For example, while the content of sexuality education curricula tends to focus on STIs, contraception, and abstinence before marriage, a study of 75 mid-adolescent Mexican and white teens found that, across the board, they spoke of desiring greater support with the emotional, relational, interpersonal, and physical elements of relationships (Adams & Williams, 2011). Their study found also that the specific needs of race and gender groups varied

such that young women, in general, desired more information about the emotional turmoil involved in romantic relationships, but Latina women desired more information about coping with family support and turmoil as a result of romantic relationships; whereas, white women were more likely to speak about the temporal nature of relationships. Additionally, while all young people discussed the need to not become attached too quickly in relationships, the tenor of this message varied across groups.

Many adolescents are reticent to seek any type of support for challenges with romantic relationships (Fry et al., 2014), but are especially unlikely to seek help from adults (Kim et al., 2016). Research suggests that young women are more likely than young men to seek help from friends to solve problems in romantic relationships, while young men are likely to feel social pressure to appear aloof from the emotional dynamics of romantic relationships (Feiring, 1999). The converse is true for sexual information. For example, Martin's (1996) research indicates that males have greater access to informal networks (friends, brothers, older male peers, and pornography) to teach about sexuality; whereas, young women's networks are less likely to serve this purpose. In the absence of conversations with adults helping teens to shape their values and feelings about sex, young people largely learn about sex through trial and error, informal networks, and pornography (Hirsch & Khan, 2020).

Given the association of early romantic relationships with the long-term stability of relationships throughout adulthood, understanding the specific educational needs of young people can help educators to meet the needs of students more successfully as they begin

participating in romantic and sexual relationships. In this paper, I explore the alignment of adolescent needs and sexuality education by asking the following:

1) What are the concerns and challenges young people identify with romantic and sexual relationships?
2) To what extent do conversations with educators address or answer these questions?
3) Where do young people go instead to obtain information related to their questions?

Methods

Study Recruitment & Participants

The participants in this study came from two separate interview studies focused on understanding the social experiences of young adults. One study specifically focused on the experiences of "Social Norms and Stressors in High School": 17 recent high school graduates (11 female) were recruited through social media posts, snowball sampling, and fliers posted on campus (see Table 1). The other study focused on "Social Norms on Campus": seven second-year college students (four female) were recruited via campus fliers. The demographic differences between these two samples are listed in Table 1. The participants in the two studies predominantly came from the same university and had similar racial and socio-economic backgrounds . The most significant difference between the two samples was their age—the Social Norms on Campus study explicitly recruited second-year college students, while the Social Norms in High School study recruited mostly pre-college and first-year college students (although it also attracted second-year and third-year college students) (see Table 2). The difference in age is most acutely apparent with the recollections of high-school messages. Those participants more recently out of high school often provided more detail about their sexuality education class. Older participants were more likely to reflect on how their knowledge about

sexuality had changed since they began college. Overall, however, the general story that the participants described regarding the content, utility, and needs they had in high school was consistent across the samples.

Eleven participants (45.8%) identified as Asian or Asian American, eight (33.3%) participants identified as white, and four (16.6%) identified as Black. One participant identified as Latino. Both studies included a series of questions about high school experiences with sexuality education, information, and resources they received about romantic and sexual relationships, any lingering questions they had, and where they went to access the information they wanted. They were asked also to complete a survey about their demographic information, including household income, parent education, sexuality education format, and feelings about their sexuality education program.

Participants came from a wide range of educational and social backgrounds. Two participants had grown up and attended high school outside the US: one in Thailand and the other in China. Two other participants had grown up outside the US—one in Europe and the other in China—but attended high school in the US. Eighteen of the participants attended their local public school and six attended a private school. In Table 2, I provide descriptive statistics about each participant's demographics and educational experience as self-reported in an online survey after the interview.

Interviews

Qualitative interviews offer a unique lens into the worlds of participants, helping to reveal how adolescents understand and make sense of their social worlds, the representations

they carry with them about relationships, and the boundary work and emotions they navigate as a result (Lamont & Swidler, 2014). For this study, semi-structured interviews allowed me to question students about how they conceptualize and organize their worlds related to romantic relationships and the challenges they believe to be salient to their experience.

In 2019, I conducted one-on-one interviews with all 24 participants. The interviews lasted anywhere between one and two hours. The interviews were semi-structured and included a base set of questions but used verbal cues from the participant to guide follow-up questions (Miles & Huberman, 1994). The research questions were initially left broad: How do teens describe their experiences with sexuality education? What resources do they identify as particularly helpful or harmful in answering their questions about romantic and sexual relationships?

The interviews began with broad questions, asking participants to describe their hometown and the two or three most pressing challenges they thought most teenagers faced in high school. They were asked also to detail the different non-platonic relationships (i.e. dating, hooking-up) that their peers engaged in. Then, they were asked to describe their sexuality education curriculum, how they thought their peers responded to the curriculum, and their own feelings about their experiences. Finally, participants were asked what questions remained about romantic and sexual relationships after the class and where they would go to find that information.

Some participants were comfortable describing sex, but others displayed some nervousness discussing sexual relationships (e.g. laughing during responses or using vague language to refer to sexual acts). I took participants' lead regarding how I asked questions, but

also had to ask direct follow-up questions to ensure that I was accurately interpreting the statements they were making. Most participants seemed forthcoming with their feelings and opinions despite their apparent nervousness regarding the use of explicit terms.

Interpretive Phenomenological Analysis

Using the transcribed interview data, I used interpretive phenomenological analysis to help me understand the lived experiences and perspectives of the participants. I followed the stages for analysis outlined in Willig (2013). I began by making notes documenting my broad observations of the data. These notes include descriptive accounts of what and how each participant described their experience with sexuality education and specific words or phrases emerging in the data (e.g. “joke” and “immature” were frequent terms used by participants) and the potential importance or implications of these words for understanding their experiences. I then began to identify themes emerging in the text, for example, wanting information about emotional dynamics, being told relationships are a distraction. Finally, I considered the ways that the different themes related to one another to “introduce structure” (Willig, 2013, pg. 88).

Findings

Young people in this study described how the pressure to excel at their academic pursuits posed challenges to their mental health, their time and availability, and the congeniality of their classmates. Although separate from their challenges with romantic encounters, these social settings established the tone for their emotional well-being, their drive for connection, and the richness of their other social connections. Romantic relationships were universally understood to be more intense versions of friendships in which time and emotional support should always be

available. While this need was considered a positive and desirable attribute for being in a relationship, young people also identified this level of commitment as problematic because of boundaries with time, emotional investment, agency, and physicality became more difficult to navigate. Messages from adults side-stepped these challenges by either describing romantic relationships as unnecessary distractions to academic and career success or by highlighting extreme versions of abusive relationships that young people could not relate to. In response, young people turned to the internet to obtain an understanding of how to negotiate relationship challenges.

The Academic Pressure Cooker

Young people described operating within a broader social context in which social relationships were complicated by and sometimes in direct conflict with the need for academic success. They described the pressure for academic achievement as a direct challenge to their personal well-being, their availability to engage in both social and romantic relationships, and the quality of their social relationships, which become competitive in the drive for academic success.

Personal Well-Being

Every participant mentioned challenges to their emotional and mental health in high school as being associated with academic pressure to succeed. Most participants had enrolled in highly selective colleges and universities, although Carol and Devon were planning to attend their local state university, and Jesse was planning to attend a local community college before transferring to a four-year college. Elizabeth described the culture of perfection at her school and

the way that it manifested into everyone needing to indicate they were "fine" even though they were not:

> *So, I guess there was just a mindset that you had to do everything and be good at everything. Um, but it just, there's not enough hours in the day and it's just it's really, really hard to try and get everything and be perfect at everything. Um, I guess another thing is that, I feel like a lot of times we're not honest with ourselves and our emotions at the community. I mean, like, if anyone asks, "How are you?" you'll automatically say, "I'm fine," but I know that, especially from living in the dorm, that like a lot of us are really stressed out and like kind of hurting because of it, but we feel as if we have to be perfect, um, like during the day.*

In contrast to Elizabeth, who experienced a school in which stress was meant to be handled perfectly and without comment, in Mary's school, stress and lack of sleep became bragging rights and a competition for who was the most stressed:

> *I think a lot of people are anxious. I feel like, I mean I'm anxious, like I have anxiety. I think a lot of people struggled with that but there was also, like, with weird culture that I didn't like, of like who is the most stressed, like who got the least sleep, like who has the most homework, or who is freaking out the most right now.*

Greg described how his need to excel and work hard manifested itself into extreme stress:

> *Being a workaholic propelled me into this new spiral of stress… I never felt, um, and not to make a, a very deep issue light. I never felt suicidal. I never felt like I would have no way out, like I'm trapped. Um, I was very stressed at times. Um, just a lot of work to do, not much of an outlet.*

Although Greg described himself as not being suicidal, these extreme manifestations of depression were not far away from any of the participants. Four participants had lost a friend or classmate to suicide during their high school years, and several others described their own battles with mental health challenges. Beth described the following:

> *I think competition was huge, and the pressure to succeed, like be included, kind of like in that one theme, created a lot of anxiety and depression. I think,*

> *and I mean you see that in everything like in class, but also like to get in college.*

Competitive, Mistrusting Social Relationships.

The focus on academic success also played a part in how young teens experienced their peers. They described how they perceived their classmates to be competitive or secretive in an attempt to outperform each other. Gabby described how she perceived her classmates to be less than helpful when asked for information as an intentional way to gain an academic edge:

> *I can think of multiple times where I would like ask for notes, like because I would like miss for competitions or something, I'd miss class. And if I would ask for notes, if it wasn't like a good friend of mine, though would give me like, not incorrect notes, but not like full ones, you know, they would leave stuff out. Or we would be doing a project and I would ask like, "Oh, how is yours looking? What kind of stuff are you doing?" And they would be like, they would give me just like a really vague answer that isn't actually helpful or like direct competition. Like I can think of a couple of times where in, especially in my science and math classes. In like my English and history classes they didn't really care, but in science and math specifically I can think of a couple of times when people would like tell me wrong answers. Like if I asked like, "Oh, how was this test? Like how was this quiz?" They'd be like, "Oh the answer is this and this." And I'd be like, I'd get the test and be like, "Oh no it isn't." And obviously the kid knew what the right answer was, they just wanted to mess up my grade…Like there's definitely competition.*

Lindsey, too, described how classmates would be secretive about their academic success to the point of it creating a "toxic environment" in which it was "hard to be open." Lindsey not only perceived her classmates to be intentionally secretive and competitive, but she also compared her own achievements to others and felt she was not doing well and "feeling bad" about her own achievements.

> *Um I think dealing with academic pressure [was the most challenging]. Um, that caused a lot of um I guess like tensions and stuff between people too because we had like this system where you could skip, like if you were entering ninth grade you could like take an exam and skip all of ninth grade's like math*

> *syllabus and go to tenth grade math syllabus. So, a lot of people, what they would do, would like not tell other people that they were skipping xyz syllabus and then just end up skipping ahead. And then we'd all come back the next year and be like, you're not in our class, what happened? And then they'd say, oh I'm in like a different class, and so then we'd all feel bad and like we were behind or something like and that became a little bit of a toxic environment cause people just wouldn't tell other people anything. And it was hard to really be open or in terms of like, oh what are you doing over the summer, and someone would be like, oh I'm visiting my family, or something of a general nature, and then you come back in the fall and you learn that they actually like did some like high-profile like summer program somewhere. So, a lot of keeping up with that was, I think, hard in terms of like people just achieving things and you probably not achieving as much and just feeling bad about it but failing to recognize that, yeah, you do have some value in what you achieve as well.*

Young people described themselves as existing in something of an "academic pressure cooker"—one in which success, perfection, and performance permeated life and significantly impacted self-esteem, stress, and emotional health. It is within these contexts of social toxicity, stress, and depression that young people witnessed and engaged in romantic relationships. Romantic and sexual relationships seemed to offer solace from the world of academic pressure in some ways while intensifying them in others.

Dating and "Having a Thing"

Asked to describe the range of non-platonic relationships high school students might engage in and the challenges and benefits associated with those relationships, participants spoke of two groupings of relationships—one predominantly sexual and described in vague terms such as "hanging out," "talking," "having a thing," or "hooking-up"; and more traditional (and also less common) dating relationships in which young people had established a clear boundary around their relationship.

Relationships had the benefit of a constant companion—someone who could be relied upon for support and time. However, these same benefits posed several challenges, such as balancing time and emotional resources to provide the level of expected care to the partner and navigating one's own needs and their partner's simultaneously. Hook-ups or "having a thing" avoided several problems by eliminating the social contract that required time and attention. At the same time, students noted that these relationships came with their own struggles—the potential for "catching emotions" or one person becoming more attached than another, hurt feelings, and the potential scorn and ridicule from peers—particularly in more conservative, rural settings.

Relationships = Being Each Other's Number One 24/7

Dating relationships were described as more intensified versions of friendships. These relationships involved a significant level of emotional support and care, but also require extensive time and attention. For Uma, and others, romantic relationships held the promise of support: "I guess it's like having someone who's like just your own like for your own or something. Someone who's always there for you." Carol said: "sort of a contractual thing about being in a relationship is you're kind of there for each other, which is nice...I think it just relieves a lot of social anxiety". She added:

> *I think in a friendship there's not a lot of obligation, you know. Um, I think I'll text you when I want to talk to you and, if I don't, you know we're still friends… But I think that [in] the relationship there is a lot more upkeep, you know. And depending on what your goals are in a relationship, you are actively working towards something. It kind of depends on what that is. But yeah, I think it's a lot more easy. It's easier to be independent and kind of self-focused in a friendship rather than in a relationship.*

For Carol, the "upkeep" required in a relationship challenges independence and the ability to make decisions without consulting with or considering her partner. Carol's depiction of relationships focuses on a critical factor of adolescence—balancing independence and identity with belonging and aspects of differentiation and closeness in romantic relationships.

Devon stated that a relationship is more than a contract for time, it also an agreement that you will prioritize a person over your friends and emotionally invest in them to the point of becoming a guide for significant decisions:

> *So, usually [being in a relationship] means that like you are extremely invested in this person. Um, oftentimes like you will kind of pick that person over your friend group most of the time. So, eventually, you know, someone's getting in a relationship when they're maybe not talking as… like not talking to their friends as much. They're hanging out with the specific person. Um, you see them like walking together after school…. So, like, so like with your friends when they ask you something like when they ask you for help with something. You give your opinion and that's it. But with [a relationship], it's more of when you're giving your opinion, you're trying to like almost persuade them to try to like, to try to understand like the kind of the better option, I guess. Basically, to try to directly help them instead of just giving an opinion, if that makes sense.*

Phoebe echoed this sentiment, describing how relationships could "isolate you, or like, cut you off from other friendships." Greg most succinctly described the challenge of balancing a relationship between meeting his own needs and maintaining an identity and supporting and dedicating himself to another person:

> *I think that in a non-platonic relationship there's this ideology you should have to be each other's number one, twenty-four seven, and that often causes people to lose sight of everything else. Um, or like give less importance of everything else, something like that. Finding a way to balance each other with everything else as well as like being incredibly dedicated with each other, but still not give up everything else for each other. Like finding the middle ground which you like doing everything, but not, doing anything, but not everything for—that's not a good way to put it. I think finding a middle ground where you can still be*

> *dedicated and care, like give anything for this person, but where you still don't lose sight of everything else that you have going on in life. That's just, that's definitely a stressful thing and just stressful like…it's tough.*

In addition to the challenge of navigating their own needs and their partners', other challenges related to boundary-setting and emotion work emerged. Charles, for example, described the likelihood of cheating and the potential for challenges with physical boundaries and consent to emerge in relationships:

> *Like one person might be looking at someone else or cheat on them, because I know that's happened to like some of my friends um, in their relationships. And that's definitely like problematic, I guess. Um, and then there's just like, I guess there's just like normal issues that come up with like communication or what one person wants to do and the other wants to do. Um, I don't think I know enough to say about what problems might occur on like the physical side because I wasn't really aware of them, but I know like, at least I heard some things about like what one person might be pushing more than the other liked.*

Charles described cheating as a common experience among his friends, a phenomenon that others, particularly males, described as a likely challenge in romantic relationships. Charles pointed also to the "normal issues," such as communication, that arise with trying to negotiate the wants and needs of two people. The challenges that students named are typical of those found in adult romantic relationships—balancing identity and intimacy, compromising desires, finding sufficient time to support another person without becoming over-burdened, managing infidelity, and creating a sexual relationship that works for both individuals.

"Having a Thing"

For teens who did not want the emotional and time burdens of a romantic relationship, "having a thing" (also called "hooking-up," "talking," or "hanging out") was an alternative that provided companionship without the emotional responsibilities. Hook-ups were common across

all school contexts and were frequently described as being more common than relationships. Hook-ups were depicted also as being more openly sexual. Devon described the following:

> *Like ["talking"] was more just meant for [sexual contact] and that's it…I have a lot of friends that actually approve of this group. I don't necessarily, for whatever the reason. It just doesn't make my stomach sit right. But a lot of my friends actually think that this is a lot easier than a relationship. So, they think they find it's a lot easier to just have someone there and not like… To be able to do the things in a relationship that you would do in a relationship, but not have like the pressure or the commitment of a relationship.*

For Devon, "talking" or hooking-up is a purely sexual endeavor that means "absolutely nothing" between two people. Although he himself did not like the idea of this type of relationship (a sentiment he repeated several times in our interview), he remarked that several of his friends find this form of relationship freeing because the emotional commitment is absent. Others, such as Gabby, were more open to this type of relationship, embracing the level of freedom and opportunity it provided:

> *You know, like a lot of kids nowadays just like want, especially girls and I'm this way so I can speak of it. Like I don't really want to have like the idea of like, oh I have a boyfriend. Like I need to spend all my time with him and if I'm not, then I'm doing something wrong. Or like I won't be able to see my friends as much because like I have a commitment to this person. But if you have "a thing" with a person, it's like oh you want to hang out. Like okay maybe I will, maybe I won't…you don't feel obligated to do anything.*

At the same time, she warned:

> *Like the problem with the having a thing with someone or hooking-up is like drawing a line of are we exclusive or not…it's just drawing a line where feelings come into play and like making sure, like even if you say you are, you're not going to be exclusive, like knowing damn well that like, if you catch feelings for someone, you're not allowed to like get mad if they hook-up with someone else if you said they're not exclusive. I think that's the biggest challenge and knowing like how to approach that.*

For Gabby, the pitfalls of having "a thing" embody the possibility of developing emotions for the person, or "catching" emotions, in a metaphor that likens emotional attachment to the flu. The balance of enjoying the lack of commitment becomes tense when devotion, jealousy, or exclusivity become part of the equation.

Underlying both dating and "talking" are challenges about the emotional management of relationships—how to hold emotional boundaries. Regarding relationships, the challenge is balancing the needs of both parties, while "talking" presents more concerns about managing one's own emotions and the potential to be hurt or jealous from becoming emotionally attached. Hooking-up has additional potential social ramifications—either good or bad, depending on the context.

"Hooking-up" or "talking" existed in all the school settings. All the participants knew about (or participated) in the hook-up culture within their school and knew people engaging in non-dating sexual relationships. The acceptability of "hooking-up" or "talking," however, varied across contexts. Beth, for example, noted that she did not experience or witness judgment about sexual exploration outside of relationships. Mary did not like the idea of hooking-up but felt that students on the whole embraced it as "something that people do." She noted also that hooking-up presented opportunities for social climbing:

> *I honestly think it was kind of a thing just because you just want the feeling of knowing that everybody knows about you. Like, oh she got with him. Like, he's cute, whatever. I think there were definitely more like, oh we're like hooking-up, it's whatever, than actual relationships.*

For students in more conservative settings, such as Carol, Eric, and Phoebe, however, hook-ups occurred in more hushed tones or students faced "sort of whispers behind their back…and sort of a judgment on the person's character because of that."

Sexuality Education

Despite the consistency of challenges young people described regarding the emotional challenges of both romantic relationships and hook-ups, the messages from adults about romantic and sexual relationships largely ignored these questions. Students who received no sexuality education received no support for their relationship questions and reported feeling behind or confused about contraception as they left high school. Students who received formal sexuality education programs predominantly learned about what they called the "basics" of STIs, pregnancy, and contraception and/or extreme and "irrelevant" examples of abuse. Among students who experienced or witnessed these types of extreme abuses, however, no support was provided.

Sexuality Education: Technical Tools, Irrelevant Lectures, and Death Warnings

Twenty-two of the 24 participants had received some form of sexuality education during high school. For most students, sexuality education was lecture-based and presented in a health or wellness class that also covered nutrition, physical activity, and drugs and alcohol. Two students had sexuality education connected with a physical education class, one with a religion class, and the other with an advisory group. The students had a range of experiences with romantic and sexual relationships. Some had no experience, while others had been sexually active for several years and had dated a number of people. Participants differed also in their

opinions about the ideal timing for sexuality education. For those who did not receive any training until senior year, many recommended sophomore year as a better time to introduce these topics to youth because "people were already having sex at that point" (Beth). For those who had sexuality education in their freshman or sophomore year, many felt that the material came too early and was "irrelevant" and should have been taught again in senior year when more people were becoming sexually active.

For participants such as Charles, who received no sexuality education in school, the lack of education was considered problematic. Charles, for example, mentioned that many of his classmates would have benefited from information about contraceptives. For him, although the information was not necessarily needed in high school, but by the time he reached college, he felt behind:

> *I find it a little bit surprising that our school never did anything like related to sex ed. So, I think it, it was just never addressed. Like there was no class or no um, no like material really around, around our campus about it. Um, so like that wasn't ever really relevant to me, but it was something that I felt would have been good to have um, for a lot of people, and just have, giving you some basic knowledge heading into now college, um. Because I realized that's something, like now I know a lot less than other people….So they had a basic knowledge of like um, hygiene and like prevention, contraceptives and how to use them, what are their effects, um, and like things in that area. And it was something that I never know and never really gave any thought to. Um, because for me it was just like, oh, there's no sex ed. Well that's just how it is. But now coming [to college] it's like oh that was a common thing and probably a useful thing.*

For students who did receive sexuality education courses, the content predominantly focused on pregnancy and STI prevention or abstaining from sexual activity. The students reported their desire for more content about romantic relationships, emotions, and the qualities of positive relationships, but were resigned to the fact that these topics were not addressed.

