

Adolescent Sexual Competence: A Paradigm Shift

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ABSTRACT. Data from the National Longitudinal Study of Adolescent Health were analyzed comparing the constructs of sexual intercourse and sexual competence using various background characteristics. Forty-two percent of the youth had experienced sexual intercourse during the previous year. Of these, the level of sexual competence was high (Mean = 5.36 on a scale that ranged from 0 to 7). Significant independent effects were found for gender and race in relation to sexual competence and for age, race, family structure, and parental education in relation to sexual intercourse. Both being a male and being black were associated with lower levels of sexual competence; whereas, being older, black, from a single-parent household, and having parents with lower levels of education were all associated with having had sexual intercourse. Findings illustrate the importance of considering sexual competence when investigating adolescent sexuality.

The purpose of this article is to examine the construct of sexual competence in order to facilitate research on adolescent sexual development and sexual health. The analysis takes a developmental perspective by focusing on the long-term goal of adolescents becoming sexually healthy adults rather than focusing solely on the problematic aspects of youth sexuality. This perspective invokes a paradigm that attempts to shape healthy development rather than focus primarily on attempting to control youth sexual behavior. Data from the National Longitudinal Study of Adolescent Health (Add Health) is examined to present information from two different approaches to investigating adolescent sexual behavior: using a more pervasive, problem-oriented approach, we examine differences between sexually abstinent and sexually experienced adolescents, and using a competence approach that focuses on sexual development and health, we examine the sexual competence of youth who are sexually experienced. We want to forward a conceptualization and operationalization of the construct of “sexual competence” by reviewing literature related to risk and competence, suggesting aspects of sexual behavior that should be considered competent, and providing information about sexual competence among adolescents in the U.S.

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Perspectives on Adolescent Sexuality

Problem-Oriented Approach

Although adolescent sexual behavior was sometimes characterized as an epidemic in the 1990s (Rodgers & Rowe, 1990, 1993; Rodgers, Rowe, & Buster, 1998; Rowe & Rodgers, 1994), the prevalence of sexual intercourse among adolescents actually declined, and the use of condoms among sexually-active teens has increased (Santelli, Lindberg, Abma, McNeely, & Resnick, 2000). Udry (1998) noted that “adolescent sexual behavior always is included in the list of ‘problem behaviors’ or ‘risk behavior’ of adolescence, although it is considered normal and acceptable behavior among adults” (p. 241). One consequence of this problem-oriented approach is that much of what has been learned about teen sexuality is based on the minority of youth who have experienced negative developmental or health outcomes. Another consequence is that the findings characterize adolescence as a period in which “sexuality is particularly dangerous and disturbing” (Chilman, 1990, p. 123).

One study that examined the family’s role in ethnic minority Miller (1999) found that parental monitoring was associated with less sexual activity. The author concluded that “considerable importance has been ascribed to [parental] monitoring in the management of adolescent sexual behavior and in the prevention of other problem behaviors during adolescence that have been found to relate to increased sexual risk-taking (p. 95). This apparently reflects a belief that being sexually active is inherently problematic and suggests that the best management of adolescent sexual behavior is preventing it.

Although it is important to know the rate of sexual intercourse and its familial and social correlates, research that uses only this perspective to guide hypotheses and shape research questions neglects learning about the process of healthy sexual development. For example, Gross (Gross, 2000) found that parental monitoring did not differentiate between sexually-active adolescents who engaged in sexual risk-taking and those sexually active youth who engaged in sexually-responsible behaviors. Although parental monitoring differentiates between sexually-active and abstaining youth, the influence of parental monitoring seems more limited when considering long-term sexual health and development.

