Background: Unwanted sexual contact, reported by 30% to 42% of young women and 10% to 34% of young men, has been associated with negative health outcomes and increased teenaged pregnancy.

Objective: To determine health services and contraceptive use among adolescents reporting unwanted sexual intercourse.

Methods: Random-digit dial methods were used to survey 1040 adolescents in Monroe County, New York; 389 (37%) were sexually active and answered a question about whether they had ever been forced or pressured to have sexual intercourse. The data were weighted to reflect the county population.

Results: Among sexually active adolescents, 20% of females and 7% of males reported unwanted intercourse (P<.001). For 37% of male and 17% of female adolescents, the survey was the first time they had disclosed the incident (P=.17). Among female adolescents reporting unwanted intercourse, 91% have a usual source of care and 62% reported a well visit in the previous 6 months. Female adolescents reporting unwanted sex were more likely to have wanted contraceptives but not gotten them because of fear their parents would find out (32% vs 11%; P=.01) and to have had sex without contraception (69% vs 52%; P=.05) than those who had not had unwanted sex.

Conclusions: Many adolescents have been forced or pressured to have sexual intercourse. Although many have never told anyone about the incident, most have visited a primary care physician or clinician. Physicians and other clinicians should screen for a history of unwanted intercourse and provide needed referrals for counseling and/or contraceptive information.

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SUBJECTS AND METHODS

We surveyed adolescents in Monroe County, New York, an area of about 1 million residents surrounding Rochester, NY. Between October 1998 and April 2000, 1040 adolescents aged 14 to 19 years were surveyed using random-digit dial methods. A list of telephone exchanges in Monroe County was obtained, and business exchanges were verified and excluded. Urban areas with high minority populations were over-sampled to improve estimates for African American and Hispanic youth. A random list of unduplicated 4-digit numbers was generated for each exchange; a total of 55,600 numbers were called up to 5 times, and numbers were identified as households or businesses. Respondents were screened for whether there were 14- to 19-year-old persons living in the household, and an algorithm was used to randomly select an adolescent. Consent was obtained from adolescents and from parents for adolescents younger than 18 years. Protocols were approved by the Research Subjects Review Board at the University of Rochester School of Medicine.

The 15- to 25-minute questionnaire included items based on the Youth Risk Behavior Survey,27 the Prevention Minimum Evaluation Data Set,17 the Commonwealth Fund Survey of the Health of Adolescent Girls,16 and previous studies18,19 of adolescents. Questions included ever having had sexual intercourse, condom and birth control use ever and at last intercourse, knowledge and use of emergency contraception, and history of pregnancy. Health services measures included having a regular physician, last well visit, confidential care, use of care without parental knowledge, and insurance and socioeconomic status. Unwanted sexual intercourse was determined by the following question, “Have you ever been forced or pressured to have sex with someone when you didn’t want to?”; this was only asked of adolescents who reported having been sexually active. Those who responded affirmatively were asked whether they had told anyone about it.

Data were double entered into a database (Microsoft Access, Microsoft Corporation, Redmond, Wash) and compared using SAS statistical software (PROC COMPARE);20 and discrepancies were resolved. Weighting variables were created based on population data for Monroe County extrapolated from 1990 census data by Claritas21 to approximate the county population by sex, ethnicity (white or Hispanic, African American or multiracial, and other), and urbanicity (city, inner-city oversample, and suburban). Frequencies and descriptive statistics and χ2 and logistic regression analyses were performed using SAS and SUDDAN22 statistical software to adjust SEs to account for the clustered sample design. A total of 1040 adolescents completed the survey. Of the household respondents, 27% refused, and an additional 12% of adolescents also refused. Telephone numbers for which household eligibility could not be determined were attributed using standard methods,23 resulting in a final adjusted completion rate for eligible teenagers of 58%. Nine adolescents did not answer the question about race and could not be assigned a weight; therefore, they were excluded from these analyses.

RESULTS

A total of 389 adolescents (37% of the sample) reported having had sexual intercourse. The sexually active adolescents were 50% female; 58% were white, 22% were African American, 9% were Hispanic or Latino, 7% were multiracial, less than 1% each were Asian and Native American, and 3% were another ethnicity. Adolescents reporting sexual activity tended to be older and nonwhite and their family had a lower financial status than those not reporting sexual activity. Most (56%) reported having enough money to buy necessities and special things; 22% reported few problems, 18% had just enough, and 3% believed their families had a hard time buying what they needed (percentages do not total 100 because of rounding). The average age of respondents was 17.6 years.