Beth stated:

> *[Sexuality education] covered a lot of technical stuff. Um, like what is a condom? How do you put it on? That was fun, we did like condom volleyball. People like blew up the condoms … for fun, but I feel like you know that was gonna happen during the class, cause like some people do all the time. Um, and like the teacher was fine with it. Uh, I don't think they talked enough about, we did not talk about consent. We did not talk about what an abusive or unhealthy relationship looks like. We did not talk about like bystander effects and like that. Um, I think they could have done, like sex ed technically did fine. It's just like relationships they didn't touch on at all. But I think like, then I think about alcohol and drugs they did well so, like I think they were just lacking relationships.*

Beth described how the sexuality education curriculum addressed the "technical" aspects of sex. She mentioned it as being "fun," though not the lectures themselves, but because students turned condoms into an (inevitable) volleyball game. She also listed several topics regarding relationships—consent, healthy vs abusive relationships—that she wished had been covered by the class but that were ignored in their entirety.

In Chelsea's class, group projects focused on understanding and describing the different potential diseases young people could get from engaging in sexual activity to advocate sexual abstinence.

> *We did like group projects. It was like everyone was put into a group, or like you had a partner and like every pair did a project on like different like STDs. We got quizzed on like how do you um contract this disease, is this like curable or is this something that you like have forever…Underneath that, like, abstinence is like the best way.*

Phoebe, who attended a Catholic school, had a class that talked more about relationships, but the content was focused on abstinence until marriage.

> *Sex ed was freshman year and it's like reading a book called "Sex and the Teenager"[2] that focused mostly on what your relationships, like, should be, in a like, philosophical standpoint of like, is it love? Is it friendship? Infatuation? And like they told us about methods of contraception, but mostly in the sense of like, these are the side effects and all the side effects ended in death every time [laughs]. It was incredible.*

While laughing and rolling her eyes during our interview, Phoebe made the point to say that what she was taught in her sexuality education class was that all choices that included sexual contact before marriage ended in death. Rather than teaching her how to reflect on her own sexual values, she summarized her experience as "bullshit, like, in terms of, we all know that people were having sex so, like obviously no one's waiting 'til marriage in like, this room, and yeah. And just, we kinda took it with an ironic eye, I guess [laughs]."

Jesse, too, commented on the extreme warnings built into his sexuality education classes, remarking that the instances of unhealthy relationships portrayed couples whose obsession and violence lead to murder.

> *Um, that was something that I saw in every single video that I ever saw in high school was about this was like there, it was mostly a boyfriend, but it was like a boyfriend that was obsessed with a girlfriend. And I actually watched a video that like the boyfriend was so obsessed with the girlfriend that he killed her.[3]*

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[2] The book she described, *Sex and the Teenager*, proclaims itself to be "rooted in Judeo-Christian and Catholic Church moral teaching, the program has a clear, straightforward goal: to encourage teens to make their own decisions to say "NO" to premarital sexual activity" (Sawyer, 2008).

[3] The film, *Bobby and Stacy*, was referred to by several other participants as a problematic aspect of their curriculum.

For most students, these examples were irrelevant and beyond what they were experiencing or needed support with. The extremity of a partner murdering another, although a real and serious outcome of some romantic relationships, did not meet students' lived experience of wanting to know "what a healthy relationship looks like" (Beth) or "what do you do if you are hooking-up with someone or, like, you're having sex with someone and like it just like ends?" (Gabby), or "how do you know if you're ready to have sex?" (Elizabeth), or "what to do on your first date" (Scott) or "how can you cultivate a long-term relationship realistically?" (Lindsey).

For lesbian, gay, bisexual, transgender, and queer (LGBTQ) students, such as Jesse, representation in the classroom was even more limited:

> *They didn't have any LGBT examples, so that, I mean that already was like I don't wanna listen to this, it's BS because I was so mad. I was like I want to learn something. Um, so that was the main issue…I mean I feel like a lot of [gay] people that I talk to do want a relationship, but they don't know anything else other than having sex. So, I don't know if education, I think that if education could talk about that. If we had like a different, like a, if we did talk about straight, you know contraceptives, pregnancy, you know consent, but we also talked about LGBT stuff, LGBT consent, LGBT sexual protection, um, because they never talked about that in high school.*

Jesse was frustrated by the social depictions of gay men as being inherently part of the hook-up culture. He was eager to see examples of healthy same-sex relationships and to learn about safe sex for himself and his partner. Jesse felt frustrated that not only were the depictions extreme examples of violence, but they were also straight, and predominantly about "college, adults, and people getting married."

Jesse was not alone in his frustration at the lack of LGBT representation. Dana recounted a class assignment in which everyone was supposed to pair up to jointly take care of a baby but "the health teacher didn't let same-sex partners take care of a baby together." Across the

participants, 72.8% reported that they had "never" or "rarely" talked about LGBTQ+ identities in their sex education classes.

Ignoring the Elephant in the Room

In juxtaposition to the severe warnings of the threats associated with pre-marital sex and unhealthy relationships, students who did witness or experience more extreme examples of relationship violence within the school did not receive the education they were hoping for. Several participants described scenarios in which highly public, dangerous, or inappropriate sexual behaviors occurred within the school but went undiscussed by teachers and administrators. Sahar described an incident in which "a student had started taking pictures of women—of like members of my grade and posting them on to a porn site and selling their image without their consent." She added:

> *Sex ed was a lot of like, "This is how you put a condom on" or like, "This is how you prevent STIs and things like that" and there's also like maybe just like "Don't hook-up with someone when you're drunk" or like, "If you see someone who is drunk like going to hook-up with someone maybe just check in" and things like that. But such a gross violation of like a sexual nature that didn't take place like at a party…something that happened within the school environment was just not addressed.*

Two other participants reported scenarios in which teachers were revealed to have had sexual relationships with students, but other than a note sent home that "talked legally a lot" and "[said] like what happened was bad," "there was no education." Naomi witnessed two student-on-student assaults in her class—one in which a popular, wealthy male assaulted a female peer, and another in which a male took pictures of young women and then blackmailed them for sexual favors. She also was the survivor of a violent incident at the hands of her boyfriend on

school grounds. Describing a meeting with her principal after the fact, she remarked, “Like I do think genuinely that he cared but not actually taking any action like concrete action more of like… like that sounds like a friend. You know. It sounds like a friend saying, can I get you anything, can I get you like donuts or whatever, but like not the principal of your school. You know. It’s just kind of very passive.”

Taken together, these stories reveal a distinct lack of alignment between student needs and the curricula and conversations being provided by educators. On the one hand, extreme examples of death and illness are used to dissuade young people from engaging in relationships, while ignoring supports that might make relationships more sustainable and beneficial to youth. On the other hand, students who did encounter these more serious relationship challenges were left to their own devices to find support, most of whom turned to independent therapists for help.

Active, Participatory Education

Two participants had experiences they labeled as positive and effective: Scott, who attended a public school in California and whose mother worked in the contraception industry, and Elizabeth, who attended a boarding school in Massachusetts. For both these students, sexuality education was not a passive lecture but was integrated into a workshop style conversation. Scott described the following:

> *These were kind of workshops that happened the week before high school started for the class, it was like a class retreat. Um, they also, there, there was a week of sex ed, um, that happens during the school year where you go to presentations um, when you’re done with classes and you go to lectures and workshops. Um, it was really cool. I think it was good, um, and it was intensified after [an incident at the school between a staff member and student], when they felt like these messages really needed to be heard. Um, so there were, there were certain like nature retreats where we would go into, for*

> *a field trip kind of, and then had workshops and talk in groups about, about scenarios of, of dodging consent or drinking and how it influences consent, kind of understanding options. We have to talk to someone who we think is um, but you know, like also just defining consent. Like, like having workshops watching, there's the video Consent is Like a Cup of Tea, or whatever that's super famous, we watched that a lot. Um, and a lot of our conversations was dealing with the gray area.*

What is different about Scott's experiences is three-fold. First, rather than cramming sexuality education into a week of health class, a retreat was set aside to attend classes, presentations, and workshops. He mentioned the discussions in groups and the scenarios and "options" that students explored within these groups and the opportunity to talk about nuanced ideas as "the gray area." Finally, regarding an incident when the school learned of a teacher-student relationship, rather than dealing with it with a letter home, the students were brought into an assembly room to have a conversation as a school.

Elizabeth, too, had frequent, separate, and small group conversations within her advisory group. They would meet in small groups at a faculty member's house with snacks and in a "very casual" environment.

> *We had kind of like a whole program for a few weeks at night. Um, it was like two hours every like Tuesday and Thursday and it just talked about what it means to be in a relationship and, um, effective skills to being in a relationship like communication and things like that. And, um, talked about consent and what that means. And, so, we had that for, really for one year. So, yeah…I thought it was really beneficial. I guess just learning about what skills are important to have like a meaningful relationship instead of just like noticing what makes a relationship bad. You also just dive into like what you would need to make a relationship work out and be very good at it…. I know we've had like various scenarios and like we act it out and it'd be like fun for those people were learning at the same time…. I don't remember the specific scenarios but it was just things that like that where we were actually being engaging and not just sitting there just being lectured about it.*

Elizabeth described not only the time and attention given to talking about relationships, but also the focus on the positive elements of a relationship and learning the skills necessary to develop meaningful communication and conversation within a relationship. Similar to Scott, she described how teens were being asked to participate in and engage in working through scenarios and bringing their own ideas and comments to the group rather than sitting as passive learners.

When in Doubt, Google It

Participants repeatedly cited the internet, television, magazines, and porn as important spaces for understanding romantic and sexual relationships in the absence of other conversations. For some, such as Ingrid, the information gathered came passively: "It is just like there and then just like being on the internet and like seeing other people talk about [relationships] you know." Naomi added: "It was more passive learning honestly. I, um, I, Um. And, ah, if, yeah, just like YouTube videos, like YouTube polls mostly." Carol, too, described how a passing meme about the book *Twilight* helped her obtain insights into abusive relationships:

> *For me, I learned a lot of [information about consent and healthy relationships] just off of social media, you know. And not even purposely you know, accidently. You're on Twitter and people's self-care threads are a big one. And just people sharing their experiences online kind of helped me figure out what I thought was healthy and what I thought was unhealthy. Um, and actually it's really funny, I think the first kind of post I saw about that was about how in the Twilight books it was kind of all the abusive things Edward the boyfriend did to Bella. I mean that was very educational. And it was just an Instagram post that was supposed to be funny, you know.*

Dana described how she was introduced to "the worst that can happen" through crime shows on television:

> *Most of my knowledge came from watching TV shows and like crime shows. Ah, it's kind of like, Criminal Minds and SVU, yeah, I mean, those are kind of extreme examples but it's just like what's the worst that can happen and how you prevent that.*

Others actively used the internet for information. Scott described the following:

> *Like outside of school, like social groups, friend groups, school, um TV shows, YouTube became a place where people like talked about relationships, talked about going on dates, what do to on your first date, stuff like that. So heavily, heavy media influence I'd say, heavy internet, um, heavy internet influence on my upbringing. It was kind of like supplemented the main narrative, which was from the authority figures in my life. But this is like when I was like, "What do you do on your first date?" You know and when I was like clueless, I went to the internet.*

Naomi reported: "I did a couple of like Google searches of like, how do you know if you were raped? Like stuff like that."

Although participants considered the internet to be a valuable resource, they also noted its shortcomings. Carol, for example, stated that the benefits she received were largely the result of a network of people she trusted, but she warned that others may not have such an educated network.

Uma's phrasing is perhaps the most poignant. She told me:

> *If you don't have like any proper education and everything you know comes from like maybe the internet, maybe porn or something, then it's just, you know, it's kind of like um when you learn driving from like those movies where they're like driving crazy. It's not like how you actually learn driving, something like that. Ah, I heard this like from one of my friends, I find it really brilliant. She's like if you learn sex from porn it's the same as learning driving from those movies. I was like, yeah that makes sense. So, I think um if you don't give that kind of like education, there is like a higher chance for um doing it wrong or causing dangers…. And if you don't give this education, people will feel like, okay, this is something that we shouldn't talk about. So even if like an issue actually arises, you don't know where to like, you know like, find people*

> *to like consult or find help. Um, so it's more like, okay um so everyone is doing this um secretly so maybe I should deal with myself and, if I can't, I will just push through it. And it's not the right way. Yeah. I think that's not the right way [laughs].*

Within an academically pressurized setting, young people identified two distinct forms of romantic relationships: dating, and a more sexual, vague "thing." Participants described the main challenges of both forms to be related to navigating the emotional boundaries around being with and supporting another person without losing independence and agency, or becoming overly attached to a non-exclusive hook-up. Although most young people received sexual education of some sort, their education was predominantly clinical and failed to provide them with the tools to navigate their questions, leading them to the internet for solutions.

Discussion

The aim of this study is to understand how young people think about romantic relationships, the challenges they identify as being most salient to romantic relationships, and how well the resources around them provide support in answering those questions. Using interpretive phenomenological analysis of 24 interviews with recent high school graduates, this study found that young people described a social setting in which they were already emotionally and socially compromised. They reported feeling stressed, anxious, and overwhelmed, while also operating within a culture in which academic competition and pressure create mistrust between peers. While thinking about relationships as something that are developed through, and help to develop, independence, agency, and collaboration, students are already struggling with their own well-being and their trust and openness with others.

Within this world, relationships offer support, care, and nurturance, while sexual relationships such as hooking-up offer a way to relax. At the same time, both forms of relationship provide a context in which young people are responsible for each other's emotional health and present challenges regarding independence and agency (also important developmental tasks) (Larson et al., 1999). In many ways, the challenges that young people reported are related to the developmental challenges we would want and expect them to have as growing adults—learning how to navigate conflict, learning emotional regulation, and distinguishing their own needs and wants from someone else's (Collins, 2003; Connolly & McIsaac, 2009, Larson et al., 1999). The participants broadly admitted that they did not know how to navigate these challenges, nor did they have a clear idea of how a healthy relationship worked.

Rather than using this opportunity to help young people navigate the importance of finding self within the context of a relationship and using dating or "having a thing" to identity formation, exploration, and capacity further for emotional skills such as empathy, sexuality education instead focuses on technical skills such as using condoms and preventing pregnancy and STIs (Coyle et al., 2016). As Hirsch and Khan (2020) found in their research, students did not have an adult "sounding board" to help understand their own values or beliefs about romantic and sexual relationships. Instead, students opted to search Google for answers to their questions about dates and relationship dynamics, or they absorbed these messages passively while scrolling through their social media feeds or collecting popular opinions from community discussion boards such as Reddit. Moreover, the students described watching depictions of relationships that felt exaggerated or unrelated to their own high school experiences.

Furthermore, students reported limited conversations with their parents, a topic that will be explored more in a future paper. However, like many others, the students did not turn to adults for support (Fry et al., 2014; Kim et al, 2016). Instead, they used the internet to attempt to define their understanding of how healthy relationships work.

Conclusion

For this high-achieving population, both romantic and sexual relationships serve as a source of solace and companionship while, at the same time, draining them of valuable resources. Given the extent of the academic pressure and social competition placed on these young people, it is prudent to ask how their need for and wariness of relationships is the result of the pressure for academic achievement. To begin to address the possibility that the context of competition could undermine the healthy development of romantic and sexual relationships, future research could compare the types of romantic and sexual relationships that similar youth form within different institutional settings that demand varying levels of competition and collaboration.

At the same time, the challenges that young people faced regarding their romantic questions went largely unanswered by their formal educational settings. Instead, technical information regarding contraceptives and extreme cases of abuse dominated sexuality education classes. Individuals such as Elizabeth and Scott, who received practical training in small, more conversational settings reported fewer questions and insecurities about relationships. Future research could explore how different formats and sizes of classes offer students opportunities to

ask questions and to develop skills to navigate the emotional challenges they most associate with dating.

Chapter 3: Teens Navigate Sexual Consent

Sexual consent is becoming a topic of increasing concern and conversation given the #MeToo movement. Awareness about the rates and impacts of sexual violence, particularly among college students, has prompted new conversations about ways to educate young people about consent and healthy relationships. Sexual assault in college has received extensive attention from researchers (Cleere & Lynn, 2013; Hirsch & Khan, 2020; Jozkowski et al., 2017; Khan et al., 2019; Muehlenhard et al., 2017). Furthermore, while the numbers of teens who experience dating violence in their adolescence is staggering, we know relatively little about how high schoolers think and/or talk about sexual consent and sexual assault. For example, where do high schoolers receive their information about consent in sexual relationships? How do they define consent, and how is it operationalized in their relationships? How does gender impact how young people understand how to obtain consent in sexual relationships?

Background

Communicating About Sex

In their book *Sexual Citizens*, which focuses on the sexual experiences and sexual assaults of college students, Hirsch and Khan (2020) describe how women lack the vocabulary and skill to talk about their "sexual project"—that is, to describe when, what, and how they want to engage in sexual interactions. In a study of the disclosure of sexual experiences, students often described sexual experiences without using the term "sex," ostensibly to maintain an image of sexual abstinence (Peterson & Muehlenhard, 2007). This strategy results from both conflicting

messages about sexuality, which paint sexually active women as "sluts," and the lack of a framework in which to discuss sexual decisions with their partners with agency (Martin, 1996).

In contrast, in the Netherlands, adolescent sexuality is more widely discussed and sexuality education programs and broader cultural norms focus on adolescent sexuality as related to "self-determination, mutual respect between sexual partners, frank conversations, and the prevention of unintended consequences." The difference in consequences for these two populations is stark. Statistics from the Netherlands suggest that Dutch adolescents (and adults) have frank and open conversations about sexuality. Dutch adolescents are more likely to report having felt control and agency over their first sexual encounter and, subsequently, had more positive feelings. Eighty-six percent of Dutch young women say they were eager to engage in their first sexual encounter (Schalet, 2011). Qualitative studies with young people in the US repeatedly report that young women feel ambiguous or even regret their first sexual experience, and that only 25% of young women feel empowered and positive about their first sexual experiences (Martin, 1996).

Gatekeepers and Double-Edged Swords

Cultural scripts about adolescent sexuality and gender are salient in the US and influence adolescents' developmental sense of self and behavior. Fears of adolescent sexuality have been particularly concentrated on young women (Fine & McClelland, 2006). For example, females are more likely to be told that they do not need or want sexual activity, and that sexual activity should be confined to monogamous, committed relationships (Fine & McClelland, 2006). Research suggests that males receive more social support for sexual activity than females, who

risk becoming targets of "slut shaming" (Lippman & Campbell, 2014; Meston & Buss, 2007; Schalet, 2011). At the same time, women must remain sexually appealing enough not to be labeled "prudes," creating a "double-edged sword" women must navigate regarding sexual activity and consent. Additionally, most US-based research on adolescent sexuality has focused on females, classifying them as more responsible for sexual decisions and at greater risk of negative consequences than men (Diamond & Savin-Williams, 2009).

The focus on young women as potential victims and young men as predators is particularly salient in the US. The common belief is that young women engage in sex for love and a relationship; whereas, young men want sex for pleasure (Karaian, 2012; Schalet, 2011). Young women are generally considered to be disinclined to have sex except for the relational benefits it offers, a presumption that Fine and McClelland (2006) have coined the "missing discourse of girls' desire." Young people themselves reflect these beliefs. In her interviews with Dutch and American adolescents, Amy Schalet (2011) found that American adolescents were far more likely to talk about this gendered dichotomy. Young men, even those who wanted a romantic relationship, referred to themselves as the exception rather than the norm.

Ambiguity, Ambivalence, and Sexual Relationships

Unwanted sex and sexual coercion continue to be sources of stress for young women across racial groups (Hird & Jackson, 2001). Research indicates that young women may be more likely than men to engage in "inauthentic" or "consensual but unwanted" sexual relationships. Interview studies suggest that young women may engage in sexual intercourse because they do not want to lose their boyfriends or to avoid conflict, rather than because they desire to have sex

(Martin, 1996). The National Survey of Family Growth (2011–2013) reported that 10.7% of young women did not want to have sex the first time they engaged in a sexual encounter and that 51.0% of young women had mixed feelings about their first sexual experience (Centers for Disease & Prevention, 2015). Research suggests that young women who engage in "inauthentic" romantic encounters—that is, people who engage in behaviors (i.e. sex) that fall outside of their description of their ideal relationship (we might consider these to be consensual but unwanted)—are more likely to indicate they are depressed, have suicidal ideation, and have a higher rate of suicide attempts (Soller, 2015).

Jennifer Hirsch and Shamus Khan (2020) describe how men contribute to this problem when they "confuse sexual agency with consent"; that is, they assume women's desire for *some* sexual contact means that they want *any and all* sexual contact that emerges in a sexual encounter. Other research suggests that young men may pressure young women to engage in sexual behaviors through the use of repeated requests (Sanday, 2013), continued arguments, or relational comments such as "you would if you loved me" (DeGue & DiLillo, 2005) to gain sexual access to women.

In this study, I explore how young men and young women define consent and how they operationalize consent in sexual relationships. In particular, I explore how young people's thoughts about consent differ across genders, and I theorize how this difference might complicate attempts to have mutually positive sexual encounters.

Methods

Study Recruitment & Participants

Interviews are an ideal way to access young people's worlds (Lamont & Swidler, 2014). Rather than exploring the behaviors of young people, this study seeks to understand how they think about consent and the social norms and worldviews they carry with them as they attempt to navigate sexual interactions.