Competence-Oriented Approach

A competence approach to adolescent sexuality focuses on how sexually-abstinent youth become sexually active in a responsible manner and how sexually-active youth engage in sexually-responsible behavior rather than behaviors that increase their risk to negative experiences and developmental outcomes. From this perspective, adolescent sexual behavior is characterized as a part of adolescent development, that like other developmental components, has the potential to result in a range of outcomes that vary from negative to positive. This perspective also involves a focus on sexual health rather than a sole focus on sexual behavior that involves two attributes – the prevalence or absence of intercourse.

Bedworth and Bedworth (1992) define health as the “quality of people’s physical, psychological, and sociological functioning that enables them to deal adequately with the self

and others in a variety of social situations” (p. 11). Based on this general definition of health, The World Health Organization (World Health Organization, 1992) defines sexual health as the “integration of the physical, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love” (p. 2).

Defined in this manner, sexual health is viewed as one aspect of an individual’s personal development. Furthermore, by becoming a sexually healthy individual a person is meeting societal expectations. That is, by not engaging in sexual risk-taking behaviors, an adolescent, and later on an adult, meets societal expectations (i.e., being sexually responsible). Aspects of personal development and meeting societal expectations both are related to social competence, a concept that is used to indicate overall psychosocial adjustment (Garmezy, Masten, & Tellegen, 1984; Masterpasqua, 1989; Zigler & Trickett, 1978).

Social competence is one dimension of the multi-dimensional construct of competence. Masten and her colleagues defined competence as “a pattern of effective performance in the environment, evaluated from the perspective of salient development tasks in the context of late twentieth-century U.S. society” (1995, p.1636). For children and adolescents the dimensions of competence often are conceptualized as major developmental tasks, such as academic achievement and peer social competence and are measured using behavioral indicators. A dimension of competence relevant to older adolescents is romantic competence (Masten et al., 1995). In Masten’s study, romantic competence included both the relationship dynamics and the sexual aspects of romantic relationships. Responsible sexual behavior was one indicator of romantic competence. Because we focus only on sexual behaviors, we use the term sexual competence (rather than romantic competence) to refer to the dimension of competence examined in this study. Thus, an adolescent who is said to be sexually competent would be one who, from the perspective of early twenty first-century U.S. society, engages in responsible sexual behavior.

Operationally, this construct is measured by examining sexual behaviors that differentiate between sexually-active adolescents who are sexually responsible and those who do not behave responsibly. We conceive of those who are sexually responsible as being sexually competent and those who are not as sexual risk-takers. Sexual risk-taking is indicated by multiple sexual partners, joint occurrences of alcohol use and sexual intercourse, and the nonuse or inconsistent use of contraceptives. On a continuum, this variable ranges from sexual risk-taking to sexual competence; consequently, adolescents who are low in sexual competence are adolescents who engage in sexual risk-taking behaviors.

This conceptualization is consistent with Stoiber and Good’s (1998) conceptualization of risk-taking behavior. They defined adolescent problem or risk-taking behaviors as “those activities or behaviors that are detrimental to the health and well-being of youth” (p. 380). Based on this definition, we conceptualized sexual risk-taking behaviors as *those behaviors that increase an adolescent’s risk for HIV infection, other STDs, and unintended pregnancy*. Inherently, simply being sexually active with another person puts one at risk for negative outcomes; however, there are certain behaviors that increase this risk. In the current study, these behaviors include (a) inconsistent contraceptive use, (b) having anal intercourse, (c) having casual sex, (d) alcohol use in connection with sexual intercourse, (e) intoxication in connection with sexual intercourse, (f) drug use in connection with sexual intercourse, (g) having sexual intercourse for money or drugs, and (h) having sexual intercourse with more than one partner (Buzwell & Rosenthal, 1996;

Gillmore, Butler, Lohr, & Gilchrist, 1992; Luster & Small, 1994; Metzler, Noell, & Biglan, 1992).

Admittedly, some of these behaviors are more “risky” than others; however, for the purposes of this study the amount of risk associated with each behavior is equal. Because our intention here is to examine patterns of behavior that represent sexual competence or sexual risk-taking, weighting responses based on the severity of risk is premature methodologically. A major purpose of this investigation is to examine the concept of sexual competence using a representative sample of sexually active youth in the United States.