Of the sexually active adolescents, 13% had ever been forced or pressured to have sex (20% of female and 7% of male adolescents; P<.001). There was no difference by age or family financial status. Rates of unwanted sex were similar between white and African American adolescents (13% and 12%, respectively), somewhat higher among multiracial adolescents (20%), and lower among Hispanic adolescents (6%) (overall P=.04). Among adolescents reporting unwanted sexual intercourse, 37% of males and 17% of females had not told anyone about the incident before the telephone interview (P=.17) (Table). The number of male adolescents who reported unwanted intercourse was too low to describe precise estimates for most variables.

More than two thirds of all female adolescents (67%) stated that they usually go to a physician’s office for medical care, and 29% usually go to a neighborhood or hospital-based clinic or a health care center (Table). The source of primary care did not differ by whether the female adolescents reported unwanted intercourse (overall P=.91). There were also no differences in the percentage of female adolescents reporting a recent well visit, having discussed confidentiality, having had private time with their physician, or having insurance. A somewhat higher proportion of female adolescents reporting unwanted intercourse reported having gone to see a physician or nurse without their parents’ knowledge; this association was not significant (Table). These female adolescents were also more likely to report wanting contraception but not getting it because of fear that their parents would find out.

Adolescent girls reporting unwanted sexual intercourse were more likely to report ever having had sex without a condom or other birth control, but were equally
Of sexually active adolescent girls and boys, 20% and 7%, respectively, have experienced unwanted sexual intercourse. Although similar to rates found in other studies,7 this is a troubling proportion, because early sexual intercourse increases their risk of sexually transmitted diseases, human immunodeficiency virus, teenage pregnancy,4 and cervical cancer.24 Many adolescents who had unwanted intercourse have also had sex without contraception. These data raise concerns about whether adolescents have the tools they need to be able to negotiate sexual encounters to their desired conclusion, whether that goal is sex using contraception or no sex at all. Programs that aim to prevent teenage pregnancy must consider ways to help young people set, and keep, boundaries with sexual partners and others who may pressure them to have sex.

Many of the adolescents who reported having had unwanted intercourse had never told anyone about the incident, despite the many adolescents in this sample who had a regular physician or other provider and a well visit in the past year. Although some of these incidents may have taken place after the visits, it is likely that in some cases, a clinician might have uncovered this history. Given the short-term consequences of unprotected sexual intercourse, and the long-term impact of coercive sexual experiences on risk behavior and health, clinicians are in the position to offer emergency contraception, referrals to counseling, and other needed services. On a positive note, many teenagers in our sample had heard of emergency contraception and teenagers with a history of unwanted intercourse were more likely to have had a clinician tell them about it. This may indicate that information about emergency contraception is reaching youth at risk in our community.

It is concerning that almost one third of adolescent girls who reported unwanted intercourse had wanted birth control but not gotten it because of fear that their parents would find out. One quarter had not discussed confidentiality with their physician or other provider and, thus, may have been concerned that their physician would disclose information to their parents. However, as most of these adolescents reported ever having had sex without contraception, these data emphasize the need for better access to and information about birth control and condoms.

While the number of male adolescents in our study who reported having unwanted intercourse was too small to detect significant differences between the groups, the proportion of adolescent boys who reported unwanted sex was concerning, especially because male adolescents are much less likely than female adolescents to have disclosed these incidents. Although the societal preconception is that men are usually the sexual aggressors, this study and others6,25 suggest that young men are vulnerable to unwanted advances and may experience some of the same negative effects as young women.

There are several limitations to this study. Our sample was slightly biased toward female respondents and to adolescents whose families have telephones; it was also