The participants in this study came from two recruitment efforts. To investigate how young people learn about and construct their understanding of romantic and sexual relationships and consent, I used a combination of community fliers, social media posts, personal invitations, and snowball sampling to "recent high school graduates" to participate in an interview and a survey about "Social Norms and Stressors in High School" in exchange for $20. Seventeen participants responded. Separately, a study of second-year non-Greek undergraduate students on a college campus were recruited through campus fliers in exchange for $40. A subset of questions in their interview protocol overlapped with questions about sexuality education and consent in high school and were, thus, incorporated into this study. Seven participants were recruited through this study, resulting in a total of 24 participants between the ages of 18 and 21. Fifteen of the participants (62.5%) identified as female and nine (37.5%) identified as male. Eleven participants (45.8%) identified as Asian or Asian American. Eight (33.3%) participants identified as white and four (16.6%) as Black. One participant identified as Latino. Four participants had spent significant parts of their childhood outside of the US (Europe, Thailand, and China); all but two participants attended high school in the US (one participant attended high school in Thailand and the other in China). Nineteen of the participants attended their local

public school, while six participants attended a private school—two attended a Catholic school, one attended a boarding school. In Table 2, I provide descriptive statistics about each of the participant's demographics. The participants were skewed toward wealthy and highly educated. Slightly less than half the participants came from families whose highest-educated parent held, at most, a bachelor's degree. Four participants came from homes in which both parents had professional degrees.

The participants came from a wide range of backgrounds; some had a great deal of agency over their romantic and sexual lives, while others experienced close monitoring by both parents and school staff. Most, though not all, of the participants described themselves as being inexperienced with both dating and sex. All knew people having sex, and all knew of at least one situation at their high school in which a peer had experienced sexual coercion by either a peer or an adult within the school. All the participants were assigned a pseudonym.

The participants from the two studies predominantly came from the same university.. The participants recruited into the High School Norms and Stressors Study were, on average, younger than those recruited into the Campus Social Life Study (see Table 1). No substantial differences were found regarding the tone or message of the stories between the two sets of participants. The most noticeable difference between the two groups was from the older male participants, who noted how college education and experiences had shifted and complicated their understanding of consent compared with what they believed in high school.

Interviews

I conducted one-on-one interviews with all 24 participants between the spring and fall of 2019. The interviews lasted between one and two hours and were semi-structured, allowing for consistent sets of questions and follow-up questions to reference thoughts or feelings that seemed relevant or significant (Willig, 2013). The research questions were initially left broad; for example, how do teens describe their experiences with sexuality education? How do they define consent? What resources do they identify as particularly helpful or harmful in answering their questions about romantic and sexual relationships?

The interviews covered several topics, including descriptions of the participants' hometowns and high schools ("Tell me about your hometown"); major stressors they associated with high school ("What would you say were the two to three most pressing challenges facing students at your high school?"); the form and role of romantic and sexual relationships among high school students ("Can you describe the types of non-platonic relationships that students engaged in at your school?"); how students define consent; and questions about their experiences and feelings about their sexuality education curriculum. The interviews were recorded and transcribed for later analysis.

As a white woman in her 30s working on a college campus with undergraduate students, I found myself somewhat distanced from the high school experience, but also familiar with some of the vernacular and experiences of students around the same age as the participants. I took an ignorant approach to the terms and phrases the participants used to allow them to describe and define them in their own words. I tried also to adopt the language of each participant to

accommodate their style and comfort level. For example, some participants used explicit or direct terms to describe body parts and sexual acts, while others used euphemisms such as "hanging out" to describe sexual encounters. The participants were quick to use laughter to diffuse discomfort but continued to answer questions in a way that felt open and direct despite their apparent nervousness.

Open Coding

I analyzed the transcripts using a multi-step iterative approach, which involved several rounds of reading transcripts, marking passages, and writing memos to understand not just the words the teens were using to define their experience, but how they were saying them (e.g. conversations about consent appeared to be rote from a curriculum; whereas, other descriptions appeared more fluid and personalized). I then began open coding for categories emerging in the data. These codes include "feelings about sexuality education," "family messages," "resources for information," "safety/danger," and "consent".

Focused Coding

During the process of open coding, divergent patterns emerged for the male and female respondents. I, therefore, separated the men's responses under "consent" from the women's and focus coded the men's and women's responses separately. Examples of focused coding for the men's interviews include "common sense" and "yes/no." Examples of focused coding for the women's interviews include "unrealistic," "being ready," and "personal strength." I additionally used clustered graphs to attempt to establish relationships between emerging themes (Miles et

al., 2014). Finally, I attempted to apply the gendered focused codes to the full sample to assess whether any similarities existed across genders.

Findings

In this section, I detail the differences that emerged in the men's and women's descriptions of and the reported processes for establishing sexual consent. Men's and women's understandings and sense of efficacy with consent varied dramatically. Women centralized the "ongoing" and "active" aspects of consent in their definitions. At the same time, they challenged whether maintaining such consent was realistic in sexual encounters. Instead, they pointed to the multitude of ways in which sexual encounters frequently went beyond (a woman's) level of comfort and created a situation in which a woman either "went along" (and, thus, consented) to continue the sexual encounter or stopped the action. Part of the challenge women named in negotiating sexual consent was their own confusion about whether they wanted a sexual experience. Instead, they learned about their sexual boundaries through reflecting on past mistakes and becoming "stronger" and "more secure" about setting sexual boundaries (i.e. refusing sexual encounters). The women did not, generally, describe learning how to express or communicate what they wanted out of a sexual encounter; rather, their focus was on being able to say no when it was not wanted. They also predominantly described themselves as being the ones who were responsible for providing consent in sexual interactions.

Alternatively, the men described the process of obtaining consent as "easy," "natural," and "common sense." For most of the men, consent was as simple as obtaining a verbal "yes," while others acknowledged the importance of getting a yes through body language, too. In line

with the women, men adopted highly gendered scripts about consent in which it was their "job" to obtain consent from women.

The Women's Story

Active, Ongoing, Free from Pressure

Women described consent as nuanced and complicated. Most of the women, such as Elizabeth, incorporated elements of "the ongoing active presence of a yes" into their definitions. Phoebe added:

> *I mean like it needs to be active, ongoing, like both people need to agree, both need, both people need to be coherent. Like, it should be, in words, like, do you want to do this? Yes. And they, they shouldn't feel pressured to do it, but like, you don't get consent from eye contact. [laughter] I think...both parties have to agree, and like, it has to be like, in, like then, and has to be kind of throughout as well if you're like changing what you're doing, stuff like that, and like, if they still wanna keep doing it.*

Phoebe described not only the need for a verbal agreement, but also the absence of pressure. She highlighted also the importance of agreement and communication throughout—"if you're like changing what you're doing"—describing a dynamic and changing interaction that requires acknowledgment of "if they still wanna keep doing it." Ingrid's sexuality education curriculum did not include ongoing consent, and she criticized this approach, stating:

> *If you give consent once that doesn't mean that it carries over forever you know… [Sex ed instructors] framed consent as basically just like ask is it okay to have sex with you and then it's like yes or no. That was mainly like their, how they, how they presented it. It's more complicated than that.*

Interrupting the Flow of Romance

Although the women highlighted and underlined the role of ongoing, active consent in their definitions, they also felt challenged by what this definition would look like in reality. The

need to check with a partner at every moment was described as an "unrealistic expectation" that did not match the women's internal imagining of what a romantic encounter was meant to be. Additionally, the women remarked that ongoing consent was rarely enacted and, instead, took the form of reactive response—choosing to either continue or stop an advance that had already been initiated. Finally, some women described how potential repercussions, including their safety and their future reputation, factored into their decision about whether to say yes or no to a sexual encounter.

The women in the study generally felt that definitions of consent were complicated and unrealistic. In part, their skepticism resulted from a disconnect between what they imagined the flow of a romantic encounter to be and the insertion of ongoing consent. Lindsey was cautiously optimistic about the possibility of active and ongoing consent working in reality:

> *Um I don't know if it's like implementable or not because I haven't run into a situation where I've had to implement that degree of like consenting. Um, but yeah, I would hope that it like gets used more commonly in like sexual situations and stuff.*

Although she had no personal experience in a sexual relationship, Ingrid was already questioning whether her understanding of consent is meaningful in an actual sexual encounter. She also described "implementing that degree of consenting," suggesting that some levels of consent might be easier than others.

Mary added:

> *I mean I definitely think it's like unrealistic…just like expecting people to stop at every second and be like, do you consent? Like that I think that just doesn't happen in real life. So, I think it definitely is more complicated than like yes and no. And I think, again like, you can say yes but not really mean it or like say no but then regret it.*

For Mary, complications emerge from two sources: the first is the likelihood that a couple will "stop at every second" to confirm consent. She added that consent is more complicated than "yes and no," because what is said and what is wanted in the moment can be misaligned, as can feelings in a single moment compared with a broader feeling outside of that moment; a yes can be disingenuous and a no can be regretted.

Going Along

In addition to questions about the reality of ongoing consent as an interruption to the expected flow of a romantic encounter, women asserted that ongoing consent did not account for the typical gender dynamics that emerged in heterosexual sexual encounters, in which men make a move and women react to it with either a yes or a no. Beth, for example, described the following:

> *[Consent needs to be] present and ongoing, ah, voluntary, active. Oh, also active, I think that's something that I have to learn too, like you're allowed to like say what you want. Um, I think sometimes, especially with like guy-girl relationships, it's like the guy has to like push a little bit and you either give in, or you don't. Um, and I feel like I've tried to not do that anymore.*

When Beth underscored the importance of present, ongoing, voluntary, and active consent, she also connected these components as something that she "[has]to learn…like you're allowed to say what you want." While she has the vocabulary to describe and define consent, the internalized knowledge that she does not have to "give in" is something that she "has to learn" and "tries not to do anymore." She also described the typical norm in which the guy "has to…push a little bit and you either give in, or you don't." Rather than problematizing the male's pushing, she normalizes it as something that they "have to" do in "guy-girl relationships," to

which the girl's option is to "give in," and be, thus, "consenting" through passivity, or to stop the interaction.

Gabby similarly illustrated a common scenario in which women are placed in the position of responding to men's actions rather than mutually consenting beforehand. She stated that consent typically translates as allowing an interaction to continue without comment.

> *I think it's not really realistic to say that you're like going to be having sex with someone and stop and be like, "Do you agree? Like are we consenting?" It's more so like if you're making out with someone and then they start to go further and you don't stop them, that's kind of the consent…. I know obviously like it's also common for a guy to go too far and the girl just kind of take it, um, or the other way around honestly…. But yeah, I would say like if they're showing signs and they're like doing things or like putting their hands places then, like, and you're not pushing them away, that's kind of the consent.*

When asked to elaborate, she explained:

> *Um, I think it's two things. One, at least, well it depends on, like, that angle. Like, I know for guys some of it is like they don't want to be an asshole and reject the girl. And usually the guy is more into like doing more sexually oriented stuff than the girls would be, so they don't really care anyways.…Um, for the girl, I would say like if, if you're a girl and you don't want to do something or you feel like you just to go along with it, it's just because you don't want, sometimes guys retaliate in a way. You know, like you don't want to be in a situation where you say no and then a guy like, obviously it'd have to be pretty extreme for a guy to send nudes to everyone, but you don't want a guy to be like, "Oh she's like a prude," or, "She's like a bitch and like won't do anything." And then like a guy you might actually want to with hears that and is like, "Oh, maybe I shouldn't approach her."*

Consent, in Gabby's perspective, carries multiple challenges. Ongoing consent not only seems unrealistic because of the level of interruption and the gendered norms, but consent also needs to be calculated between desire and interest in a single sexual encounter and the potential social consequences a woman might face later. Gabby particularly highlighted the ramifications of saying no to a sexual encounter—the potential for retaliation through name-calling or some form

of public revenge. She also pointed out how saying no to a sexual encounter becomes interpreted not as a single moment of consent or a personal agentic choice but as a personality trait—the rejection of one potential partner marks her as a "prude" and, thus, impairs her opportunity to connect with desired partners in the future. Men, she believed, are also placed in positions in which they go further sexually than they had planned to, but she did not problematize this as an issue of consent, instead asserting that "they don't really care anyways."

Overall, women maintained the definition of consent as an ongoing agreement of mutual desire but experienced it as a series of decisions that occur outside of an ongoing conversation. Whether the result of a retroactive response to progressing intimacy that occurs without discussion or as a series of calculations on future repercussions to their feelings or reputations, consent is a complex and multi-faceted issue that largely exists outside of a conversation about what is wanted in a single sexual interaction.

Learning from Experience & Mistakes

Agency, desire, and communication seemed illusive for most of the women in the sample. Elizabeth, who otherwise experienced a comprehensive and active sexuality education program, said her one lingering question was, "How do you know if you're ready for a romantic relationship/sexual relationship?" Mary questioned whether it was ever possible to know "when you're ready" for a sexual encounter, and stated that confusion and insecurity are inherent parts of the teen sexual experience:

> *I definitely think that there's always like something that plagues teenagers, is like when am I ready to do certain things? Like do I want to? Do I have to? Do I feel like I have to? That's like a theme, I think… [how do people navigate that?] Um, I think like sadly, more often than not, people sort of go further*

> *than they were ready to go, I think. Not that it's always bad. I mean not that it's always like… Again, as long as you feel, I think as long as you feel like safe and like supported by the person that you're with, it's okay to like be nervous or not sure if your, you know what I mean? Like I think in culture there's this thing like you should do it when you're ready, you know what I mean. But what does that mean? Who knows when you're ready for something, you know what I mean…? But I don't think teenagers know what that means at all. Like no one has a moment where it's like, I'm ready, you know what I mean…. So, I think that people kind of navigate those situations by either doing it, or not doing it and then assessing afterwards.*

Mary's definitive statement that "no one has a moment where it's like 'I'm ready'," is followed by what many described as the only way to learn about sexual boundaries and consent: "people kind of navigate those situations by either doing it, or not doing it, and then assessing afterwards."

Describing the advice she would give to a high school student about sexual relationships and consent, Naomi stated:

> *But like the real advice that I would give is like, um, like, know you're going to make mistakes and know you're going to meet people who are, you know, you think are one thing and they turn out to be the other. And to just, ah, to just know when to ask for help and, and turn to somebody if you're not sure that what is, is going on is, is right. To ask for help, and to ask for guidance, and to ask people. Um, sort of ed...to just educate yourself because it's your life, and it's like, it's like your body and your, your journey. So, it, and unfortunately it sort of is your...not your responsibility but like, if you're not gonna educate yourself, nobody else is gonna do. And, um, yeah. So.*

Beth echoed this sentiment when asked to describe how she is learning to say what she wants:

> *I think a lot of it's observation. I think a lot of it's making mistakes. Like every time I learned to make a boundary it was because I had not set one and something went wrong, but that's also just me. I feel like I'm the kind of person that just says yes to a lot of stuff, and then I'm like, oh shit that was dumb. Like, so I mean, some people have great boundaries beforehand. I just didn't (laughs).*

Carol described a similar situation:

> *I think a big part of [learning about consent] has been conversations with my friends [about] things that have happened to them or things that we've experienced and sort of how did you deal with it or what made that, what made you uncomfortable about that? And sort of what would you do if this happened? And what does that look like for you and what are your values?*

She added:

> *You have to be really secure [to not give into pressure] and you have to realize that not doing something doesn't make you any less of somebody. And if you have a reason that you really want to, if you have a value you want to uphold through, um, the like action of you know not doing something. You need to really know that you need to be really secure in that. You need to really, I think, just know your reason for not doing it and know your reason for walking away and be really strong in that because it's a lot. It's very easy to get swayed and then be on the other end of that and say, well I don't really enjoy the fact that I did that, or I didn't. I didn't want to do it, but you know, now that I've done it type thing.*

Carol and Beth not only tied their understanding of their sexual desires and sexual consent to their experiences and mistakes, but also to their personal traits. For Beth, her challenge is that "she is the kind of person that just says yes to a lot of stuff" compared with others with "great boundaries"; whereas, Carol was adamant that "you have to be really secure [to not give into pressure]." Lindsey similarly described herself as someone who "sometimes has a problem saying no to people asking for things":

> *I would have to basically stand up and say look, I don't feel comfortable doing this, or if someone is like trying to get you to do something, just say like no.*

In addition to women's assessment of the need for personal strength and awareness of values to negotiate consent, it is important to note that what women are actually describing is the capacity to say no to an unwanted interaction. They are not imagining or considering the possibility of knowing what they do want sexually or how to ask for it.

Chelsea is the exception to this pattern. She stood out among the women as having a more active and positive outlook on sexual experiences. She attributed her confidence to several dynamics, including her training on a sports team and communicating with teammates, as well as her "huge mouth" and her own innate "knowing":

> *I think communication is super important. And um, I think as someone who's never really like held back what I'm going to say. Like all my friends and pretty much everyone I know will tell you like I have a huge mouth. Like I will like never back down from whatever it is. I feel like I have to say, um, you know, I'm freely upfront to people. And like I don't like hold back, which, honestly, I think has like scared away like a lot of guys I have ever hooked up with. And they are just like, oh my god, like what? And like I'm not going to like beat around the bush and like let you just assume things. Like I'm going to tell you, like what it is I want, what it is that I'm comfortable with. Like, whatever. So, I think, for me, it's like something I always knew.*

Chelsea is the only woman in this study who mentioned specifically asking for what she wants sexually, in addition to what she does not want. She noted also that she has "scared away like a lot of guys" through her direct approach. This comment could allude to her own insecurity about her directness or could refer to it being odd or unusual for men to encounter a woman who is direct in asking for what she wants. This comment could allude also to the potential consequences women face when they do speak directly about their sexual desires.

The Men's Story

Women described consent as dynamic and unrealistic, but the men largely felt that consent was straightforward and commonsense. The definitions men provided for consent were technical, straightforward, and built on an expectation of a clear "yes," whether communicated verbally or non-verbally. To establish consent in a sexual interaction was framed as something of

a contractual and contextual negotiation in which clear terms and expectations were set out and followed.

Consent as "Common Sense"

Men described their understanding of consent in high school to be instinctual, obvious, and simple. Although their definitions varied from being solely based on verbal consent, to a combination of verbal and non-verbal communication, to a more generalized "treating people right," most expressed a high level of certainty in their understanding of and ability to navigate consent. Charles described consent as something that he "never really thought about," it was "just something I kind of knew in the back of my head, like, oh, people have to agree to what they're doing." Devon, who proclaimed several times that, "I was taught everything there was to know," explained, "Consent is quite literally… if someone is willing to have sex with you or not. If they are not, then you are not giving them sex…. Like are they saying yes? Are they saying no? Like I'd be asking for a specific answer." Similarly, Eric told me, "on a simple level, one person asks, and another person clearly says yes. Um, there's really not much more to it than that in my mind." Jesse said, "consent is verbal and non-verbal… it could be as simple as a 'no,' but it can be an 'I don't know,' it could be body language." Jesse described the prospect of obtaining an "ongoing enthusiastic yes" as "unrealistic" but continued to describe consent as something that is easy, saying, "… it comes naturally, it's all natural." He added, "I mean, if you're a human you could probably read [body language]." Jason stated that what he knew about consent he learned from "being raised right… and to treat people how you want to be treated and then that kind of translated over to relationships."

Scott was the only man who described consent as something more than an instinctual or natural "yes or no." He also had a drastically different sexuality education experience from the other men, having taken a comprehensive sexuality education course in his freshman year of high school, which included workshops, videos, and class discussions about consent. He was also raised in an "extremely pro-contraception" family, with one of his parents working in the contraception industry. Scott reported:

> *A lot of our conversations [in my class] were dealing with the gray area of consent and realizing that it is not a black and white thing. And the reason it causes a lot of problems is because there's like, people are unclear about its nuance. Um, because it does manifest itself in a nuanced way.*

Scott described how consent "manifests" itself in a nuanced way in sexual interactions and that a lack of understanding of this nuance is what "causes a lot of problems." In many ways, his considerations align with how the women described consent as something that requires ongoing thought and negotiation.

The Problem with… Other Men

Although Scott attributed issues around consent to a lack of awareness of nuance, other men in the study attributed issues around consent to other men. They felt that the common sense and straightforward dynamics of consent were easy to follow, but also described witnessing peers who did not treat consent with the same care or consideration. Will described the following:

> *I would say [consent] is pretty common sensical to me, but I don't know whether it is common sensical for others in my high school…. I can always hear conversations from some other men [about] their sexual experiences. They say that a lot and expressly in a very obscene way. And even I feel uncomfortable. I feel like, and after hearing those things, I feel like those people are treating sex as something that is very haphazard or something that is disposable.*

Jesse commented that, “boys, um, hear it all the time, ‘No means no’ blah blah blah. Um, but they don’t really know how to stop, or they don’t know what the other person wants.” Greg stated, “if they’re adamantly not sober, then even if we agreed upon something earlier, I know I can’t do anything. And I think, unfortunately, that’s not what most people think, which is a whole other issue in and of itself.”

For the interviewees in college, they noted that their understandings of consent became more complicated after attending the requisite seminar on sexual consent at orientation. Charles noted that, “coming [to college] it was kind of like showcasing that um, maybe sometimes it gets a little bit blurry if one person’s like say drunk or something and that’s not something I had really considered before.” Greg added, “there’s much more of an influence of alcohol and other substances in college. Um, and so you see more people who are not as able to give consent.”