Methods

Data

The focus of the Add Health project was to investigate the antecedents of adolescent health-related behaviors within a social context. The study began with a nationally representative sample of adolescents in grades 7 through 12 in the United States between April and December 1995 (Wave I). Youth were interviewed again between April and August 1996 (Wave II). The primary sampling frame was all high schools in the U.S. that had an 11th grade and at least 30 students ($N = 26,666$). From this a “systematic random sample of 80 high schools was selected proportional to enrollment size, stratified by region, urbanicity, school type, and percentage white” (Resnick et al., 1997, p. 824). More than 70% of the originally selected schools agreed to participate. When available, one feeder school (i.e., middle school or junior high) for each selected high school also was selected with probability proportional to its student contribution to the high school.

Ninety percent of all students enrolled in the selected schools participated in the in-school phase of the survey. Once the in-school data were collected, all students who completed a questionnaire and those who did not complete a questionnaire but who were listed on a school roster were eligible for selection into the core in-home sample. A random sample of 16,000 students was selected for the in-home interview. Approximately 200 students from each school pair were selected, creating a self-weighted sample (Bearman, Jones, & Udry, 1997). A parent of each adolescent was interviewed with 85% of the parents participating in the survey.

Adolescents who were in grades 7 to 11 at Wave 1, 88% of the original in-home sample, were selected to participate in Wave 2. The 88% also included individuals who were part of a sibling pair (i.e., genetic sample) but who were not originally in grades 7 to 11. Additional information about the Add Health study can be found in Bearman, Jones, and Udry (1997), Udry and Bearman (1998), or Kelly and Peterson (1997).

Analytic Sample

Our analyses were based on two subsamples taken from the public use version of the study. This version of Add Health contains approximately half of the core sample (Bearman et al., 1997). One subsample (SXC), used for the sexual competence analyses, consists of those adolescents who reported having had sexual intercourse by Wave 2 data collection and who reported having sexual intercourse during the year prior to their second interview (i.e., Wave 2) ($n = 1525$). This selection was based on an item from the Wave 2 contraception section that asked adolescents about birth control use in the past 12 months. If an adolescent had reported that they had had sexual intercourse at Wave 2, they were asked a series of questions related to

the use of contraception; otherwise, they were skipped out of the section. Based on the series of skip patterns in this section, it was determined that those adolescents who answered this item experienced their most recent intercourse after the time of their last interview. Additional selection criteria included eliminating those youth for whom information was missing for gender or ethnicity, married adolescents, and adolescents under the age of 13 at Wave 2 because relevant contraceptive questions were not asked of youth 12 and under.

A second subsample, used only for sexual intercourse (SXI) analyses, consists of those adolescents who participated in Wave 2, eliminating only those youth for whom information was missing for gender or ethnicity, married adolescents, and adolescents under the age of 13 ($n = 4447$). By definition, these samples are not mutually exclusive because all of the youth in the sexually active group in which competence can be examined (SXC) also are included in the subsample that is used to examine whether or not the youth has experienced sexual intercourse (SXI).

Measures

Two dependent variables were used in this study. The first, sexual competence, is measured by summing the number of sexual behaviors or behaviors related to sexual intercourse (e.g., contraceptive use) that an adolescent has or has not engaged in that are identified as decreasing the risk for pregnancy or contracting HIV or other STDs. In total, the sexual competence scale was constructed from 24 items that asked adolescents about their sexual behaviors (see Table 1 for items used to measure each behavior). For seven different behavioral indicators, adolescents were scored 0 to indicate sexual risk-taking and 1 to indicate sexual competence, forming a scale that ranged from 0 (high sexual risk-taking) to 7 (high sexual competence). Reports of: (a) not drinking or being intoxicated at first or most recent intercourse, (b) not using drugs at first or most recent intercourse, (c) not engaging in anal sex, (d) using birth control all of the time, (e) not having sex for money or drugs, (f) not having casual sex, and (g) having had only one sexual partner were each scored as 1. Reports of these behaviors were taken from Wave 2. Preliminary analyses illustrated that although the distribution was negatively skewed (-.73), there was no serious violation of the normality assumption (Huck, 2000) and therefore, no adjustments needed to be made to the data. The second dependent variable, used for analyses with the SXI sample, is a dichotomous variable (i.e., yes/no) constructed from a Wave 2 item that asked participants if they had ever had sexual intercourse.