### Table: Health Services and Contraceptive Use by Sexually Active Adolescents Reporting Unwanted Intercourse*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male Adolescents</th>
<th></th>
<th>Female Adolescents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reporting</td>
<td>Not Reporting</td>
<td>Reporting</td>
<td>Not Reporting</td>
</tr>
<tr>
<td></td>
<td>Unwanted</td>
<td>Unwanted</td>
<td>Unwanted</td>
<td>Unwanted</td>
</tr>
<tr>
<td></td>
<td>Intercourse</td>
<td>Intercourse</td>
<td>Intercourse</td>
<td>Intercourse</td>
</tr>
<tr>
<td></td>
<td>(n = 14)</td>
<td>(n = 173)</td>
<td>(n = 56)</td>
<td>(n = 221)</td>
</tr>
<tr>
<td>Usual source of care†</td>
<td>(62)</td>
<td>(68)</td>
<td>(69)</td>
<td>(66)</td>
</tr>
<tr>
<td>Physician’s office</td>
<td>.36</td>
<td></td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>Clinic or health center</td>
<td>(16)</td>
<td>(25)</td>
<td>(22)</td>
<td>(31)</td>
</tr>
<tr>
<td>Other</td>
<td>(22)</td>
<td>(7)</td>
<td>(8)</td>
<td>(3)</td>
</tr>
<tr>
<td>Well visit in the past 6 mo</td>
<td>(50)</td>
<td>(68)</td>
<td>(62)</td>
<td>(72)</td>
</tr>
<tr>
<td>Discussed confidentiality with physician</td>
<td>(58)</td>
<td>(74)</td>
<td>(74)</td>
<td>(76)</td>
</tr>
<tr>
<td>Has medical insurance</td>
<td>(78)</td>
<td>(94)</td>
<td>(92)</td>
<td>(89)</td>
</tr>
<tr>
<td>Sought care without parental knowledge</td>
<td>(12)</td>
<td>(14)</td>
<td>(42)</td>
<td>(30)</td>
</tr>
<tr>
<td>Foregone contraception because of fear of parents finding out</td>
<td>(31)</td>
<td>(5)</td>
<td>(32)</td>
<td>(11)</td>
</tr>
<tr>
<td>Ever had sex without contraception</td>
<td>(42)</td>
<td>(42)</td>
<td>(69)</td>
<td>(52)</td>
</tr>
<tr>
<td>Used a condom at last intercourse</td>
<td>(83)</td>
<td>(74)</td>
<td>(69)</td>
<td>(66)</td>
</tr>
<tr>
<td>Used other contraception at last intercourse</td>
<td>(15)</td>
<td>(33)</td>
<td>(40)</td>
<td>(48)</td>
</tr>
<tr>
<td>Heard of emergency contraception</td>
<td>(74)</td>
<td>(56)</td>
<td>(71)</td>
<td>(80)</td>
</tr>
<tr>
<td>Physician told about emergency contraception</td>
<td>(0)</td>
<td>(18)</td>
<td>(58)</td>
<td>(34)</td>
</tr>
<tr>
<td>Used emergency contraception</td>
<td>(0)</td>
<td>(8)</td>
<td>(13)</td>
<td>(8)</td>
</tr>
<tr>
<td>Have been pregnant</td>
<td>(NA)</td>
<td>(NA)</td>
<td>(33)</td>
<td>(25)</td>
</tr>
<tr>
<td>Have gotten someone pregnant</td>
<td>(26)</td>
<td>(8)</td>
<td>(11)</td>
<td>(NA)</td>
</tr>
</tbody>
</table>

*Data are given as percentage of adolescents unless otherwise indicated. Unweighted n’s are shown. However, data are weighted to adjust for the telephone sampling strategy and oversampling of ethnic minority youth. NA indicates data not applicable.

†Percentages may not total 100 because of rounding.
Unwanted sexual contact is associated with adverse health outcomes among adolescents. Primary care clinicians often miss opportunities to screen for unwanted contacts and their sequelae, and this is an important aspect of health services and reproductive care for these youth. Most adolescents with a history of unwanted intercourse (20% of females and 6% of males) have received routine primary care, but many have never disclosed these incidents to their physicians. Adolescent girls with a history of unwanted sex were less likely to use contraception and more likely to have deferred care because they feared loss of confidentiality. Clinicians should confidentially screen all adolescents for a history of unwanted sexual contact and for reproductive care needs.

limited to Monroe County. However, we adjusted for nonresponse and sample/population differences, and telephone surveys are able to accurately reflect the population of youth. We also considered the response rate and is comparable to other recent random-dialed telephone surveys. Also, because we asked the question only of adolescents who reported having sexual intercourse, it is possible that there were respondents who had been forced to have sex but who did not say they had sexual intercourse. Finally, this study only focused on heterosexual intercourse, and likely underestimates the proportion of young people affected by male-male unwanted contact and of young men and women affected by unwanted contact other than intercourse. Future research is needed on young men to determine whether those who have had unwanted sexual experiences are also more likely to engage in risky sexual behaviors and whether they have the same health outcomes (and thus opportunities for intervention) as other adolescent boys.

Physicians and allied health professionals can play an important role in mitigating the effects of unwanted sexual intercourse on adolescents, providing information on emergency contraception and contraceptive options, and referring patients for counseling if the episodes have triggered emotional distress or reactionary sexual activity. This study underscores the need for clinicians to screen for unwanted sexual activity among female and male adolescents and to ensure that these discussions remain confidential. Clinicians can also play an important role in helping adolescents learn to say no in coercive encounters or to avoid situations that may increase their risk. Clinicians need to ask their adolescent patients whether they have been forced or pressured into sexual intercourse; as difficult as it may be for adolescents to discuss these issues, ignoring them can only make a difficult situation worse.

What This Study Adds

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