“Terms of Consent”

Men in the sample predominantly used technical and contractual language to describe consent, suggesting that their interpretation of consent in reality aligned with how they defined and thought of consent as a definition. Jesse stated, “if somebody says ‘stop’ in the middle of what you’re doing, then it’s not consent anymore. You’re going to have to stop”. The use of the phrases “have to stop” and “can’t do anything” highlights the imperative these men feel to refrain from engaging in behavior that is unwanted by their partners and, at the same time, continues to indicate a clear line in which sexual activity is “okay” or “not okay.” Charles incorporated a different type of contractual language into his description of consent, stating that, “what you’re consenting to is like exactly what you’re consenting to, it’s not just like you can

bring up something else." This statement suggests that a sexual encounter is static and confined rather than fluid and dynamic. Again, the use of contractual language suggests a straightforward agreement rather than a dynamic or nuanced encounter.

Additionally, men's descriptions suggest that the most complicated elements of consent may occur prior to engagement in sexual activity; whereas, women detailed challenges in the midst of or even in reaction to sexual advances.

Outlining his considerations for consent in a college environment with alcohol, for example, Greg described the following:

> *[Now in college], you may not be able to agree to terms of consent like before going out or something, which I think sometimes in high school, we were like "Oh, like I wanna like kiss this person and they wanna kiss me." We can agree upon, but now it's like you meet somebody and they're in a drunk state of mind, or… they're just in like an intoxicated state of mind and you can't give consent. But you don't know that they're not sober because you've never met them. And just like, it's just adds many more variables.…My philosophy is, somebody, if I had agreed upon, not agreed, but like talked about something with somebody before going out and they are in a different condition than that of which we had agreed upon I guess, like if I had talked with somebody about doing something tonight and then we go out and they drink a lot, and they're adamantly not sober, then even if we agreed upon something earlier, I know I can't do anything.*

Greg framed consent in contractual language and the ability to "agree to terms." He described his perception that determining terms for consent "prior to going out" was easier in high school due to the lack of alcohol. He mentioned the "variables" that factor into his decision-making, describing something of a decision-tree map for deciding about consent. If a potential sexual partner becomes intoxicated after they made plans for sexual engagement, he knows "he can't do anything." The transactional and simplistic way men described consent does not appear to be the result of a lack of care for their partners. Greg, for example, who described the "terms

of consent," connects consent and sex to expressions of affection, noting that, in the absence of a sexual encounter, "there are so many other ways to show affection. Um, consensual affection while somebody is drunk. Whether that be hanging out, taking care of them, making sure they get back to their dorm safely. Like the little things. Um, still have the same affection [if] it's not physical." For Will and Scott, consent is more than just technicalities and rules; it is also about expressions of responsibility and trust. Will, who sexually educated himself through reading books, attributed many of his attitudes about sex to his Asian background.

> *My own belief is that sex is a responsibility… if a person is waiting to have a sexual relationship with you and, uh, in a formal way, like you guys have a, you love each other, that means he's putting the trust in you and you need to be responsible for his or her trust. And you need to, and from that, there are so many times you, you are responsible for and you need to be ready for that instead of treating sex as something to relieve your stress or pressure.*

Will described the trust given in a sexual relationship and the feeling of responsibility to care for and protect that trust. Scott similarly described the need for "mutual trust" and how it is related to a "good sexual, romantic relationship."

College and Close Contacts

Two men, Scott and Shawn, stood out as having distinct stories from the rest. Both these men had close friends who had been affected by a sexual assault, and both had become actively involved in sexual assault prevention efforts in college. Scott had received robust, active sexuality education training in school that involved discussions, roleplays, and workshops about healthy relationships and communication. Scott was raised by a parent who worked in the contraception industry. He described consent as something that requires understanding and trust, and he stated that clarity is critical in sexual interactions:

> *Like this was a very intense thing for us in high school, and I think our parents, my, my parents certainly stressed like that you need to feel comfortable with this person and that, that feeling safe um, and feeling like mutual trust, these things are very important for having a good sexual, romantic relationship. In that vein, along with that, when this trust is ever like unclear or there is not this mutual understanding, something is wrong. Like, like you need to stop and, and you should not proceed.*

Scott is distinct from the other men in the sample in that he is aware that trust might become "unclear" during a sexual encounter and that it is the lack of mutual understanding and clarity, rather than the lack of a yes, that should drive a sexual encounter to stop.

Shawn also described sexual encounters as more nuanced than a simple yes or no. He attributed his understanding to experiences he had in college, which he had attended for two years.

> *I guess one thing that I don't think is talked about enough is like continual consent, so like not just like consent like, "Hey, you want to do this?" and then like "That's it," but you have to like concede to have consent throughout the act and at any point you can concede consent and also consent isn't like you can't give consent if you're drunk. I think that's pretty clearly emphasized but also if you don't say anything that doesn't mean its consent. I think that's one thing. Also, within relationships what that looks like, like what consent looks like. I don't think it's really talked about much. If you're in a relationship you can't be sexually assaulted, I think that's a stigma. I don't know. I guess another thing from a man's standpoint, many people I know, they view women as a prize to be won and something to be used, and so changing that perspective and viewpoint of feeling women in that way should change.*

Shawn spoke of several friends he knew within the college community who had been assaulted. He pointed out that consent "throughout the act" is an important element of a sexual encounter and highlighted that not saying anything does not necessarily mean consent has been given.

Scott and Shawn are interesting cases and worth pursuing with future research. How did Scott's rigorous training impact how he thinks about consent, and how did their proximity to the sexual assaults of friends impact their awareness of consent?

Discussion

This study explores how young people think about consent in romantic relationships and how these perceptions might differ across gender. Interviews with 24 recent high school graduates found that men largely felt that consent was straightforward and commonsense; whereas, the women defined consent as more dynamic, active, and ongoing. In contrast to the assured confidence the men described regarding knowing what consent is and how to navigate it, the women stated that the definitions they had been taught about consent were "unrealistic," describing the challenge of repeatedly obtaining consent. Instead, the women described a "typical" scenario in which women were pushed by men into a decision in which they either needed to "go along" with an experience or stop it. The women questioned the possibility of ever feeling "ready" for a sexual interaction, and instead suggested that the way to learn about boundaries and desires is through making mistakes in sexual encounters. Even the women who indicated they did have a sense of what they did and did not want described the challenges they faced in holding to their desires. In these instances, women's personal traits—their strength, their resolve, and their commitment to their values—become key to preventing unwanted encounters.

Dynamic vs Static Understandings of Consent

Although the young women defined consent as something dynamic and ongoing, the men defined consent as something that was a clear-cut "yes or no." In their book *Sexual Citizens*,

Hirsch and Khan (2020) describe the ways in which describe how sexual assault and sex are complicated by the fact that one person can walk away thinking an interaction was mutual and pleasurable while the other feels violated. That the men and the women in the sample placed the significance of sexual consent at different moments within a sexual interaction—men largely at the beginning of a sexual encounter or at the first indication that a woman's capacity to give consent is impaired and women throughout—may help explain some of the discrepancies in the feelings associated with a sexual encounter.

Both the men's and women's conversations and assessments of consent in sexual interactions lack an expectation of a detailed or elongated conversation and communication about sex. Although achieving consent was important for all participants within this study, neither the men nor the women (except for Scott) described the importance of a conversation regarding what both people want a sexual interaction to be and what they would or would not enjoy. For men, a yes or no is the indicator of consent to sexual interactions. For young women, the lack of awareness about their own desires, even during a sexual encounter, made sexual conversations challenging. In other research, this level of discomfort in both communicating about and identifying sexual wants is not uncommon for young women (Khan et al., 2019; Martin, 1996; Peterson et al., 2011). For men, this lack of conversation stems from the "common sense" nature of consent; whereas, for the women, the lack of conversation concerns the "unrealistic" expectation that such a conversation will be ongoing and the expectation that sexual advances would be handled retroactively.

The common factor in both the men's and the women's stories is the refrain that males are the ones wanting and asking for sex and responding to women's "yes" or "no." Sexual conversations are not set up to be conversations in which both parties describe what they want. The impetus is on women. Research has discussed this issue previously—that women are the gatekeepers (Diamond & Savin-Williams, 2009; Fine & McClelland, 2006; Meston & Buss, 2007; Schalet, 2011), but the gatekeeper combined with the responsibility on women to say yes or no, rather than for parties to learn how to describe their desires, means that the pressure is on women to know what they want, and that education is lacking. Women do not know what they want and can find themselves having sex that they do not want and making decisions by not making decisions. Women feel responsible for deciding, and men expect the answer to come from women (unless alcohol is involved).

Women in this study reported doing significant emotion work both during and after a sexual experience to assess how they feel about the interaction they had and how to "better" themselves for future interactions. This work seems to be largely the result of their own lack of clarity and understanding about what they want in the moment. This level of emotion work is not apparent among the men in the sample. Research by Schalet (2011) points to the possibility that this absence is the result of a lack of social acceptability for men engaging in this type of emotion work regarding sex. Martin (1996) indicates that this situation may be because males have more agency regarding their sexual desires. It is unclear within this present sample what drove the men's lack of emotion work, although the stories from the young women suggest that there are men who engage in sexual contact they do not want, but either do not care or ignore it,

so as not to appear “a jerk.” From most of the men, no emotion work is evident at all. Scott and Shawn are exceptions to this observation. Future research could explore how educational opportunities such as Scott experienced might alter how men think about consent and what effect that has on bridging understandings of consent. Additionally, future research could interview young men and women prior to them attending college and, again, after college orientation to explore how these orientation programs impact understandings of consent, such as how they appeared to Shawn.

Conclusion

In this chapter, I used interview data from 24 young people to explore how young people conceptualize consent and how these conceptualizations might differ by gender. This study points to a significant gap in expectations between males and females. Although consent was universally understood to be an important element of a sexual encounter, what consent looked like and how it should be achieved differed considerably between males and females. These differences point to a concerning gap that could complicate sexual interactions, leaving men thinking consent has been obtained while young women continue to feel unsure about their sexual interactions. Moreover, this study points to how women’s lack of sexual agency confuses young women as they attempt to navigate sexual interactions, causing them to learn about their sexual wants through trial and error.

Chapter 4: First Exposure to Sexual Assault Across the Life-Course and Implications for Long-Term Health: An Intersectional Approach

The #MeToo movement has made socially visible a phenomenon that has been documented in the sexual assault literature for decades: women are at high risk of sexual assault during their lifetime, largely by males with whom they work, live, and go to school (Koss et al., 1987). The lifetime rates of sexual violence against women are well documented: between 20% and 25% of women have reported being sexually assaulted (Khan et al., 2019; Muehlenhard et al., 2017). Decades of research on the impacts of sexual force from the 1980s and 1990s document the rates of assault among adult women (Campbell & Wasco, 2005), the likelihood of re-victimization for women who experience childhood sexual abuse (Finkelhor et al., 2015; Swartout et al., 2011), and the correlation of victimization and increased depression (Campbell & Wasco, 2005; Yuan et al., 2006) and other physical health problems (Golding, 1999). Despite the robust literature, several domains remain unexplored. Developmentally, we know very little about the differences between individuals who are first assaulted in childhood and those first assaulted in adolescence and how their outcomes might vary.

Developmentally, we know that children have sensitive periods in which they might be more impacted by maltreatment and abuse (Kaplow & Widom, 2007; Shonkoff et al., 2012). Research into these "sensitive periods" has largely focused on childhood adversity, particularly among children aged 0 to 3 years old. However, new research in neuroscience has helped to raise awareness about adolescence as a secondary period in which young people's brains are particularly malleable to social messages and a need for belonging (Dahl, 2004), and that stress during this life stage may be associated with compromised mental health (Eiland & Romeo,

2013). Knowing *when* people are at risk of being sexually assaulted and the potential impacts of that assault are important as pathways for understanding how and when young people might be particularly vulnerable to assault. Moreover, understanding the long-term health trajectories of individuals exposed to assault at different ages can help us glean developmental moments when individuals might be more susceptible to the potential long-term health consequences associated with sexual assault. Finally, understanding patterns of assault across early stages of life can offer important insights about when we need to introduce robust interventions in both prevention and post-assault support structures (Wachs et al., 2014).

Sexual assault can be understood as "non-consensual sexualized touching (e.g. fondling private parts), attempted penetration (e.g. oral, anal, or vaginal sex) or completed penetration" (Khan et al., 2019, p. 11:3). "Non-consensual" sexual acts take a wide range of forms, from violent physical attacks to non-physical coercion through threats, repeated and ongoing pressure, and the use of substances such as alcohol and drugs. Much of the literature on sexual assault has combined experiences of physical (PFSF) and non-physical assault (NPSF) in considerations of both the rates and health consequences of assault (Plichta & Falik, 2001; Swartout et al., 2011). However, the two forms of assault may differ regarding the way trauma manifests. For example, females may be more likely to seek treatment and support for PFSF than for NPSF. Women who are non-physically assaulted may face greater levels of victim-blaming from formal institutions, which has the potential to turn into higher levels of self-blame.

In considering rates and risk of sexual assault from a developmental lens, we need to consider how other salient social categories (gender, race, sexual identity, and class) might

impact the patterns and outcomes of individuals who are assaulted. As a historically gendered construct, male victims of sexual assault have been paid relatively little attention (Khan et al., 2019). Popular conceptions still hold males as being incapable of being assaulted, creating potential barriers to support-seeking for males who do experience assault (Hlavka, 2016). Thus, little is known about the perpetration of assault against males and the long-term consequences to their health, though research points to negative psychological and physical outcomes (Peterson et al., 2011).

Gender and race scholars have documented how sexual violence can be weaponized as a form of racial violence; sexual assault was an integral part of the colonization of Native Americans and of slavery, and the remnants of this racialized dominance continue to plague women of color (Armstrong et al., 2018). The sexual assault literature documenting the rates, patterns, and outcomes of sexual assault against women have, however, focused on differences between white and non-white women, or Hispanic and non-Hispanic women, and have been slow to distinguish the experiences of women from across multiple racial backgrounds (Campbell & Wasco, 2005). Even less is known about sexual violence against men of color, although some research has documented particularly high rates of sexual assault against black males and Native American males (Wahab & Olson, 2004).

Correlations between sexual assault and poor mental health, and reduced reports of general health, are well documented (see Khan et al., 2019). Some smaller-scale studies have additionally focused on the effect of assault on women's reports of physical pain, headaches, and gynecological functioning (Golding, 1999). Although the strength and consistency of the

associations between assault and women's health are well established, cross-sectional studies have, regarding the temporality of the relationship between assault in earlier life and health in later life, been limited by the inability to assess or document health prior to an assault as a control for health post-assault (Golding, 1999). However, the new wave of physiological data in large-scale survey studies has opened up the capacity to study not only self-reports of health, but also physiological functioning. Allostatic load, for example, is a measure that allows for a snapshot understanding of the level of "wear and tear" on individuals' physiological systems and provides insights into the level of chronic and ongoing stress.

This chapter uses data from the Longitudinal Study of Adolescent to Adult Health, a nationally representative dataset with over 15,000 participants, to explore patterns of age at first sexual assault. This paper contributes to the literature in four main ways: First, it uses nationally representative data to explore patterns of first assault across a range of different demographics (e.g. gender, race, class, and sexual identity). Second, this paper uses longitudinal data to explore the long-term mental and physical health consequences of sexual assault using self-reported and biological measures of "wear and tear" on the body's stress systems. Third, this paper explores the unique impressions that physical and non-physical sexual force leave on the health of individuals who are assaulted. Finally, this paper explores the importance of distinct developmental stages as predictors of how assault impacts health outcomes.

Background

Physical & Non-Physical Sexual Assault

Definitions of sexual assault and the behaviors associated with it vary considerably in attempts to capture the broad range of experiences that individuals might face. Much of the literature on sexual assault has combined experiences of PFSF and NPSF in its considerations of both the rates and health consequences of assault. Plichta and Falik (2001) evaluated whether participants had been the "victim of a sexual assault" or the "victim of a rape." Swartout and Swartout (2011) asked women whether they had "engaged in sexual intercourse when [they] didn't want to because a man threatened or used some degree of physical force [twisting your arm, holding you down, etc.] to make you?" Additionally, as with the previous question, researchers have framed questions in highly gendered ways that eliminate the possibility of men's assault or sexual assault perpetrated by a female. For example, interviews from the first wave of Add Health data in 1996 asked females for experiences with experiences of victimization from sexual force and males for experiences with perpetration of sexual force.

Researchers have found discrepancies in reporting based on how a question about sexual assault is framed. Asking someone to report whether they have been raped or sexually assaulted results in different reporting from asking someone to report whether they experienced penetrative sex without their consent. Labeling an experience as rape or sexual assault may have negative associations for a respondent and an attached stigma of victimization or lack of control that prevents a respondent from answering in the affirmative (Hlavka, 2016; Khan et al., 2018).

First Assault and Developmental Contexts

Individuals may be first exposed to sexual violence at any age. Some research has focused on victimization among specific populations, such as children (Cammack & Hogue, 2017; Lindert et al., 2014) and college women (Cleere & Lynn, 2013; Khan et al., 2018; Muehlenhard et al., 2017). Others have tried to describe assaults on "adult women," including anyone who was assaulted after the age of 14 (Campbell & Wasco, 2005; Koss et al., 1987). Both these approaches fail to consider the vastly different cognitive and developmental periods of individuals as they progress from childhood to adolescence.

In her sociological piece "Where are the Children?" Nancy Whittier (2015, p. 96) describes how child sexual abuse needs to be considered "as both part of and distinct from other forms of sexual violence." Sexual force at any age is driven by domination and power. From this perspective, consideration needs to be given to age as a dimension of power. Compared with adults, children have significantly fewer recourses for gaining support and less authority and believability within formal institutions. We know less about the experiences of young people as they transition from childhood into adolescence and adulthood, although David Finkelhor, Shattuck, Turner, and Hamby (2014) assessed the lifetime prevalence of assault among adolescents using national telephone surveys with 15, 16 and 17-year-olds and noted the considerable increase in affirmative responses in females between the ages of 15 and 17.

Developmentally, we know that there are sensitive periods in which young people are more vulnerable to the impacts of traumatic events (Kaplow & Widom, 2007; Shonkoff et al., 2012). Most of the literature has focused on early childhood, but research on risk and resilience

documents how trauma at any developmental stage can cause maladaptive functioning and have negative "*cascading*" consequences that undermine development in future stages if not addressed (Masten & Cicchetti, 2010). Conversely, targeted interventions that support the repair of these traumas can cause cascading positive outcomes.

Psychosocially, developmental stages are critically important for understanding how young people make sense of and engage with their social environments. The formative years of childhood, during which children make sense of their world, differ considerably from adolescence, when an individual develops an adult body and attempts to develop a sense identity, agency, and social belonging with their peers, for example.

Even within developmental stages, meaning-making and social understandings vary. Research on teenagers' perceptions of sex, for example, suggests that early teens (13-15) tend to conceptualize sex as something that is funny or to be joked about; whereas, older teens (16-18) regard sex as an avenue for intimate connection with a partner. Rape and sexual assault are not sex and should not be considered such; however, as Hirsch and Khan (2020) describe, it is simultaneously important to "study assault in concert with sex." We might infer here that the different mindsets about sexual activity coupled with the prevalence of sexual assault within romantic contexts might mean that early and late adolescents might interpret sexual assault differently.

Consequently, we might expect differences in the trajectories and consequences of people because of the age of first assault. Sexual assault at these different stages may trigger or demand different forms of emotional responses and lead to different patterns of emotional and physical

outcomes. Research on children, for example, documents that children who are sexually abused have higher risks of being assaulted again in later life (Finkelhor et al., 2015; Humphrey & White, 2000). Less is known about individuals who are first assaulted in adolescence. Understanding the patterns of first sexual assault across developmental stages is important both for creating opportunities for prevention that match young people's developmental imperatives, and for creating targeted treatment options that help repair specific interpretations or impacts of assault at different developmental stages.

Considering Social Identities in Developmental Models

Culturally, US discourse centers on the victimization of women by men. Furthermore, cis-gendered females have been consistently proven to have the highest rates of sexual assault (Armstrong et al., 2018; Campbell & Wasco, 2005; Finkelhor et al., 2014; Khan et al., 2019). In evaluating the developmental importance of sexual assault on long-term outcomes, social categories such as race, gender, and sexual identity must be considered. Research on the development of youth from intersectional perspectives reveals the importance of considering how "social group memberships differentially combine to affect the experiences of … youth across developmental domains" (Ghavami et al., 2016). Sociologists have urged a literature review that considers sexual violence as both a "cause and a consequence" of inequality (Armstrong et al., 2018). Despite the repeated imperative by multiple scholars to place sexual assault into other social contexts, little has been done in the assault/health literatures to advance this work (Khan et al., 2019; Whittier, 2015). As an established act of power and dominance, we

might expect that sexual assault would differentially occur across gender, race, sexual identity, and class.

Gender

Sexual violence has predominantly been constructed as a gendered expression of power and domination: an act of violence perpetrated by a man against a woman. The vast majority of research on sexual violence, outside of child abuse, has focused on sexual assault in the context of violence against women. Furthermore, given the high rates of assault of women by men, this approach has been largely warranted. Significant bodies of research have described how females are socialized to adhere to a difficult balance between being pure and being sexually appealing (Mollborn, 2017; Schalet, 2011), becoming objectified in the public eye, and being at risk of sexual assault by men near them, normalizing violence at their expense (Hlavka, 2014; Thomas, 2017).

Research about sexual assault against men indicates a small but consistent percentage of the male population who are victims of sexual violence: roughly 3% are victims of sexual assault and 1.5% are victims of rape (David Finkelhor et al., 2014). Documentation of male assaults has been largely limited due to measures that preclude males from being victims of assault. Research into male victims has included random sampling through national calls (e.g. Finkelhor et al., 2014), but most studies rely on convenience samples (predominantly college students) or special populations, such as sexual assault in prison or males treated in clinical settings (Peterson et al., 2011). A study using the Add Health data examined rates of sexual abuse by non-parents prior to

the age of 18 and found that males reported an earlier age of physical sexual force than females (Cammack & Hogue, 2017).