The independent variables in this study consist of what are typically considered sociodemographic or background variables (see Table 1 for item(s) used to construct each variable). Except for race and gender, expectation maximization was used to calculate values to impute for missing data on the independent variables (Acock, 1997). This method of imputing missing information results in less biased estimates than do other methods such as dropping cases or using sample averages (Acock, 1997).

Table 1
Operationalization of Dependent and Independent variables..

Variables	Select descriptors of variable
Dependent variable items	
Always use a condom	How often use condom
Anal intercourse	Ever had anal intercourse
Casual sex	Non-romance sex with anyone
Contraceptive use	Most recent sex-used birth control
Drinking and sexual intercourse	Most recent sex-drink alcohol
Drugs and sexual intercourse	Most recent sex-drug use
Drunk during sexual intercourse	Most recent sex-drunk
More than one sexual intercourse partner	Romantic Partner-(1-3)-had sex Romantic Partner-(1-3)-had intercourse Total number of sex partners Number of nonromantic sex partners
Sex for money or drugs	How often-sex for drugs or money
Independent variables	
Age	Calculated age
Gender	Biological sex
Ethnicity	Are you Hispanic or Latino origin; What is your race (white); What is your race (black or African American); What is your race (American Indian or Native American); What is your race (Asian or Pacific Islander); what is your race (other)
Variables	Select descriptors of variable
Family structure	Lives with mother; Lives with father; Lives with biological parents; Who acts as a mother; Who acts as a father
Household income	Total household income
Household education	Highest level of education completed by residential father; Highest level of education completed by residential mother
Residence	Dominant land use of immediate area

Measures of adolescent individual characteristics included gender, race, and age. Both samples had equal proportions of females and males (Table 2). The mean age at Wave 2 is 16.72 for the SXC sample and 15.93 for the SXI sample. Race was determined by two self-report items: one item for Hispanic or Latino origin (yes/no) and 1 item for racial identity (check all that apply). If more than one category was indicated, adolescents who indicated they were of Hispanic or Latino origin were designated as Hispanic and eliminated from any other race categories. For the remaining adolescents who indicated multiracial backgrounds, if black or African American was one of the categories then that became their designated race. “The process was repeated for the remaining race categories in the following order: Asian, Native American, other, and white.” For the present analyses only Blacks, Hispanics, and Whites were included

(Blum et al., 2000). Both samples had nearly the same racial proportions with approximately 2/3 of each sample consisting of whites. Looking concurrently at gender by race, the largest discrepancy between the two samples is found for the inclusion of white males (i.e., SXI sample had 5.5% more).

Table 2

Sociodemographic Characteristics of the Sexual Competence and Sexual Intercourse Samples.