Gender theorists suggest that men who are sexually assaulted are subject to a "status violation" (Hlavka, 2016). In other words, the privilege afforded to them as males and our cultural understandings of males as being powerful (and often as the "perpetrators") places males who are assaulted in a position in which they must navigate the competing scripts of their "male" identity with their "victim" identity. Research suggests that adult males may be less likely to depict early sexual experiences as non-consensual, but that for those who are assaulted, they may be less knowledgeable about where to find resources for post-assault support

Racial Identity

Race/ethnicity is not just an individual identity, it is also a social identity. Racism, for example, may be both a driver of sexual assault against people of color and may also affect how non-white victims/survivors of assault are treated in post-assault treatment systems (Campbell et al., 2009).

Individuals with non-white ethnic/racial identities continue to be relatively understudied populations regarding sexual violence (Khan, 2019). Research into differences in rates and patterns of sexual assault have compared "white vs non-white" women and "Hispanic vs Non-Hispanic" women but have largely failed to consider the possibility that differences exist between different non-white communities (Campbell et al., 2009). However, a few studies do point to differences in potential for victimization being associated with racial identity.

Regarding sexual abuse in childhood, research has found that Asian children have significantly lower rates of assault compared with other race/ethnicities. Researchers have theorized that this difference potentially results from underreporting in these communities, but also suggest that these reduced rates may reflect cultural values that emphasize the importance of family responsibility, community ties, and highlight spirituality and self-control as important traits of masculinity (Finkelhor et al., 2013; Zhai & Gao, 2009).

The National Violence Against Women Survey found that Native American women and men experience higher rates of both IPV and sexual assault (being made to have sex/oral sex/anal sex/penetration through the use of force or threat or harm) than men and women of other ethnic backgrounds (Tjaden & Thoennes, 2000; Wahab & Olson, 2004).

Men of color, particularly Black and Hispanic men, have been socially vilified has having not only sexual agency, but sexual aggression, but their sexual victimization has gone largely unexplored (Whittier, 2015).

In addition to differences in patterns of assault, research suggests that the potential outcomes for racial/ethnic minorities post-assault may vary considering that non-white women are more likely to face victim-blaming in treatment settings. Additionally, documented police brutality and the fear of deportation may create additional stressors and burdens for people of color when thinking about post-assault options for reporting and seeking treatment (Freedman, 2013).

Sexual Identity

The highly gendered manner in which sexual assault has been constructed (that is, male perpetrators assaulting female victims) means that sexual assault within the LGBTQ community has been slow to be revealed. As described above, men are still largely considered immune to sexual assault (setting aside the context of prison). Moreover, popular culture largely ignores the possibility of women as perpetrators of sexual force. However, emerging research into the LGBTQ community suggests that both males and females who identify as bisexual or homosexual have higher rates of sexual assault than their heterosexual peers (Khan et al., 2019; Peterson et al., 2011). Previous research using the Add Health dataset suggests that individuals who do not identify as 100% heterosexual have higher rates of both PFSF and NPSF, and individuals who identified as bisexual were at greater risk of poly-victimization—that is, multiple types of abuse (Schwab-Reese et al., 2018). The first age of assault and health outcomes were not considered.

Sexual Assault and Health

Sexual assault is categorized as a severe trauma for women, with the potential to cause multiple, long-term negative outcomes, including depression (Lindert et al., 2014), increased substance abuse (Kilpatrick et al., 1997), and economic consequences (Campbell et al., 2009). Moreover, it is not necessarily the single act of violation alone that can create trauma, but the cumulation of additional trauma as individuals decide about disclosure and reporting.

These outcomes have been theorized as resulting not only from the assault itself, but from the stress and anxiety surrounding post-assault experiences with formal institutions and informal

support systems. Research has documented that the social norms of American society tend to blame sexual assault victims for their own victimization, leading to two potential roads for additional trauma post-assault. The first is hostile environments that sexual assault victims come into contact with (e.g. the medical, legal, and mental health systems), which perpetuate scripts of victim-blaming through questions about the victims actions, style of dress, alcohol consumption (Campbell et al., 2009; Campbell & Wasco, 2005; Filipas & Ullman, 2006). The second is the victim's own self-blame, which may result both from his/her own pre-assault beliefs and repeated contact with a system that perpetuates these beliefs in both explicit and implicit ways (Campbell et al, 2009).

Stress, whether from an acute traumatic incident or repeated incidents over time, can impact both mental and physical health. Research has largely focused on the health outcomes of women who have experienced sexual assault. Findings suggest that early experiences with sexual assault are linked to poor mental and physical health outcomes. Kilpatrick, Resnick, and Acierno (1997) found that women who had been assaulted had higher rates of substance abuse. Their study did not include males and made no distinctions between PFSF and NPSF (although they did consider differences between forced vaginal, oral, and anal sex). Golding (1999) found that women who had been sexually assaulted had higher rates of depression, lower reported general health, and increased gynecological health problems such as chronic pelvic pain. Using a cross-sectional study design, Plichta and Falik (2001) found that females who reported that they had been the "victim of a sexual assault" or the "victim of a rape" reported lower general health and were more likely to report having a chronic health condition. However, few longitudinal studies

have been conducted that allow for the control of earlier reports of psychological and physical health.

Physiological Dysregulation

A growing body of research has explored how trauma and chronic psychosocial stress can "get under the skin" and place individuals at heightened risk of later health problems. In a state of allostasis, the body can fluctuate in response to stress and return to optimal functioning during times of non-stress. However, in individuals who experience persistent stress or who cannot turn off a stress response following a traumatic event, the repeated demands on the body's stress systems place significant burden on the body's capacity to return to allostasis, leading to "a 'domino' effect on interconnected biological systems that overcompensate and eventually collapse themselves, leaving the organism susceptible to stress-related diseases" (Juster et al., 2010).

This systemic dysregulation is called *allostatic load* and can be used to describe a level of "wear and tear" on the body (Beckie, 2012; Duong et al., 2017; McEwen, 2003). As biological systems begin to compensate for the overuse of the body's stress response systems, changes happen in the body's cardiovascular, metabolic, and immune systems. The measuring of heightened though subclinical levels of these different systems generates an overview of a person's overall functioning and relative level of physiological burden before they reach a level of clinically recognized disease (Juster et al., 2010; McEwen, 1998, 2003).

We might theorize that sexual assault could increase the level of stress, which could lead to allostatic load. Sexual assault is traumatic, but becomes more so in post-assault settings in

which victim-blaming and a lack of meaningful support structures increase and perpetuate the trauma of an assault.

Present Study and Research Questions

This study uses data from a nationally representative sample to assess rates of sexual assault across race, gender, and sexual identity groups and to explore long-term health impacts. This study takes advantage of a diverse range of sexual experiences to tease apart how different experiences across childhood and adolescence might predict adulthood health and well-being, as measured through self-reports of depression and health and biological measures of stress on the body. This study contributes to the literature in two main ways: First, the study takes advantage of a nationally representative database to explore rates of first PFSF and NPSF to determine how intersectional identities might impact experience. Second, this study explores different patterns of first assault across the life-course and considers the potential developmental effect these first experiences have on long-term health, including biological measures of metabolic, inflammatory, and cardiovascular health. To achieve these goals, the following research questions have been formulated:

1) What are the patterns of first sexual assault experiences across the life-course? How do these patterns differ across gender, race, sexual orientation, and class?
2) How do the health and well-being of adults who report being sexually assaulted differ from adults who do not report being sexually assaulted?
3) Are there health differences among those who report no assault, physically forced assault, non-physically forced assault or both forms of assault?
4) Are there health differences depending on whether a person reports a first assault in early childhood (ages 0-3), middle childhood (4-6), late childhood (7-9) pre-adolescence 10-12), early adolescence (13-15), late adolescence (16-18), and young adulthood (19-25)?

Methods

Participants

This study draws on the first four waves of data from the Longitudinal Study of Adolescent to Adult Health (Add Health). The Add Health study began in 1994 as a nationally representative survey of 90,118 adolescents in 7th through 12th grade (ages 11-19). The survey collected data on a wide range of psychological, economic, physical, behavioral, and social dynamics associated with adolescence. A subset of eligible survey participants (N=20,745) were selected for in-home interviews and were interviewed five times across 24 years—1995 (Wave 1, ages 11-19); 1996 (Wave 2, ages 13-21); 2001-2002 (Wave 3, ages 18-26); 2008-2009 (Wave 4, ages 24-32); 2016-2018 (Wave 5, ages 32-42; data not yet released). Information about the dates for each wave, the participants, and measures collected at each time point are detailed in Table 3.

To measure the association between age of first sexual assault and self-reported health measures, I used the data of participants who had participated in both Wave 1 and Wave 4 and who had complete data available for all the variables in the model (N=14,631). To measure patterns of biological measures of health, I added the additional condition of complete anthropometric and blood spot variables (N=12,063).[4, 5]

[4] Using guidelines presented in Hughes, Heron, Sterne and Tilling (2019), I ran checks on missing data to ensure complete case analysis would not introduce bias into the regression models. Complete data was predicted by participants with higher parent education (b=.002, t=2.30, p=.022) participants who had not experienced sexual force (b=-.012, t=-4.75, p<001) and participants who were not experiencing current abuse (b=.056, t=-18.30, p<.000). None of the outcome variables predicted incomplete data when modeled with covariates. Complete case analysis could, thus, be run without introducing bias into the models.

[5] See Table 4 for a list of descriptives by sample.

The questions regarding sexual violence were retrospective and, for many participants, included recollections of events before the collection of Wave 1 data. To include individuals whose first exposure took place in childhood, I included all participants, even those whose first sexual assault fell before the "baseline" depression and health data were collected. Thus, some attenuation bias may exist in these models.

Measures

Physically and Non-Physically Forced Sexual Assault.

In Wave 4, participants were asked two questions about PFSF and NPSF. First, the participants were asked to indicate (yes or no) whether they had ever been "***physically forced*** *to have any type of sexual activity against [their] will?"* The participants who indicated yes were additionally asked, "*How old were you the first or only time this happened*?" Second, the participants were asked whether they had ever been forced *"in a* ***non-physical way****, to have any type of sexual activity against [their] will. For example, through verbal pressure, threats of harm, or by being given alcohol or drugs?"* The participants who indicated yes were then asked, "*How old were you the first or only time this happened*?" In both questions, the participants were asked to exclude any experiences with a parent or adult caregiver.[6]

Indicator variables were used to document whether an individual had *ever* been subjected to **PFSF** and/or **NPSF**. Separate indicator variables were used to reflect whether an individual

[6] The participants were separately asked about parental sexual abuse.

had *exclusively* experienced PFSF, NPSF, or *both physical and non-physical sexual assault (BSF).*

To capture age of first sexual force, I used the continuous variable to document age of first PFSF and age of first NPSF. I additionally created indicator variables to reflect developmental stage of first assault: early childhood (0-3), middle childhood (4-6), late childhood (7-9) pre-adolescence (10-12), early adolescence (13-15), late adolescence (16-18), and young adulthood (19-25).[7] There was a moderate correlation between PFSF and NPSF $r(14,646)=.581$, $p<.001$.

To capture the effect of first experience of force on long-term health, when modeling the age of force for individuals who had experienced BSF, I used the earliest age of any sexual force. Among individuals who reported BSF, 77.62% reported both forms of sexual force occurring at the same age. An additional 14.85% experienced NPSF prior to PFSF (see Table 5 for correlations).

Health Outcomes

To evaluate the effect of sexual force on health, I used three measures of health—one measures of mental health (depressive symptoms) and two measures of physical health (self-reported general health and physiological measures of allostatic load).

[7] Legally, children, pre-adolescents, and early adolescents are not considered capable of consent to sexual experiences. In this paper, I am not addressing legal definitions of rape and consent, but rather rely on individuals' identification as having experienced forced sexual activity.

Depression. In Wave 4, participants were asked to respond to five questions from the Center for Epidemiological Studies Depression Scale (CES-D). The answers to these questions described the frequency (never/rarely, sometimes, a lot of the time, most/all of the time) that they experienced depressive symptoms, such as being "bothered by things that usually do not bother you" or "feeling too tired to do things." The scores from each item were added together into a constructed variable with a score ranging from 0 to 15, with 15 reflecting a higher number of depressive symptoms. The depressive symptoms levels for Wave 1 were constructed using matching variables from Wave 4.

Females [M=2.84, SD=2.69] reported significantly higher depressive symptoms than males (M=2.32, SD=2.34) for Wave 4 [$F(1,14629)=154.00$, $p<.001$]. There were also statistically significant differences between racial groups at Wave 4 [$F(5,14625)=23.38$, $p<.001$]. Native American (M=3.17, SD=2.96) and Black (M=2.96, SD=2.73) participants reported significantly higher levels of depression than white (M=2.43, SD=2.48), Hispanic (M=2.59, SD=2.50), and Asian participants (M=2.53, SD=2.28). At Wave 4, individuals who identified as mostly heterosexual, bisexual, and mostly homosexual had significantly higher levels of reported depression than 100% heterosexual and 100% homosexual identifying participants [$F(4,14547)=75.44$, $p<.001$].

General Health. In Wave 1 (1996) and Wave 4 (2008), participants were asked to rate their own health when answering the question, "In general, how is your health?" on a scale of 1 (excellent) to 5 (poor). Participants, on average, described themselves to be in good health: 59.42% of males and 56.60% of females described themselves as having "Excellent" or "Very

Good" health; 8.47% of males and 9.90% of females described themselves as being in "Fair" or "Poor" health [$F(1,14629)=22.55$, $p<.001$]. The white participants reported significantly better health than all the other racial groups, with 61.66% reporting "Excellent" or "Very Good" health compared with 53.80% of Black participants, 53.51% of Hispanic participants, 54.84% of Asian participants, and only 47.99% of Native American participants [$F(5, 14625)=20.44$, $p<.001$]. Heterosexual and bisexual participants generally reported poorer health than their 100% heterosexual peers, and the bisexual participants reported poorer health than their mostly heterosexual peers [$F(4,14547)=12.23$, $p<.000$].

Allostatic Load. In Wave 4, a series of non-invasive biological measures was collected from the participants by trained and certified interviewers using anthropometric measures such as weight, height, waist circumference, cardiovascular measures using blood pressure and pulse, and metabolic and inflammation measures using dried blood spots (Entzel et al., 2009; Whitsel, Cuthbertson, et al., 2012; Whitsel, Tabor, et al., 2012). For this study, seven biological measures were combined create a measure of allostatic load: three measures of cardiovascular functioning (systolic blood pressure, diastolic blood pressure, and high-density lipoproteins to Total Cholesterol (HDL:TC)), three measures of metabolic functioning (glycated hemoglobin (HbA1c), waist circumference, and body mass index (BMI)), and one marker of inflammation (high sensitivity C-reactive Protein (hsCRP)). These seven were chosen for inclusion in consultation with Duong's (2017) assessment of the most commonly used variables in allostatic load research.

Composite allostatic load scores were constructed such that, for each measure, individuals falling in the least healthy quintile of each of the biomarkers were given a 1, and others in the sample received a 0 (Duong et al, 2017). The exceptions to this system were biomarkers with a distinct clinical cut-off that fell below the least healthy quintile. For BMI, the participants who were clinically categorized as obese (37.07%) were given a 1 and others were scored with a 0. For hsCRP, individuals classified as having high CRP (40.65%) were given a 1 and others were given a 0. Following Duong et al. (2017) and Juster et al. (2010), I used a summation method for each of the seven variables, so that each biomarker was combined to create a score from 0 to 7, with 0 indicating lower risk and better health and 7 indicating higher risk and lower health.

The average score for allostatic load was 1.39 (SD=1.44). Males, on average (M=2.18, SD=1.68**),** had a higher allostatic load than females (M=2.00, SD=1.65) [F(1,12061)=34.23, p<.001]. Significant differences were found in allostatic load across racial identities [F(5,12247)=40.74, p<.001]. Black (M=2.43, SD=1.73), Hispanic (M=2.24, SD=1.73), and Native American (M=2.38, SD=1.87) individuals had higher levels of allostatic load than white (M=1.92, SD=1.65) and Asian participants (M=1.91, SD=1.65). No significant differences in allostatic load were found across sexual identities [F(4,12375)=.89, p=.47].

Demographic and Health Covariates

I controlled for demographic, health, and relational violence measures known to be associated with long-term health outcomes.

Demographic Controls. Biological sex,[8] race, and parent education measured at Wave 1 were used as baseline demographic covariates. Females comprised 52.57% of the study population at Wave 4 (53.27% of the allostatic load sample).

The participants were asked to identify all racial categories that applied to them. For individuals who selected multiple racial categories, they were additionally asked to identify which racial category "best described" their racial background. I created a single race variable using self-reported racial identity at Wave 1 and categorizing individuals who identified as multiple racial identities into their "best described" category. Participants identified as white (53.67%), Black (21.86%), Hispanic/Latino (15.11%), Asian (6.43%) and American Indian/Native American (2.04%) and Other (0.89%).[9]

Parent education served as a proxy for socioeconomic status because of a high level of missing data on income. This factor was created using the higher level of the mother's or father's education. The participants were categorized as having a parent with less than a high school degree (11.86%), a high school diploma, GED, or vocational training (30.05%), some college education (21.65%), a college degree (23.30%), or post-college education (13.14%).

Sexual identity was collected at Wave 4 by asking the participants if they identified as *100% heterosexual* (86.32%), *mostly heterosexual* (9.66%)*, bisexual* (1.53%)*, mostly homosexual* (.86%)*,* and *100% homosexual* (1.29%) or *not attracted to males or females* (.32%)*.*

[8] Gender identity was not collected in the Add Health Survey

[9] Allostatic load sample by race: white 55.23%, Black 20.54%, Hispanic 14.66%, Asian 6.60%, Native American 2.11%, Other 0.85%

Baseline Health. Measures of health (obesity, general health, depression) collected at Wave 1 were used as controls for baseline health. The participants' BMIs were calculated using self-reports of height and weight. Participants with a BMI equal to or higher than 30 were categorized as "Obese" (7.29%). The white participants had significantly lower rates of obesity at Wave 1 (5.7%) than the Black (9.4%), Hispanic (9.1%), and Native American (10.9%) participants. The Asian American participants had lower rates of obesity (6.3%) than the Black and Native American participants but did not significantly differ from the white or Hispanic participants. Obesity at Wave 1 was significantly correlated with obesity at Wave 4 $r(12{,}061)=.330$, $p<.001$.

General health was measured through the same single item—"How would you rate your general health?"—used in Wave 4. At Wave 1, 72.21% of males and 64.77% of females reported being in "Very Good" or "Excellent" health, and 5.51% of males and 8.09% of females reported being in "Fair" or "Poor" health. White participants reported the best health, with 61.42% reporting "Excellent" or "Very Good" health compared with 53.18% of Black participants, 53.32% of Hispanic participants, 55.20% of Asian participants, and only 47.69% of Native American participants. Conversely, Native American participants reported the poorest health, with 15.86% reporting "Fair" or "Poor" health compared with 9.43% of Asian Americans, 12.91% of Hispanic/Latino participants, and 11.21% of Black Americans. General health reported at Wave 1 was moderately correlated with reported general health at Wave 4 $r(12{,}061)=.278$, $p<.001$.

The CES-D scale for depression was used to measure depression at Wave 1. Females, on average (M=3.25, SD=2.92), reported higher levels of depressive symptoms than males (M=2.40, SD=2.35) at Wave 1 [F(1,14629)=364.89, p<.001].

Relationship Violence.[10] Three measures of relationship violence (parental sexual abuse and IPV and sexual violence in a current romantic relationship) were included in the model as controls.

Parental sexual abuse has been associated with sexual abuse in later life. There was a small but significant correlation between experiences of childhood sexual abuse by a parent/guardian and PFSF (r(14,629)=.157, p<.001) and NPSF (r(14,629)= .150, p<.001). I used an indicator variable (yes/no) to control for the experience of sexual abuse by a parent/guardian as an effect on adult health. Nearly 1000 participants (6.27%) reported being "touched in a sexual way" by a parent/guardian before the age of 18. For females, the rate of sexual abuse was significantly higher (7.94%) than the rate of parental sexual abuse of males (3.24%) [F=(1, 14629)=151.26, p<.001]. Black participants reported statistically higher rates of parent sexual abuse (6.10%) than white (4.59%) and Asian (3.78%) participants [F(4,14507)=4.92, p=.001].

Intimate partner violence in a current relationship was also documented. These questions included a report of how often their partner "slapped, hit, or kicked [them]," "threatened violence, pushed or shoved [them], or thrown something at [them] that could hurt" and how often the participant "had an injury such as a sprain, bruise, or cut because of a fight with [their] partner." Since sexual force may be part of, but also distinct from, IPV, I opted to control for

[10] Analyses were run with and without these measures and did not alter the findings. The final models reported in this paper include these measures.

these variables. Males were more likely to say they had experienced physical violence at the hands of their partners: 16.83% of males reported being slapped, hit, or kicked by their current partner at least one time in their relationship compared with 8.05% of females. Similarly, 22.07% of males reported that their partner had threatened violence, pushed, or shoved them compared with 18.01% of females [$F(1, 14629)=35.71$, $p<.001$]. Equal percentages of males and females (5%) reported being injured at least once by their partners, but females reported more frequent injury than males [$F(1,14629)=5.16$, $p=.0231$].

Analytic Plan

Patterns of First Age of Sexual Force. To analyze patterns of types of sexual force and age of first assault by groupings of gender, race, sexual identity, and class, I began by running one-way analysis of covariance (ANOVA) for experience of each type of sexual force (PFSF/NPSF) separately and the experience of both types of assault (BSF) across developmental stage by gender, race, sexual identity, and parent education. Post hoc analyses using the Bonferroni criterion for significance were used to determine significant differences between groups.

The rates of sexual force appeared more similar within genders than within other demographic groupings. Therefore, ANOVAs exploring differences in sexual force patterns by race, sexual identity, and parent education were additionally run separately for males and females.

Long-Term Health Consequences. To analyze health outcomes for individuals who had experienced PFSF, NPSF, and BSF, I first examined bivariate associations between health

outcomes and experiences of PFSF and NPSF. All continuous predictors were standardized prior to analysis.

Health Differences by Type of Sexual Force. The high correlation between individuals' experience of physical force and non-physical force meant I opted to run regressions using indicator variables for exclusively PFSF, exclusively NPSF, or BSF. I then used multi-step regressions to explore whether cardiovascular, general health, and depression varied between individuals who had and had never been sexually assaulted, controlling for baseline health and demographic covariates. I additionally tested race and gender interactions with experience of sexual assault. Three-way interactions by race and gender were not possible due to limited observations (particularly among males) and collinearity. Analyses were weighted using Add Health longitudinal sampling weights, which adjust for complex sample design, selection, and nonresponse.

Life-Course Stage. Finally, I used the developmental variables to determine whether the age of first or only experience with each type of sexual force is associated with variation in health outcomes.

Findings

Overview

I first present rates of sexual force across gender and race and provide descriptive statistics about the rates and ages of sexual force across these social groups. Then, I turn to the long-term health outcomes (depression, general health, and allostatic load) of individuals

subjected to sexual force and describe how these results differ according to the developmental stage at which the first instance of sexual force occurred.

Gender and Race Trends Across the Life-Course

Across all racial groups, females were assaulted at a higher rate than males for both PSFS [$F(1, 14629)=719.78$, $p<.001$] and NPSF [$F(1,14629)=921.37$, $p<.001$]. Among females in the sample, 13.83% of women reported PFSF, while 1.92% of males reported PSFS. For NPSF, 19.81% of females reported an assault, while 3.87% of males reported an assault. On average, males were *physically forced* at younger ages than females [$F(1,1162)=65.67$, $p<.001$] (see Figures 1-4). Not only were males less likely to be assaulted, but they were also less likely to experience multiple types of assault (see Figures 5 and 6).

The average age of first/only PFSF for females is 15.9 (SD=5.80), and 11.06 (SD=7.00) for males. Roughly 18% of women who had been sexually forced experienced their first physical assault before the age of 10. By the time they were 16, an additional 51.19% of assaulted women had experienced their first assault. Before turning 10, 50% of males reported PFSF. An additional 30% of males were physically assaulted by the time they were 16. Males were also significantly younger at the age of first NPSF [$F(1,1751)=5.19$, $p=.023$]. The average age of first NPSF is 16.4 for females and 15.3 for males. Roughly one-third of assaulted males (31.02%) experienced NPSF before the age of 10, and 15.36% of NPSF females had been assaulted by the age of 10.

Males and females who identified as Asian reported the lowest rates of PFSF for their respective gender groups (see Table 6). Males who identified as Native Americans reported the

highest levels of PFSF (M=.038, SD=.19) and had significantly higher rates of assault than Asian males (M=.0075, SD=.09) [F(4, 7254)=2.79, p=.02]. Black males reported the highest rates of NPSF across males and had significantly higher rates of NPSF than their white (M=.0178, SD=.13) and Asian (M=.008, SD=.09) peers [F(4, 7247)=4.02, p=.003]. No racial differences were found across males for the report of both NPSF and PFSF (see Table 6 and Figures 5 and 6).

Asian men had a statistically significant earlier age of PFSF than their Black male peers [F(4,133)=3.48, p=.01]; however, it should be noted that only four Asian males reported the age of PFSF assault, three of whom reported PFSF in their infancy and one who reported it at age six. No significant age differences were found between racial groups for first NPSF across males [F(4,266)=1.04, p=.388].

Females who identified as Native Americans and white reported the highest rates of both PFSF and NPSF across females. They had significantly higher rates of PFSF than Hispanic (Mean=.1073, SD=.31) and Asian females (Mean=.0659, SD=.25). Black females (Mean=.0246, SD=.16) had significantly higher rates of PFSF than Asian females [F(4,8238)=10.99, p<.001]. White and Native American females reported significantly higher rates of NPSF than their Black, Hispanic, and Asian female peers [F(4,8236)=28.50, p<.001]. White and Native American women are more likely than Hispanic and Asian women to experience BSF in their lifetime. Black women are more likely to experience BSF than Asian women [F(4,8236)=11.82, p<.001]. No age differences were found across racial groups for either first PFSF [F(4,1122)=.45, p=.776] or first NPSF [F(4,1598)=1.64, p=.162].

Gender and Sexual Identity

Among males, rates of sexual assault also varied across sexual identity for PFSF [F(4,7273)=21.14, p<.001], NPSF [F(4,7267)=18.93, p<.000] and BSF (see Table 7). Males who reported being *mostly heterosexual*, *bisexual* or *mostly homosexual* reported significantly higher rates of both PFSF and NPSF than their *100% heterosexual* peers. Males who identified as *mostly homosexual* or *bisexual* also reported statistically higher rates of PFSF than males who identified as *100% homosexual.* Men who identified as *bisexual* had statistically higher rates of experiencing both PFSF and NPSF than men who identified as *100% heterosexual or 100% homosexual*. Men who identified as *mostly homosexual* had significantly higher rates of assault, and significant differences were found regarding age of first assault (See Table 7).

Females who identified as *bisexual* reported the highest rates of PFSF (32.31, SD=.47) and had statistically higher rates of PFSF than their *100% heterosexual, mostly heterosexual*, and *100% homosexual* peers. Women who identified as *mostly homosexual* had higher rates of PFSF than *100% heterosexual* identifying females [F(4,8249)=39.99, p<.001]. Females who identified as *bisexual* also had significantly higher rates of NPSF than *100% heterosexual* (Mean, SD) and *100% homosexual* (Mean, SD) identifying females, and *mostly heterosexual* and *mostly homosexual* identifying females had higher rates of NPSF than *100% heterosexual* identifying females. [F(4,8255)=52.01, p<.001]. No significant differences were found regarding average age of first sexual force; however, the pattern of force varied across the lifetime.

Parent Education

There were no significant differences in the rates of sexual force by parent education level across genders or within gendered groups [F(4, 9603)=1.01, p=.400]. There were also no significant differences in age of first assault among males; however, females whose highest-educated parent had less than a high school degree had an earlier average first PFSF (M=13.8, SD 6.43) compared with females whose highest-educated parent had a college degree (M=16.9, SD=5.43) or higher (M=16.7, SD=5.24) [F(4,600)=3.25, p=.01], and an earlier NPFS (M=14, SD=12.9) than females with a parent who had a received an advanced degree (M=16.1, SD=6.89).

Depression

Non-physical sexual assaults are associated with a .271 standard deviation increase in depressive symptoms at Wave 4 (p<.001), while PFSF predict a .374 standard deviation increase in depressive symptoms (p<.001), and individuals who reported experiencing BSF had even higher rates of depression (b=.410, t=11.620, p<.001) (See Table 8). No gender interactions were found. Race interactions suggest that individuals who identified as Native Americans who had been exposed to both PFSF and NPSF had significantly higher rates of depression (b=.702, t=3.17, p=.0012) than peers from other racial groups who had been exposed to the same violence.

Individuals who had suffered BSF and who had been assaulted for the first time in early childhood (b=1.152, t=5.170, p<.001), middle childhood (b=.256, t=2.060, p=/039), early adolescence (b=.416, t=3.490, p<.001), late adolescence (b=.450, t=6.990, p<.001), young

adulthood (b=.457, t=6.940, p<.001), and adulthood (b=.710, t=4.870, p<.001) experienced higher levels of depression at Wave 4. Developmentally, the experience of NPSF with a first assault in pre-adolescence (b=.601, t=3.710, p=.027) and young adulthood (b=.140, t=2.420, p=.015) predicted higher levels of depression in adulthood. Individuals who were first physically assaulted in late childhood (b=.608, t=3.620, p=.000), early adolescence (b=.724, t=4.790, p=.000) and young adulthood (b=.268, t=2.1130, p=.034) similarly had higher rates of depression in adulthood (see Table 9).

General Health

Individuals with a history of BSF also reported poorer general health at Wave 4 compared to indviiduals who had not been assaulted (b=.244, t=7.030, p<.001), as did individuals who had exclusively experienced PFSF (b=0.222, t=3.620, p<.001) (See Table 10). Individuals with a history of exclusively NPSF did not report poorer physical health (b=-.003, t=-.07, p=.945). Women who reported PFSF had worse general health outcomes than males who had experienced PFSF. Race interactions indicate the Black (b=.886, t=3.74, p=.000) and Native Americans (b=.942, t=3.69, p<.001) individuals who suffered BSF means had poorer health outcomes than peers from other racial groups. Race by gender interactions indicates that Black males who experienced BSF were particularly likely to report poor health (b=1.62, t=3.35, p=.001).

Youth who experienced BFS for the first time in middle childhood (4-6) (b=.473, t=3.860, p<.001), early adolescence (13-15) (b=.266, t=3.460, p=.001), late adolescence (.279, t=4.390, p<.001), and young adulthood (p=.178, t=2.730, p=.006) reported worse general health

than their non-assaulted peers and peers who were assaulted at different developmental stages. Individuals who experienced NPSF in middle childhood (b=.442, t=2.780, p=.005) also reported poorer general health outcomes in adulthood, as did individuals who experienced PFSF in middle childhood (b=.366, t=2.210, p=.027) , pre-adolescence (b=.391, t=2.620, p=.009), and late adolescence (b=.436, t=3.520, p<.001) (see Table 11).

Allostatic Load

No significant differences in allostatic load were found among individuals who had experienced sexual force nor individuals who had not (see Table 12)

Discussion

The purpose of this study was three-fold. First, this study aimed to explore the rates of sexual force and the age of first risk of sexual force by gender, race, and sexual orientation. Second, this study aimed to explore the association between sexual force and mental and physical health outcomes in adulthood. Finally, this study aimed to determine whether particular developmental stages are greater predictors for negative health outcomes among those who had experienced sexual force. Through the analyses, several important patterns emerged.

First, the Add Health dataset made it possible to look at the rates and ages of sexual assault across race, gender, and sexual orientation and class. Within this sample, 13.12% of males and 30.21% of females between the ages of 25 and 32 reported experiencing some form of sexual force in their lifetime, rates that generally align with past research. The results from this paper suggest that young men are less at risk of sexual assault than women overall, but they are disproportionately impacted by sexual force in their childhood; whereas, women become

increasingly at risk as they move through adolescence and into adulthood. If we consider Whitter (2015), one possible explanation for this diverging pattern is the growing social power of young men as they age and gain access to the privilege of being both an adult and a male. Although the rates of sexual assault for women indicate lower numbers of first assaults in adulthood than in adolescence and young adulthood, it is important to remember that the current sample ranges from 25 to 32 years old, and not all individuals in this study had yet reached their 30s. Thus, we might expect the most recent wave of data to indicate higher levels of assault among this population.

Although gender is a significant driver for patterns of sexual assault, other salient social categories, such as race, sexual orientation, and class, also predict patterns of assault aligned with previous research, in which both Asian males and females had significantly lower rates of sexual assault than their same-sex peers. Previous research suggests that lower rates of abuse across Asian families may be attributable to different valuations of masculinity in Asian cultures compared with Western cultures (Finkelhor et al., 2013; Zhai & Gao, 2009). White and Native American women had the highest rates of assault among women in the studies. Among men, Native American males reported the highest rates of PFSF and BSF. Black males reported the highest rates of NPSF. We know little about the dynamics associated with these differences in rates of assault across racial groups, nor the extent to which racialized violence might drive these differences. Similar power dynamics are at play when considering the disproportionate number of bisexual individuals reporting sexual force. Although parent education did not predict rates of sexual assault across males and females, females with high school educated parents were, on

average, exposed to sexual force at an earlier age than women from families with parents who had at least a college degree.

Overall, when thinking about the reported rates of assault across groups, we must consider how both power and perception play roles in the choice to disclose sexual force (Hlavka, 2016; Khan et al, 2018). In general, researchers report that sexual assault is underreported, even in anonymized surveys, and it depends on how a question asks people to label their experiences (as assault, rape, force, or a series of unwanted acts) (Khan, 2019, 2020). Although this survey comes from an anonymized, nationally representative sample, the role that social power associated with race might play in the decision to disclose an assault must be considered. For example, white women may feel a greater capacity to report sexual assault as holders of white privilege; whereas, Black women may feel inclined to protect themselves from further sexual stigmatization. Further research into labeling decisions and the community and cultural outcomes is important to understand fully these dynamics.

This chapter additionally explored how early sexual force predicts health outcomes for individuals who experienced PFSF and NPSF. Although this understanding does not completely address the differences of experience that are possible regarding sexual assault (stranger vs partner, level of violence, etc.), it does allow for some distinction between assaults that are physically forced vs those that occur through more verbal means, such as coercion. Overall, my data suggest that both types of assault impact long-term health, but it is unclear whether the long-term impacts are the result of the assaults themselves or are exacerbated by poor support in the aftermath of an assault. Both PFSF and NPSF impact mental and self-reported physical health.

Although, in the studies, assaults were not associated with compromised physiological functioning as measured through allostatic load, we might expect that, without support, the mental health challenges and ongoing stress could manifest in physiological symptoms later. Native American and Black men and women who had been sexually forced reported particularly poor physical health outcomes. Considering past research, which highlights how men of color and, in particular, Black men have been vilified as sexually aggressive (Whittier, 2015), future research should consider the potential stigma facing men who seek support following an assault. Additionally, fear of police involvement and discriminatory support environments may add extra layers of trauma for people of color seeking treatment (Freedman, 2013).

Finally, this thesis explored the role of the developmental stage of first assault on long-term health. Research has extensively explored sexual abuse in childhood and adulthood (which brackets together, for instance, 14-year-olds with 25-year-olds) but has largely overlooked *when* people become at risk of being sexually assaulted. Understanding when young people are most at risk of sexual violence is important for targeting interventions. Examining the health outcomes of young people assaulted at different developmental stages, middle childhood appears to be the only developmental stage during which sexual force is less likely to have a long-term effect on health. It is possible that this group is more likely to externalize behavior or obtain familial or teacher support in a way that youth in other developmental stages are less likely to receive. It is also possible that the developmental and cognitive development stage for this age group protects them from some of the long-term consequences of sexual force. Future research should explore

whether there are distinct differences in the types of support available in this age group that help to buffer them against the longer-term impacts of assault.

This study cannot explore how people may be at risk of multiple assaults or the effect that multiple assaults might have for long-term health consequences. We might anticipate that, for those exposed to more frequent sexual force, either through repeated assaults or sexual violence within a relational context that is ongoing, the negative outcomes might be exacerbated.

Although this research builds on others (Humphrey & White, 2000; Swartout et al., 2011, Testa et al., 2010; Thompson & Kingree, 2010) to explore distinctions between PFSF and other forms of NPSF, this study has limitations that apply to other research on sexual assault because it requires participants to identify themselves as having been forced to engage in unwanted sexual activities. The questions presented fit into a middle ground between asking participants to identify themselves as "rape" or "assault" victims while not completely removing words that might attach stigma to answering in the affirmative. Additionally, these questions do not allow for the breakdown of different types of forced sexual activity, although we might presume from the labeling literature that those involved in the study are reporting more severe forms of sexual assault. Furthermore, the contexts in which these first assaults happen is unavailable through these data.

Conclusion

Trauma can have cascading effects on development. This chapter reveals that we are doing a poor job of interrupting the trauma associated with sexual force and that we may be exacerbating such trauma due to how formal systems are set up to respond to people who have

been assaulted. As I described in Chapter 2, young people transitioning from high school to college are often learning about consent and sexual assault for the first time in college, even though many have witnessed examples of sexual force in high school. Even in the presence of highly publicized sexual abuse, educational institutions are failing to respond to the reported needs of student safety. The students' narratives and these patterns of assault across early life suggest that prevention efforts need to occur far earlier than college orientation, and that treatment and support options need to be improved considerably to aid in the healing of young people who are sexually assaulted.

Chapter 5: Conclusions

Across these three studies, teens reported a wide range of romantic and sexual experiences. Some of the participants had not dated at all by the end of high school, while others found enjoyment in sexual connections with their classmates in formalized relationships or informal "things." Among the nationally representative sample, a significant proportion of both males (13.12%) and females (30.21%) experienced sexual force in some form (70-80% of those assaults occurring prior to age 16). Despite the diversity of their experiences, participants were united in describing their sexuality education as distinctly misaligned with their experiences. Where they wanted tools for navigating emotional dynamics associated with connection and intimacy, they received technical lessons about anatomy, contraception, and STIs. Where they craved models of healthy relationships, they were instead provided with the most extreme examples of abuse and violence that left a young woman dead at the hands of a young man. Moreover, when young people faced real, harmful challenges regarding their own sexual autonomy and consent, they were met with legal jargon or silence. The teens' lack of knowledge and education is clearly evident in the distinct gap between males and females when thinking about consent. Although young people clearly understood the importance and definition of sexual consent, the reality of what consent could look like remained obscure, and their abilities for navigating such an encounter were lacking. Women knew the importance of ongoing consent but had no idea how to identify or name their wants within an interaction. Men, conversely, thought consent was straightforward and static—a clear yes or no. From their descriptions, it is

not difficult to imagine how someone could feel satisfied with a sexual encounter and another person be confused or disappointed.

Healthy relationships matter in adolescence and as youths develop into adults. Such relationships matter for mental and emotional health, for feelings of social belonging, connection, self-esteem, and they matter for physical health (Joyner & Udry, 2000; Robles, 2014). As young people begin to engage in romantic and sexual encounters, we need to do better at scaffolding their experiences and supporting them developmentally to navigate the challenges in front of them successfully.

In Study 1, I described how young people defined and identified romantic relationships as a salient part of the adolescent experience. Whether teens undertake these relationships themselves or are exposed to relationships vicariously through their peers, young people are cognizant of both the benefits and the challenges of engaging in non-platonic relationships. Among this sample of interviewed students, relationships offered much needed support—a guaranteed friend and companion in the midst of a world that they described as socially toxic, overwhelming, and academically demanding. Moreover, relationships offer their own challenges—they require time and attention, they create isolation from friends, and they require compromise and a balance between one's own interests and the interests of partners. For those who do not want the commitment or the emotional requirements associated with dating, having "a thing," physical intimacy, companionship at social events, and an easy date to a dance is appealing. Many teens found benefit and relief in this less contractual arrangement, but navigating these relationships presented challenges, too. Such relationships hold the potential for

heartbreak, jealousy, or unanticipated and unreciprocated emotional attachment. As teens navigated romantic and sexual relationships, nearly every participant wanted to know the answer to the important question: “What does a healthy relationship look like?”

Regarding learning how to navigate relationships, the youth in this sample found that the adults around them either remained silent or provided information that was important but not directly linked to the challenges they identified as most salient. Like most teens in the US, the majority of participants in the interview sample received some form of sexuality education. On the whole, students described their sexuality education experiences as being filled with technical information about anatomy, STIs (and treatment), risks, pregnancy, and contraception. Some participants learned about relationship abuse. Young people with formal access to this material found it useful. They were glad to know about safe sex practices such as condoms and other contraceptives. At the same time, young people criticized their programs for failing to meet their relational needs. Describing them as “technical” or “basic,” “a joke” or “BS,” teens commented on the lack of practical relevance of many of these courses. Participants criticized the content as being not age appropriate—as being behind the stage teens were at because they were already engaged in sexual activity, or as too far ahead in discussing relationships among adults and married couples rather than the challenges that might emerge for high school students. Furthermore, LGBTQ youth struggled even more to see themselves in the curriculum, finding it particularly challenging to learn about sexual health and safety and relational health.

Teens reported that unhealthy relationships were depicted as highly violent and abusive, using films that portrayed women being killed by their obsessive boyfriends. However, these

films failed to display any positive or meaningful components of relationships. Moreover, courses did not offer practical training to provide students with the skills to navigate relationship challenges in their own lives. Some participants in my interview sample struggled with abusive and violent relationships in their adolescence, but, oddly, while sexuality education curricula used fear and worst-case scenarios to warn teens of the risks of relationships, teens who had to navigate such challenges found that support was unavailable to them.

For all participants, the internet became a trusted source for information—whether it was videos on YouTube, pornography, or social media memes that critqued popular TV and movie characters, teens relied on these resources to create their own understanding of what a healthy romantic and sexual relationship should be. This study's findings are consistent with burgeoning research that suggests young people have questions about romantic relationships that are not being met by their sexuality education curricula (Albury et al., 2017; Coyle et al., 2016; Hirsch & Khan, 2020). Moreover, this study identifies ways in which young people's questions are tied directly to emotional and social tasks associated with their developmental stages—those related to identity and intimacy. Rather than receiving support from adults around them, this study suggests that young people are turning to popular media or attempting to forego the components of romantic relationships that require the types of differentiation required to navigate relationships later in life.

In Study 2, I further explored young people's ideas about sexual consent—how they defined consent and what they thought that meant in practical terms for a sexual encounter. I found stark differences between males and females. Females rooted their definitions in the

importance of continuous and ongoing consent but did not know what that looked like in an actual romantic encounter. Instead, women dismissed the idea of continuous and ongoing consent as unrealistic in practice. Young women reported that, in their experiences, consent came in response to advances—their role was to allow or deny. This view led to a broader skepticism about consent in sexual encounters because they held an idealized vision of a romantic encounter, and yet their reality involved a halting progression of allowances and/or denials. Women generally questioned their own capacity to know when they were ready to have sex and described their ability to decide as something they learned through making mistakes and later reflection. Men, on the other hand, talked about consent as though it was straightforward and easy—a clear yes or no. Although they recognized that not all men felt as they did about the importance of consent, the men in this sample felt that consent was common sense and had clear rules and boundaries. These findings are largely consistent with emerging work from Hirsch and Khan (2020) about the ways that sexual assault manifests on campus and how young people are ill-prepared to navigate important conversations about their sexual wants and needs. At the same time, this research points to the distinct need to begin conversations with young people about consent and sexual needs earlier.