Variable	SXC sample	SXI sample
Gender		
Female	50.2%	49.2%
Male	49.8%	50.8%
Race		
Black	21.3%	16.8%
Hispanic	14.2%	13.5%
White	64.5%	69.7%
Gender by Race		
Black Female	10.3%	08.5%
Hispanic Female	06.0%	06.6%
White Female	34.0%	34.2%
Black Male	11.0%	08.4%
Hispanic Male	08.2%	06.9%
White Male	30.0%	35.5%
Family Structure		
One-parent	37.7%	28.6%
Two-parent	62.3%	71.4%
Mean age	16.72 (<i>SD</i> =1.44)	15.93 (<i>SD</i> = 1.63)
Household income		
≤ \$20,000	25.6%	21.2%
\$21,000-\$40,000	31.5%	31.5%
≥ \$40,000	42.9%	47.3%
Household education	<i>Mdn</i> = GED or high school	<i>Mdn</i> = GED or high school

Within the context of the family, income, household educational attainment, and family structure were examined. The median household income of the SXC sample (\$35,000) is less than the median income of the SXI sample (\$45,000). Because income had a non-normal distribution in both samples, it was reduced to three categories: less than \$21,000; between \$21,000 and \$40,000; and greater than \$40,000 (Blum et al., 2000). Both samples had the same percentage (31.5%) of adolescents living in households in the middle income category, however, the SXI sample had 5% more in the highest income category. Family structure was measured as one-parent or two-parent. This classification refers to adults in the home that act as a mother or

act as a father. Proportionately, the SXC sample has fewer two-parent households (62.3% two-parent) than does the SXI sample (71.4% two-parent). Household education was measured as the highest level of educational attainment by a parent or caregiver, ranging from 0 (never went to school) to 7 (professional training beyond college). The median level of family educational attainment for both samples is a GED or high school diploma. For the SXC sample, 21.2% reported having a college degree or higher as the highest educational attainment for either the father or the mother and for the SXI sample it was 28.3%.

Finally, adolescent's residence, measured as rural, suburban, urban, and other, was included as a contextual or extrafamilial variable. Approximately one quarter of each sample lived in areas that were classified as rural and two thirds lived in suburban or urban residential areas.

Analytic Methodology

All reported estimates are based on weighted data and WESVAR software was used to adjust test statistics for the complex sample design of the Add Health study. Missing data analyses and imputations for the independent variables were conducted in SPSS.

Multiple regression analysis was used to examine the relationship between sexual competence and each sociodemographic variable. Overall model significance was tested using an F statistic and the multiple coefficient of determination (adjusted R^2) represented the percentage of the total variation in sexual competence explained by the set of predictors. After examining the overall performance of the model, individual t statistics are reported to examine the individual contribution of each independent variable. Education and age were coded as continuous variables and the parameter estimates represent the average change in level of sexual competence associated with each unit of increase for each variable while controlling for all other variables. Family structure, gender, race, and income, were dummy coded with males, whites, two-parent, and \geq \$41,000 as the referent groups. Thus, the associated parameter estimates in the models represent the difference in average level of sexual competence for that group relative to the intercept term.

Logistic regression analysis was conducted to examine the relationship between sexual intercourse and the sociodemographic variables. Sexual intercourse was coded 0 "no" and 1 "yes." A model chi-square statistic was used to test if the overall model is statistically significant. Percent correct predictions and Cox-Snell R^2 also are used to evaluate the overall model. Odds ratios ($ExpB$) and associated 95% confidence intervals are used to represent the odds change in the dependent variable for a change of one unit in the independent variable, while controlling for all other variables in the model. The Wald statistic is used to test the hypothesis that a coefficient of an independent variable is significantly different from zero. An odds ratio equal to 1 means that there is a 50/50 chance that the event will occur with a small change in the independent variable. Therefore, the odds ratio is significant if the 95% confidence interval does not include a value of 1 (Wang, Eddy, & Fitzhugh, 1995).

Statistical power analyses (Cohen, 1992) were conducted to determine if the sample sizes were sufficient to test these models. With alpha = .05 and an unweighted sample size of 1525 (SXC sample) and 4447 (SXI sample), after listwise deletion for cases missing a dependent variable, power analyses indicated that the sample sizes were large enough to detect small effect sizes (i.e., variance accounted for equal to 2%) with power = 1 for each analysis.