In Study 3, I used nationally representative, longitudinal data to explore the extent to which early experiences of sexual force were associated with compromised mental and physical health in adulthood. I explored also the age at which young people were most at risk of experiencing sexual force, noting that males are most at risk of assault in early life; whereas, females become increasingly at risk of assault as they age. Significant racial disparities existed in

the rates of assault among this population. Native American women and men, white women, and Black men reported some of the highest rates of sexual force; whereas, Asian men and women reported the lowest rates of assault. Further research is needed to explore the protective factors that might be buffering Asian youth from assault. Existing research suggests that differences in how masculinity is framed and praised would be a good starting point for further exploration (Finkelhor et al., 2013; Zhai & Gao, 2009). Sexual force, whether PFSF or NPSF, has long-term implications for individuals' levels of depression and self-reported health. Except for middle childhood, sexual force at any developmental stage was associated with significant long-term effects on health. Native Americans and Black men who had been sexually forced had significantly worse health outcomes than their peers, raising questions about the availability or stigma of support for these populations.

Returning to the findings from Studies 1 and 2, they further emphasize the need to talk to young people earlier about sexual consent and sexual violence, and to provide trauma-informed interventions for young people subjected to any form for sexual violence. These findings additionally suggest the need for exploration about the benefits of a combination of universal interventions and targeted interventions: that is, the availability of universal educational programs, such as those described by Scott and Elizabeth, which focus on conversation, role-playing scenarios, and small group settings. At the same time, we need greater insight into how particularly vulnerable populations, such as Native Americans and Black men, are being more greatly exposed to and more significantly harmed by sexual force, and we need targeted interventions to alleviate the disparities in the long term.

Healthy relationships matter. The navigation of relationships in adolescence has implications for health and well-being throughout the life-course. This dissertation explored three key elements that comprise young people's early experiences with romantic and sexual intimacy: how they think about and seek information about relationships; how they think about engaging in mutually pleasurable sexual activity; and the costs that sexual force has on their long-term well-being. This study highlighted the reality that there is no universal solution for young people as they begin to navigate relationships. Adolescents have different timing, different social demands, and face different challenges regarding romantic and sexual experiences. Some young people wanted contraception and relationship support in their early high school years, but others were not ready to hear such messages until near graduation. What was missing for all the students in this sample, however, was a feeling of efficacy and agency to navigate these challenges with the tools, skills, and internal models to inform them what healthy romantic and sexual relationships could look and feel like physically and emotionally. Elizabeth and Scott, the two participants who felt well-served by their sexuality education experiences, offer us a useful approach for considering the next steps of how comprehensive, workshop-based sexuality education programs might develop student capacity to: 1) drive conversations about romantic and sexual relationships; 2) explore their own wishes and hopes around these relationships; and 3) learn the emotional and relationship skills to navigate romantic and sexual challenges with a sense of efficacy.

Figures and Tables

Study 1 and 2

Table 1: Interview Recruitment Samples

Sample	Number	Female	Age	White	Black	Asian	Latino	<BA	BA	Masters+
High School Stress	17	11	18.5	7	3	6	1	1	5	11
Campus Social Norms	7	4	20.1	1	1	5	0	1	4	2
TOTAL	**24**	**15 62.5%**	**18.9**	**8 33.3%**	**4 16.6%**	**11 45.8%**	**1 4.1%**	**2 8.3%**	**9 37.5%**	**13 54.2%**

Table 2: Interview Participant Demographics and Education

Name	Sample	Race	Age	Household Income	Parent Education	H.S.	H.S. Location
Carol	HS Stress	white	18	$50,000-$100,000	Master's	Private	Colorado
Devon	HS Stress	Black	18	$150,000-$200,000	Bachelor's	Public	Illinois
Jesse	HS Stress	Latino	18	$100,000-$150,000	Master's	Public	Illinois
Eric	HS Stress	white	18	$50,000-$75,000	Bachelor's	Public	Indiana
Charles	HS Stress	Asian	18	$150,000-$200,000	Bachelor's	Public	Florida
Ingrid	HS Stress	Black	18	$50,000-$100,000	Professional	Public	United States
Will	HS Stress	Asian	18	$50,000-$100,000	Less than HS	Public	Connecticut
Lindsey	HS Stress	Asian	18	$250,000-$350,000	PhD	Public	New Jersey
Beth	HS Stress	Asian	21	$250,000-$350,000	Master's	Public	New York
Greg	HS Stress	white	19	$350,000-$500,000	Master's	Public	United States
Naomi	HS Stress	Asian	21	$100,000-$150,000	Bachelor's	Private	Chicago
Phoebe	HS Stress	white	18	$100,000-$150,000	Master's	Private	Minnesota
Mary	HS Stress	white	18	>$1,000,000	Professional	Public	New York
Gabby	HS Stress	white	18	>$1,000,000	Professional	Public	Illinois
Uma	HS Stress	Asian	18	$100,000-$150,000	Bachelor's	Public	Thailand
Elizabeth	HS Stress	Black	18	< $50,000	Master's	Private	Massachusetts
Teresa	HS Stress	White	19	>$1,000,000	Master's	Public	Alabama
Chelsea	Soc. Norms	Asian	20	$150,000-$250,000	Bachelor's	Public	New Jersey
Stephanie	Soc. Norms	Asian	20	$50,000-$75,000	Bachelor's	Public	China
Scott	Soc. Norms	white	21	>$1,000,000	Masters	Private	California
Sahar	Soc. Norms	Asian	20	>$1,000,000	Professional	Private	Minnesota
Shawn	Soc. Norms	Black	21	$150,000-$200,000	Bachelor's	Public	California
Jason	Soc. Norms	Asian	20	< $50,000	Bachelor's	Public	Illinois
Dana	Soc. Norms	Asian	20	$50-$100,000	High School	Public	New York

Study 3

Table 3: Add Health Waves of Data

	Wave 1	Wave 2	Wave 3	Wave 4
Year	1994-1995	1996	2001	2008
Participant Age Range	11-20	13-22	18-27	25-34
Measures				
Sexual Force				• Physical Sexual Force • Age Physical Sexual Force • Non-Physical Sexual Force • Age Non-Physical Sexual Force
Other Relationship Violence				• Parent sexual Abuse • Current physical abuse • Current partner sexual force
Demographic Controls	• Biological Sex • Race • Parent Education			• Sexual Identity
Health Measures	• CES-D • General Health • Height • Weight			• CES-D • General Health • Systolic blood pressure • Diastolic Blood Pressure • Total Cholesterol • Body Mass Index • Waist Circumference • HbA1c • High-sensitivity C-reactive protein

Table 4: Descriptive information on Full study sample, Allostatic Load Sample

	Full Sample (N=14,631)		Allostatic Load Sample (N=112,063)	
	Mean (or %)	SD	Mean (or %)	SD
Allostatic Load	2.08	1.70	2.09	1.70
Female (percent)	53%	0.50	53%	0.50
Racial Ethnic Identity (percent)				
white	53.67	0.50	55.23	0.50
Black	21.86	0.41	20.54	0.40
Hispanic	15.11	0.36	14.66	0.35
Asian	6.43	0.25	6.60	0.25
Native American	2.04	0.14	2.11	0.14
Other	0.89	0.09	0.85	0.09
Parent Education (percent)	2.96	1.24	2.96	1.23
Less than HS	11.86	0.32	11.55	.32
HS Diploma	30.05	0.46	30.35	.46
Some College	21.65	0.41	21.85	.41
College Degree	23.30	.42	23.42	.42
More than College	13.14	.34	12.83	.33
LGBTQ				
100% Heterosexual	86.32	.34	85.90	.35
Mostly Heterosexual	9.97	.30	10.04	.30
Bisexual	1.53	.12	1.52	.12
Mostly Homosexual	0.86	.09	0.91	.10
100% Homosexual	1.29	.11	1.37	.12
Physical Sexual Force (PFSF)	.08	.27	.08	.28
Age First Physical Sexual Force	15.51	6.12	15.56	6.13
PFSF by Developmental Stage (percent)				
PFSF Early Childhood	2.84	.17	2.67	.16
PFSF School Aged	7.73	.27	8.12	.27
PFSF Late Childhood	8.93	.29	8.81	.28
PFSF Pre-Adolescence	7.39	.26	7.03	.26
PFSF Early Adolescence	17.96	.38	17.82	.38
PFSF Late Adolescence	24.31	.43	24.75	.43
PFSF Young Adulthood	25.95	.44	25.35	.44
PFSF Adulthood	4.90	.21	5.45	.23
Non-Physical Sexual Force (NPSF)	.12	. 32	.13	.33
Age First Physical Sexual Force	16.41	6.02	16.41	6.04
NPSF by Developmental Stage (percent)				
NPSF Early Childhood	2.22	.15	2.30	.15
NPSF School Aged	6.73	.25	7.09	.26
NPSF Late Childhood	6.45	.25	6.23	.24
NPSF Pre Adolescence	5.99	.24	5.64	.23
NPSF Early Adolescence	16.89	.37	16.34	.37
NPSF Late Adolescence	24.93	.43	25.98	.44
NPSF Young Adulthood	30.69	.46	30.18	.46
NPSF Adulthood	6.10	.24	6.23	.24
Enough Sleep Wave 1	.71	.45	.71	.45
Depression W1	2.85	2.70	2.87	2.72
Depression W4	2.59	2.54	2.60	2.57
General Health W1	2.11	.91	2.12	.91
General Health W4	2.33	.91	2.35	.91
Obese W1	22.61	4.52	22.58	4.42

Table 5: Correlations of Main Variables

		1	2	3	4	5	6	7	8	9	10	11
1	AL											
2	Female	-0.115***										
3	Race Group	0.052	-0.008									
4	Parent Education	-0.103	0.027	0.073***								
5	PFSF	-0.006	0.219***	-0.018*	-0.026*							
6	NPSF	-0.032***	0.255***	-0.046***	0.001	-0.581***						
7	Depression W1	0.015	0.158***	0.074***	-0.101***	0.121***	0.117***					
8	Depression W4	0.032***	0.113***	0.044***	-0.097***	0.161***	0.154***	0.261***				
9	General Health W1	0.120***	0.100***	0.055***	-0.127***	0.069***	0.073***	0.221***	0.104***			
10	General Health W4	0.293***	0.0434***	0.069***	-0.146***	0.0911***	0.075***	0.140***	0.237***	0.276***		
11	Stress W4	-0.058***	0.0445***	-0.006	0.065***	0.009	0.022*	0.014	-0.017	-0.023*	0.028**	
12	BMI W1	0.487***	-0.063***	0.056***	-0.092***	0.017	-0.014	0.053***	0.046***	0.213***	0.223***	-0.030**

* p<.05 ** p<.01 ***p<.001

Figure 1: Frequency of First NPSF by Developmental Stage by Gender

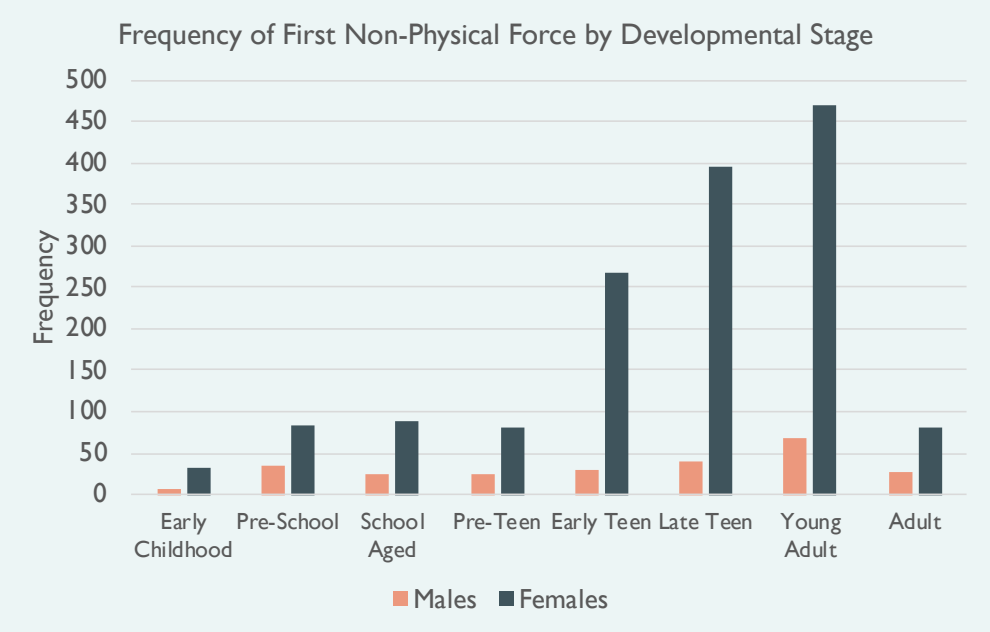

Figure 2: Percent of First NPSF by Developmental Stage by Gender

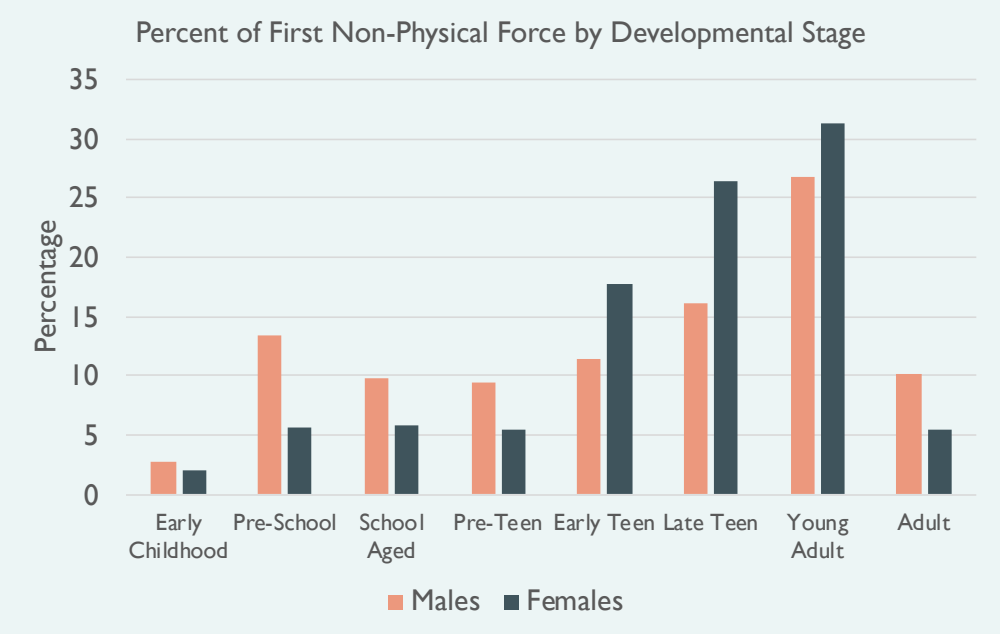

Figure 3: Frequency of First PFSF by Developmental Stage by Gender

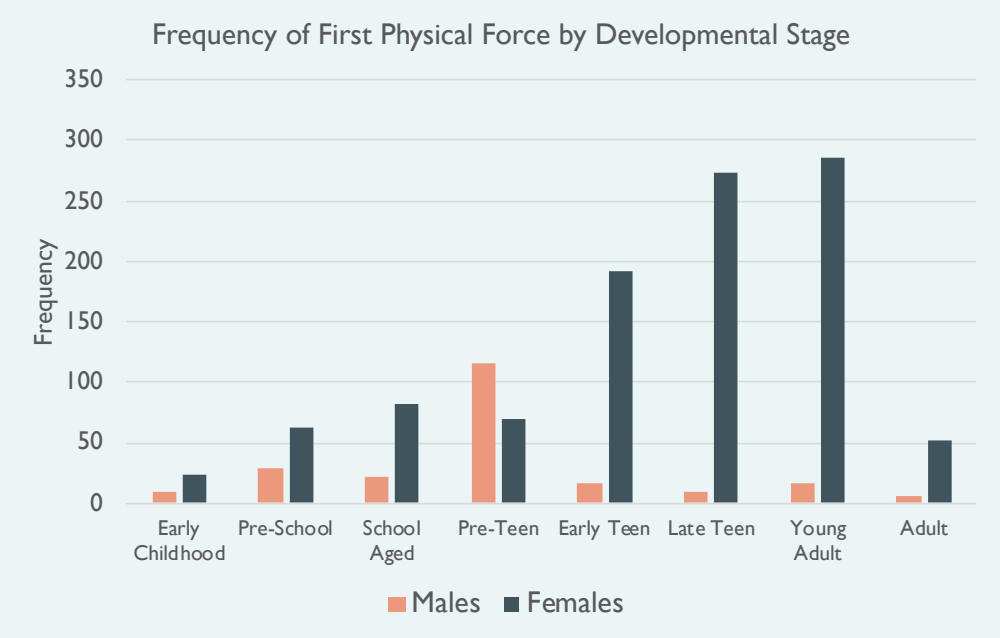

Figure 4: Percentage of First PFSF by Developmental Stage by Gender

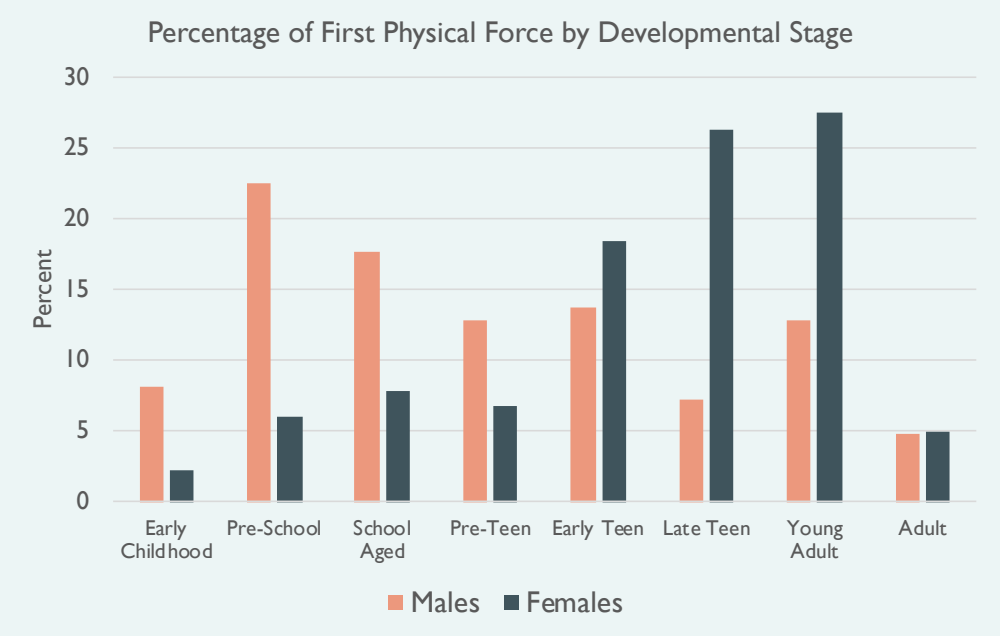

Figure 5: Physical and Non-Physical Sexual Force Among Females by Race

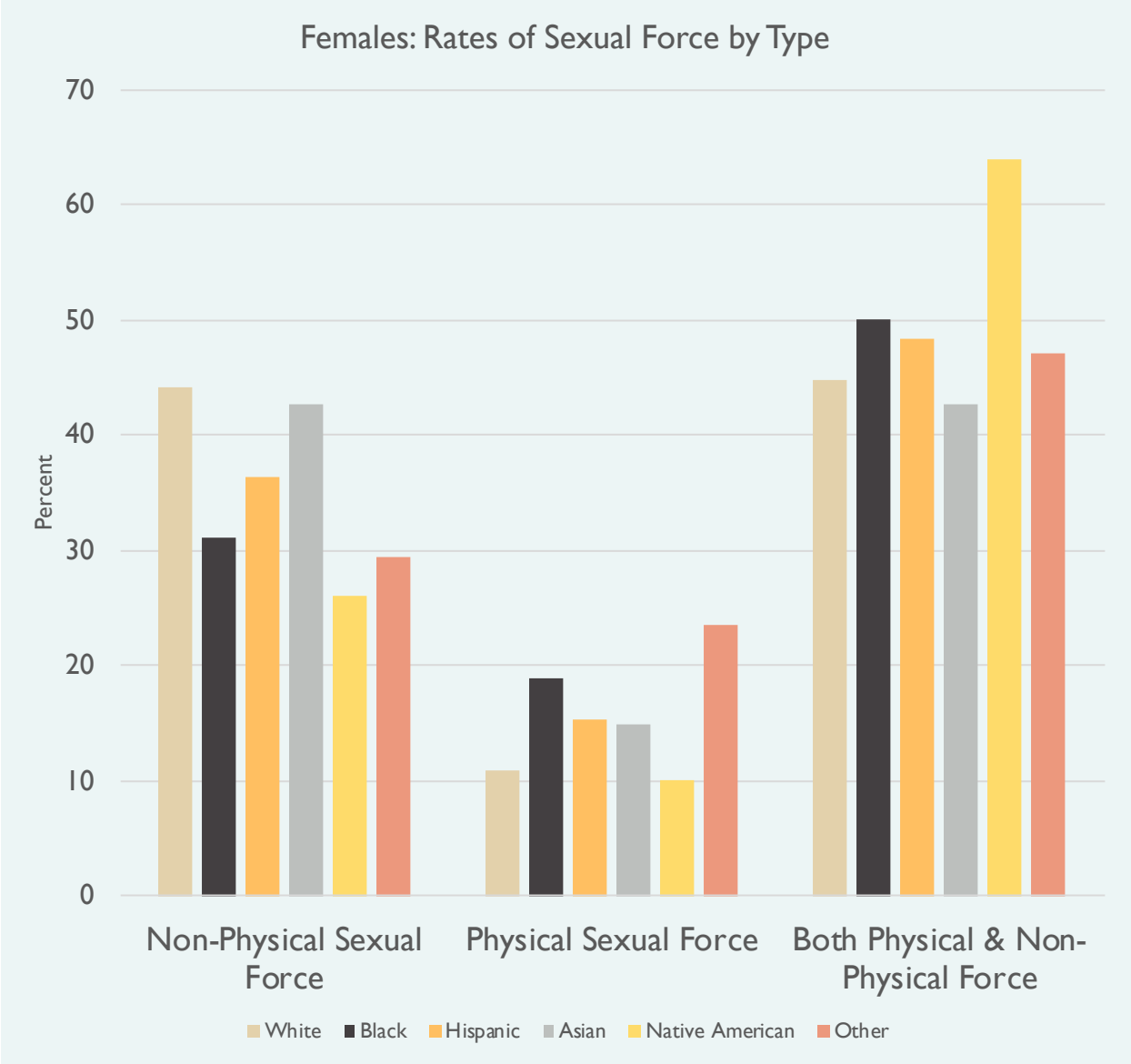

Figure 6: Physical and Non-Physical Sexual Force Among Males by Race

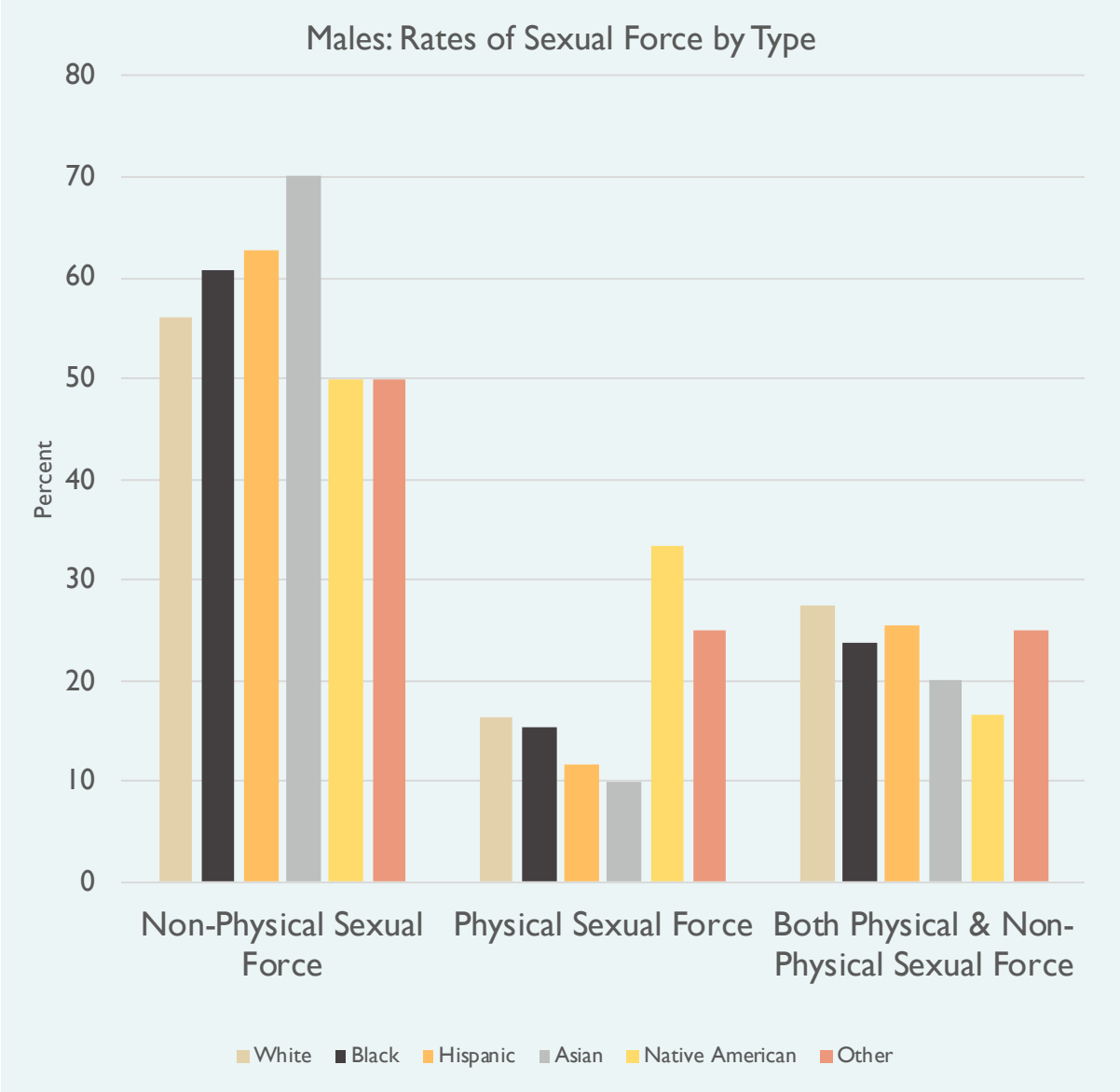

Table 6: Rates and Ages of First Sexual Force by Race and Gender

	Racial Group	PFSF				NPSF				BSF	
		%	SD	Age	SD	%	SD	Age	SD	%	SD
Male	white (N=3932)	01.78%	.13	10.6	6.52	03.38%	.18	15.4	7.62	01.09%	.13
	Black (N=1465)	02.46%	.16	13.6	7.63	05.26%	.22	16.5	6.65	01.50%	.12
	Hispanic (N=1099)	01.82%	.13	9.4	4.73	04.19%	.20	14.37	7.40	01.28%	.11
	Asian (N=529)	00.75%	.09	2.3	2.50	02.08%	.14	12.45	8.08	0.57%	.08
	Native American (N=234)	03.80%	.19	12.0	8.67	05.13%	.22	15.25	7.89	02.56%	.16
Female	white (N=4358)	15.10%	.36	15.8	5.56	23.61%	.42	16.5	5.42	12.28%	.33
	Black (N=1882)	13.97%	.35	15.9	5.88	16.32%	.37	16.1	6.10	10.21%	.30
	Hispanic (N=1184)	10.73%	.31	16.2	6.70	13.86%	.35	16.8	6.62	8.03%	.27
	Asian (N=516)	06.59%	.25	16.1	6.20	10.47%	.31	17.4	5.54	4.65%	.21
	Native American (N=383)	18.48%	.39	16.7	5.96	24.09%	.43	15.2	7.22	15.51%	.36

Table 7: Rates and Ages of First Sexual Assault by Gender and LGBTQ Identity

LGBTQ		PFSF				NPSF				BSF	
		%	SD	Age	SD	%	SD	Age	SD	%	SD
Male	100% Heterosexual (N=6791)	1.58%	.12	10.6	6.76	03.39%	.18	15.3	7.35	0.99%	.10
	Mostly Heterosexual (N=245)	5.71%	.23	11.4	8.28	09.4%	.29	14.6	8.3	2.86%	.17
	Bisexual (N=53)	13.2%	.34	9.4	6.70	16.98%	.38	12.0	6.76	9.43%	.30
	Mostly Homosexual (N=58)	10.34%	.31	17.3	5.99	15.52%	.37	15.7	6.58	8.62%	2.83
	100% Homosexual (N=131)	3.82%	.19	14.4	9.13	7.63%	.27	18.6	7.44	3.05%	.17
Female	100% Heterosexual (N=6631)	11.66%	.32	16.0	5.86	16.83%	.37	16.7	5.72	8.99%	.29
	Mostly Heterosexual (N=1279)	21.81%	.41	15.9	5.34	31.74%	.47	16.1	5.53	17.83%	.38
	Bisexual (N=195)	32.31%	.47	15.5	6.2	38.97%	.49	14.9	6.66	28.72%	.45
	Mostly Homosexual (N=72)	23.61%	.43	14.5	7.1	31.94%	.47	15.1	7.90	16.67%	.38
	100% Homosexual (N=77)	18.18%	.39	14.5	6.62	19.48%	.40	13.0	4.80	10.39%	.31

Table 8: Regression Results NPSF PFSF and Force Groups Predicting Depressive Symptoms

	MODEL 1			MODEL 2			MODEL 3		
				NPSF					
	b	t	p	b	t	p	b	t	p
Female	0.052	3.080	0.002	0.056	3.320	0.001	0.065	3.680	0.000
white	-0.170	-9.000	0.000	-0.155	-8.210	0.000	-0.154	-8.140	0.000
Parent Education	-0.046	-6.710	0.000	-0.043	-6.330	0.000	-0.043	-6.340	0.000
General Health Wave 1	0.026	3.070	0.002	0.025	2.900	0.004	0.024	2.870	0.004
Depression Wave 1	0.215	24.370	0.000	0.211	23.960	0.000	0.211	24.010	0.000
Enough Sleep	-0.060	-3.150	0.002	-0.057	-3.010	0.003	-0.057	-3.010	0.003
Obese Wave 1	0.044	1.360	0.173	0.046	1.450	0.147	0.046	1.460	0.144
LGBTQ	0.111	8.940	0.000	0.104	8.450	0.000	0.104	8.460	0.000
Parent Sexual Abuse				0.246	6.720	0.000	0.246	6.710	0.000
Current Abuse				0.328	9.330	0.000	0.324	9.220	0.000
NPSF	0.321	3.080	0.002	0.271	10.340	0.000	0.371	6.130	0.000
NFSF X Female							-0.122	-1.840	0.066
				PFSF					
Female	0.056	3.340	0.001	0.058	3.470	0.001	0.062	3.640	0.000
white	-0.160	-8.490	0.000	-0.146	-7.760	0.000	-0.145	-7.720	0.000
Parent Education	-0.042	-6.200	0.000	-0.040	-5.900	0.000	-0.040	-5.890	0.000
General Health Wave 1	0.027	3.140	0.002	0.025	2.950	0.003	0.025	2.950	0.003
Depression Wave 1	0.213	24.160	0.000	0.209	23.730	0.000	0.209	23.750	0.000
Enough Sleep	-0.067	-3.530	0.000	-0.063	-3.340	0.001	-0.063	-3.340	0.001
Obese Wave 1	0.042	1.300	0.193	0.044	1.400	0.163	0.045	1.400	0.160
LGBTQ	0.109	8.840	0.000	0.103	8.340	0.000	0.103	8.330	0.000
Parent Sexual Abuse				0.237	6.480	0.000	0.236	6.450	0.000
Current Abuse				0.338	9.660	0.000	0.337	9.640	0.000
PFSF	0.424	0.000	0.363	0.374	11.920	0.000	0.473	5.560	0.000
PFSF X Female							-0.114	-1.250	0.212
				Force Group					
Female	0.039	2.280	0.023	0.045	2.620	0.009			
white	-0.165	-8.750	0.000	-0.151	-8.000	0.000			
Parent Education	-0.044	-6.430	0.000	-0.041	-6.100	0.000			
General Health Wave 1	0.025	2.940	0.003	0.024	2.800	0.005			
Depression Wave 1	0.212	24.010	0.000	0.208	23.630	0.000			
Enough Sleep	-0.064	-3.360	0.001	-0.061	-3.210	0.001			
Obese Wave 1	0.043	1.350	0.179	0.045	1.430	0.154			
LGBTQ	0.106	8.560	0.000	0.100	8.140	0.000			
Parent Sexual Abuse				0.225	6.120	0.000			
Current Abuse				0.323	9.220	0.000			
NPSF	0.207	5.980	0.000	0.163	4.700	0.000			
PFSF	0.382	6.160	0.000	0.339	5.490	0.000			
BSF	0.465	13.270	0.000	0.410	11.620	0.000			

Table 9: Regression Results Developmental Stage of Assault Predicting Depressive Symptoms

	NPSF			PFSF			BSF		
	b	t	p	b	t	p	b	t	p
Female	0.094	5.630	0.000	0.095	5.730	0.000	0.064	3.790	0.000
white	-0.164	-8.650	0.000	-0.162	-8.530	0.000	-0.163	-8.610	0.000
Parent Education	-0.045	-6.580	0.000	-0.044	-6.450	0.000	-0.043	-6.330	0.000
General HealthW1	0.030	3.520	0.000	0.031	3.580	0.000	0.027	3.200	0.001
Depression W1	0.223	25.130	0.000	0.222	25.060	0.000	0.215	24.310	0.000
Enough Sleep	-0.060	-3.150	0.002	-0.062	-3.220	0.001	-0.068	-3.550	0.000
ObeseW1	0.042	1.310	0.190	0.040	1.240	0.215	0.039	1.230	0.218
LGBTQ	0.119	9.540	0.000	0.121	9.680	0.000	0.113	9.110	0.000
Early Childhood	0.301	1.030	0.304				1.152	5.170	0.000
Middle Childhood	0.032	0.200	0.845	0.194	0.800	0.427	0.256	2.060	0.039
Late Childhood	0.231	1.460	0.143	0.608	3.620	0.000	0.074	0.590	0.553
Pre-Adolescence	0.601	3.710	0.000	0.027	0.120	0.903	0.416	3.490	0.000
Early Adolescence	0.015	0.180	0.855	0.724	4.790	0.000	0.410	5.270	0.000
Late Adolescence	0.124	1.920	0.055	0.248	1.960	0.051	0.450	6.990	0.000
Young Adulthood	0.140	2.420	0.015	0.268	2.130	0.034	0.457	6.940	0.000
Adulthood	0.314	2.580	0.010	-0.151	-0.570	0.567	0.710	4.870	0.000

Table 10: Regression Results Type of Force Predicting General Health

	MODEL 1			MODEL 2			MODEL 3		
NPSF									
	b	t	p	b	t	p	b	t	p
Female	-0.030	-1.800	0.071	-0.032	-1.920	0.055	0.021	0.250	0.806
white	-0.126	-6.710	0.000	-0.120	-6.390	0.000	-0.046	-2.680	0.007
Parent Education	-0.078	-11.610	0.000	-0.077	-11.330	0.000	-0.118	-6.310	0.000
General Health Wave 1	0.226	26.670	0.000	0.225	26.570	0.000	-0.075	-11.160	0.000
Depression Wave 1	0.083	9.480	0.000	0.081	9.270	0.000	0.225	26.520	0.000
Enough Sleep	0.036	1.930	0.053	0.038	2.020	0.043	0.078	8.980	0.000
Obese Wave 1	0.311	9.840	0.000	0.313	9.900	0.000	0.035	1.870	0.062
LGBTQ	0.030	2.480	0.013	0.026	2.100	0.036	0.312	9.880	0.000
Parent Sexual Abuse				0.197	5.420	0.000	0.024	1.940	0.052
Current Abuse				0.089	2.540	0.011	0.186	5.090	0.000
NPSF	0.137	5.350	0.000	0.111	4.280	0.000	0.088	2.520	0.012
NPSF X Female							0.025	0.820	0.413
PFSF									
Female	-0.035	-2.080	0.038	-0.037	-2.230	0.026	-0.044	-2.590	0.010
white	-0.121	-6.490	0.000	-0.116	-6.210	0.000	-0.117	-6.280	0.000
Parent Education	-0.077	-11.350	0.000	-0.075	-11.130	0.000	-0.075	-11.140	0.000
General Health Wave 1	0.226	26.670	0.000	0.225	26.560	0.000	0.225	26.560	0.000
Depression Wave 1	0.081	9.250	0.000	0.079	9.050	0.000	0.079	9.000	0.000
Enough Sleep	0.033	1.740	0.081	0.035	1.860	0.063	0.035	1.850	0.064
Obese Wave 1	0.310	9.820	0.000	0.312	9.890	0.000	0.311	9.870	0.000
LGBTQ	0.028	2.310	0.021	0.024	1.950	0.052	0.024	1.970	0.049
Parent Sexual Abuse				0.186	5.100	0.000	0.188	5.160	0.000
Current Abuse				0.089	2.560	0.011	0.090	2.600	0.009
PFSF	0.234	7.580	0.000	0.207	6.630	0.000	0.037	0.440	0.659
PFSF X Female							0.195	2.160	0.031
Force Group									
Female	-0.039	-2.290	0.022	-0.040	-2.340	0.019			
white	-0.122	-6.540	0.000	-0.117	-6.250	0.000			
Parent Education	-0.077	-11.400	0.000	-0.075	-11.150	0.000			
General Health Wave 1	0.226	26.610	0.000	0.225	26.520	0.000			
Depression Wave 1	0.080	9.210	0.000	0.079	9.020	0.000			
Enough Sleep	0.034	1.780	0.075	0.035	1.880	0.061			
Obese Wave 1	0.310	9.830	0.000	0.312	9.890	0.000			
LGBTQ	0.027	2.240	0.025	0.023	1.910	0.056			
Parent Sexual Abuse				0.183	5.030	0.000			
Current Abuse				0.086	2.480	0.013			
NPSF	0.048	1.410	0.160	0.028	0.800	0.425			
PFSF	0.222	3.620	0.000	0.196	3.190	0.001			
BSF	0.244	7.030	0.000	0.214	6.100	0.000			

Table 11: Regression Results Developmental Stage of Assault Adult General Health

	NPSF			PFSF			BSF		
	b	t	p	b	t	p	b	t	p
Female	-0.008	-0.500	0.615	-0.015	-0.940	0.347	-0.028	-1.680	0.093
white	-0.123	-6.570	0.000	-0.123	-6.560	0.000	-0.124	-6.650	0.000
Parent Education	-0.077	-11.370	0.000	-0.078	-11.540	0.000	-0.077	-11.330	0.000
General HealthW1	0.229	26.940	0.000	0.229	27.000	0.000	0.226	26.700	0.000
DepressionW1	0.086	9.860	0.000	0.086	9.840	0.000	0.081	9.300	0.000
Enough Sleep	0.035	1.860	0.062	0.037	1.930	0.053	0.033	1.760	0.078
ObeseW1	0.309	9.780	0.000	0.309	9.750	0.000	0.312	9.870	0.000
LGBTQ	0.033	2.710	0.007	0.034	2.800	0.005	0.030	2.490	0.013
Early Childhood	0.108	0.370	0.709	-0.073	-0.300	0.761	0.012	0.050	0.957
Middle Childhood	0.442	2.780	0.005	0.366	2.210	0.027	0.473	3.860	0.000
Late Childhood	0.088	0.570	0.570	-0.088	-0.400	0.686	0.179	1.450	0.148
Pre-Adolescence	-0.020	-0.130	0.899	0.391	2.620	0.009	0.091	0.780	0.438
Early Adolescence	-0.133	-1.700	0.089	0.025	0.200	0.845	0.266	3.460	0.001
Late Adolescence	0.113	1.770	0.078	0.436	3.520	0.000	0.279	4.390	0.000
Young Adulthood	-0.054	-0.950	0.344	0.229	0.880	0.380	0.178	2.730	0.006
Adulthood	0.063	0.520	0.600	-0.015	-0.940	0.347	0.155	1.080	0.282

Table 12: Regression Results Sexual Force Predicting Adult Allostatic Load

	MODEL 1			MODEL 2			MODEL 3		
Non-Physical Force									
	b	t	p	b	t	p	b	t	p
Female	-0.087	-4.610	0.000	-0.082	-4.360	0.000	-0.086	-4.450	0.000
white	-0.108	-5.120	0.000	-0.108	-5.100	0.000	-0.108	-5.130	0.000
Parent Education	-0.058	-7.680	0.000	-0.059	-7.810	0.000	-0.059	-7.800	0.000
General Health Wave 1	0.079	8.400	0.000	0.080	8.450	0.000	0.080	8.470	0.000
Depression Wave 1	0.000	0.040	0.966	0.000	0.030	0.973	0.000	0.000	1.000
Enough Sleep	0.099	4.760	0.000	0.099	4.730	0.000	0.099	4.730	0.000
Obese Wave 1	1.053	29.280	0.000	1.053	29.280	0.000	1.052	29.260	0.000
LGBTQ	-0.003	-0.200	0.840	0.000	-0.030	0.973	0.000	-0.030	0.975
Parent Sexual Abuse				-0.117	-2.920	0.003	-0.116	-2.910	0.004
Current Abuse				0.031	0.800	0.424	0.033	0.850	0.398
NPSF	-0.015	-0.540	0.586	-0.005	-0.190	0.849	-0.064	-0.910	0.361
NFSF X Female							0.070	0.920	0.360
Physical Force									
Female	-0.085	-4.580	0.000	-0.080	-4.300	0.000	-0.081	-4.300	0.000
white	-0.108	-5.150	0.000	-0.108	-5.120	0.000	-0.108	-5.120	0.000
Parent Education	-0.058	-7.710	0.000	-0.059	-7.830	0.000	-0.059	-7.830	0.000
General Health Wave 1	0.079	8.430	0.000	0.080	8.470	0.000	0.080	8.470	0.000
Depression Wave 1	0.001	0.100	0.924	0.001	0.080	0.935	0.001	0.080	0.939
Enough Sleep	0.100	4.790	0.000	0.099	4.750	0.000	0.099	4.750	0.000
Obese Wave 1	1.053	29.290	0.000	1.053	29.290	0.000	1.052	29.280	0.000
LGBTQ	-0.002	-0.160	0.874	0.000	0.000	0.996	0.000	0.010	0.989
Parent Sexual Abuse				-0.114	-2.850	0.004	-0.113	-2.840	0.005
Current Abuse				0.033	0.840	0.403	0.033	0.850	0.398
PFSF	-0.037	-1.090	0.274	-0.026	-0.760	0.447	-0.059	-0.620	0.537
PFSF X Female							0.037	0.370	0.712

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