Results

Sexual Competence

The overall sexual competence mean was 5.36 ($SE = .04$) and scores ranged from 0 to 7 with a median score of 6. Overall, the levels of sexual competence varied little between sample subgroups. The largest difference was between females and males, female sexual competence was 6% higher than male sexual competence (Table 3). All other differences, including race, income, family structure, and residence were less than 5%. Little or no correlation was shown to exist between sexual competence and age or household education.

The multiple regression model was significant, $F(11, 121) = 2.49, p < .01$, though it only explained 2% of the variance in sexual competence scores (Table 4). Gender and race were the only significant factors in the model. Males had lower sexual competence scores, as did Black youth.

Table 3
Descriptive Statistics of Sexual Competence and Sexual Intercourse

Variable	Sexual Competence		Sexual Intercourse	
Age	$r = -.01, SE = .03$		<u>M</u>	<u>SE</u>
			no: 15.38	.10
			yes: 16.66	.10
Gender	<u>M</u>	<u>SE</u>	<u>No</u>	<u>Yes</u>
	female: 5.53	.05	female: 58.5%	41.5%
	male: 5.19	.06	male: 57.0%	43.0%
Race	<u>M</u>	<u>SE</u>	<u>No</u>	<u>Yes</u>
	black: 5.22	.07	black: 42.0%	58.0%
	hispanic: 5.29	.10	hispanic: 57.6%	42.4%
	white: 5.42	.05	white: 61.5%	38.5%
Family structure	<u>M</u>	<u>SE</u>	<u>No</u>	<u>Yes</u>
	one-parent: 5.35	.06	one-parent: 44.4%	55.6%
	two-parent: 5.35	.05	two-parent: 64.3%	35.7%
Household income	<u>M</u>	<u>SE</u>	<u>No</u>	<u>Yes</u>
	≤\$20,000: 5.35	.07	≤\$20,000: 47.6%	52.4%
	\$21,000-\$40,000: 5.32	.06	\$21,000-\$40,000: 56.3%	43.7%
	≥\$41,000: 5.39	.07	≥\$41,000: 63.2%	36.8%
Household education	$r = .00, SE = .02$		<u>M</u>	<u>SE</u>
			no: 4.65	.10
			yes: 4.18	.10
Residence	<u>M</u>	<u>SE</u>	<u>No</u>	<u>Yes</u>
	rural: 5.35	.09	rural: 57.6%	42.4%
	suburban: 5.33	.06	suburban: 63.3%	36.7%
	urban: 5.42	.06	urban: 52.7%	47.3%
	other: 5.13	.18	other: 48.0%	52.0%

Table 4
Regression Models of Sexual Competence and Sexual Intercourse

	Multiple Regression		Logistic Regression	
	<i>B</i> (<i>SE</i>)	β (<i>SE</i>)	β (<i>SE</i>)	<i>ExpB</i> (95%CI)
Age	-.00(.03)	-.00(.03)	***.55(.33)	†1.72 (1.62, 1.84)
Gender	***.34(.09)	.13(.03)	.01(.10)	1.01 (.86, 1.18)
Race				
Black	*-.22(.10)	-.06(.03)	** .46(.13)	†1.59 (1.23, 2.05)
Hispanic	-.05(.11)	-.01(.03)	-.07(.16)	.93 (.68, 1.27)
Family structure	.04(.09)	.01(.03)	***.64(.09)	†1.89 (1.58, 2.27)
Household education	.02(.03)	.03(.03)	**-.13(.04)	†.88 (.82, .95)
Household income				
≤\$20,000	.01(.12)	.00(.04)	.08(.13)	1.09 (.85, 1.40)
\$21,000-\$40,000	-.05(.11)	-.02(.04)	-.01(.09)	.99 (.82, 1.19)
Residence				
Rural	.07(.20)	.02(.06)	-.07(.20)	.93 (.62, 1.40)
Suburban	.06(.18)	.02(.06)	-.25(.22)	.78 (.51, 1.20)
Urban	.19(.18)	.07(.06)	-.06(.20)	.94 (.63, 1.41)
R ²	** .02		*** .18	

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

† *ExpB* is significant

Sexual Intercourse

The second set of analyses examined the prevalence of adolescent sexual intercourse. The proportion of sexually active youth was 42.2% ($SE = 1.93$), and on average, youth who reported being sexual experienced were more than a year older than sexually abstinent youth. Males were more likely to have experienced sexual intercourse than were females; however, only 1.5 percentage points separated the two groups (Table 3). Black youth were between 1.4 and 1.5 times less likely to report being abstinent than were Hispanic and White youth, respectively. Reports of sexual intercourse experience were 56% higher for adolescents in one-parent households than adolescents in two-parent households. A greater proportion of teens in high-income families were not sexually experienced than those teens in medium and low-income families. The mean household education level for sexually experienced youth was 11% lower than that of youth who were not experienced. Sexual experience was least common among teens living in suburban communities when compared to urban, rural, and other communities. The highest proportion of sexually experienced adolescents were living in urban areas.

The logistical regression model was significant (Table 4). Age, race, family structure, and household education were related to adolescent sexual intercourse. For each increase of year in age, adolescents were nearly 2 times more likely to be sexually experienced. Compared to whites, Blacks were more likely to be sexually experienced. Adolescents in one-parent families were more likely to be sexually experienced than teens in two-parent families. Likelihood of being sexually active was inversely related to household education.

Discussion and Conclusions

In this study, sexual competence had a theoretical range of 0 to 7, with 7 indicating the highest level of sexual competence. The overall mean for this sample was 5.36, indicating a fairly high level of sexual competence. As reported by The Alan Guttmacher Institute (1999), 80% of sexually active women between the ages of 15-19 do not become pregnant and 75% of sexually active adolescents are STD free. In other words, a large majority of the sexually active adolescent population does not experience a negative outcome, thus, we should expect high levels of sexual competence.

Findings suggest that sexually competent adolescents are more likely to be females and white or Hispanic. Comparing the problem-oriented approach with the competency approach, the study suggests that although older adolescents are more likely to be sexually active, age does not have an effect on sexual competence. In other words sexual competence does not seem to be related to delayed sexual activity.

Similarly, although adolescents in two-parent families are less likely to be sexually active than adolescents in one-parent families, family structure is not associated with sexual competence. This implies that living in a two-parent household, where monitoring might be more prevalent (Miller et al., 1999), does not necessarily result in sexual competence. In addition, household education level has no impact on sexual competence even though it does differentiate between sexually-experienced teens and sexually-abstinent teens. The current study suggests that although familial characteristics might influence the timing of intercourse, they are less influential with regards to the development of sexual competence. If sexual competence is influenced by the family, it is more likely an interactive process (e.g., communication) that affects adolescents' sexual competence.

One of the limitations of this study is that, in essence, this sample is self-selected in that these adolescents were in school at Wave 1. It might be that adolescents who engage in the riskiest sexual behaviors have dropped out of school for various reasons, including pregnancy. Therefore, sexual competence among sexual active adolescents might be a bit overestimated. Another limitation is that the data used from the Add Health study for this study is self-reported data on a sensitive topic. They might have underreported socially undesirable behaviors.

In conclusion, there is a growing emphasis on examining variables that shape and constrain adolescent sexuality that have not been examined in previous research. This means going beyond the prevailing stereotype of young people as irresponsible and hedonistic. When we look at the different contexts that affect adolescent sexual behaviors, it is important to recognize that as researchers and practitioners we are a part of adolescents' macro-social environment. Thus, we need to consider how the predominate use of a problematic approach affects adolescent sexuality and how it affects the way that we, as a society, view adolescent sexuality. According to

Chilman (1990) the problem-oriented approach “prevent[s] a positive approach to supporting the healthy sexuality of young women and men during their adolescent years” (p. 123).

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