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# Differences by Sexual Minority Status in Relationship Abuse and Sexual and Reproductive Health Among Adolescent Females

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A B S T R A C T

**Purpose:** Little is known about adolescent relationship abuse (ARA) and related sexual and reproductive health among females who either identify as lesbian or bisexual or engage in sexual behavior with female partners (i.e., sexual minority girls [SMGs]).
**Methods:** Baseline data were collected from 564 sexually active girls ages 14–19 years seeking care at eight California school-based health centers participating in a randomized controlled trial. Associations between ARA, sexual minority status and study outcomes (vaginal, oral, and anal sex, number and age of sex partners, contraceptive nonuse, reproductive coercion, sexually transmitted infection [STI] and pregnancy testing) were assessed via logistic regression models for clustered survey data.
**Results:** SMGs comprised 23% (n = 130) of the sample. Controlling for exposure to ARA, SMGs were less likely to report recent vaginal sex (adjusted odds ratio [AOR], .51; 95% confidence interval [CI], .35–.75) and more likely to report recent oral sex (AOR, 2.01; 95% CI, 1.38–2.92) and anal sex (AOR, 1.76; 95% CI, 1.26–2.46) compared with heterosexual girls. Heterosexual girls with ARA exposure (AOR, 2.85; 95% CI, 1.07–7.59) and SMGs without ARA exposure (AOR, 3.01; 95% CI, 2.01–4.50) were more likely than nonabused heterosexual girls be seeking care for STI testing or treatment than heterosexual girls without recent victimization.
**Conclusions:** Findings suggest the need for attention to STI risk among all girls, but SMGs in particular. Clinicians should be trained to assess youth for sexual contacts and sexual identity and counsel all youth on healthy relationships, consensual sex, and safer sex practices relevant to their sexual experiences.



**IMPLICATIONS AND CONTRIBUTION**

This study assesses sexual minority and heterosexual adolescent girls' experiences of relationship abuse and poor sexual and reproductive health. Findings highlight the need for clinicians to ask about both sexual identity and behavior among youth and provide comprehensive testing and treatment for sexually transmitted infections framed within a discussion of healthy relationships.

Adolescent relationship abuse (ARA)—physical, sexual, and psychological abuse or harassment in romantic or intimate relationships—is experienced by as many as one in three youth [1,2]. Female adolescents who experience ARA are more likely to report sexual risk behaviors including early sexual initiation,

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multiple sexual partners, and inconsistent condom use [3,4] and sexual and reproductive health outcomes, including unintended pregnancy and sexually transmitted infections (STIs) [5–8]. These associations are likely related to the fear of and limited agency to negotiate whether, when, and how young women engage in sexual behavior with their abusive partners [3,7]. Recent studies have also documented reproductive coercion as another mechanism linking ARA and unintended pregnancy [5,9]. Collectively, these studies underscore the substantial burden of ARA on young women's reproductive and sexual health.

Until recently, research on ARA has focused almost exclusively on violence in heterosexual relationships, generating little understanding of the experiences of girls who *either* identify as lesbian or bisexual *or* have sex with female partners (subsequently referred to as sexual minority girls [SMGs]). One recent nationally representative study found the prevalence of lifetime physical intimate partner violence to be higher among bisexual (61%) and lesbian women (44%) compared with their heterosexual counterparts (35%), and intimate partner rape was highest among bisexual women (22%) compared with heterosexual women (9%) [10]. A recent study confirmed these findings, with lesbian adolescents (ages 15–20 years) six times more likely and bisexual adolescent females three times more likely than heterosexual adolescents to have been forced by a man to have sexual intercourse [11]. Although these studies confirm that ARA is a concern for SMGs, they do not include girls who may not identify as lesbian or bisexual but have same-sex sexual contacts, thus missing a unique population at risk for ARA [12].

Similar to studies on ARA, only a handful of recent studies have considered the sexual and reproductive health of SMGs. One study documented that sex under the influence of alcohol or drugs, having multiple sex partners, and having unprotected vaginal sex with male partners were common among sexual minority adolescent and young adult women and associated with pregnancy and STIs. This study also found that sexual coercion was associated with greater sexual risk behavior [13]. However, experiences of sexual minority women were not compared with those of heterosexual women. One nationally representative study found that bisexual girls were more likely than heterosexual girls to have ever used emergency contraception and to have had a pregnancy termination [11]. Another study found that bisexual girls reported more pregnancy compared with their exclusively heterosexual counterparts, despite a greater likelihood of hormonal contraceptive use [14]. Although clinical settings serving adolescents are key sites for ARA prevention and intervention [15], little is known about the care-seeking patterns, risk profiles, and ARA experiences among SMGs who attend such clinics.

Despite the increasing attention in the literature to the health of SMGs, no studies of the sexual and reproductive health of these adolescents consider the role ARA may play in their sexual and reproductive risk and reason for seeking clinical care. Furthermore, studies comparing heterosexual and sexual minority youth are rarely comprehensive in their measurement of sexual minority status (i.e., including both sexual identity and sexual contacts). Finally, there are no studies of ARA among SMGs using school-based health centers (SBHCs), an important clinical setting given SBHCs, typically located in lower-income communities of color, reach adolescents with numerous barriers to accessing confidential clinical care [16]. The purpose of the present study was to assess experiences of ARA and associations with sexual and reproductive health among a sexually active sample of adolescent females at SBHCs, to examine sexual behavior and sexual risk among SMGs, controlling for ARA, and to determine whether associations between ARA and outcomes differ by sexual minority status.

## Methods

### *Data*

Data were collected as part of a cluster randomized trial, "School Health Center Healthy Adolescent Relationships Program," that evaluated a brief psychoeducational intervention in SBHCs to promote healthy relationships and reduce ARA. Eight SBHCs in Northern California were randomly assigned to the program or a wait-list control condition. Youth ages 14–19 years seeking services at one of the SBHCs were invited to participate (n = 1,012, 95% participation rate). Primary reasons for nonparticipation were lack of time and plans to move away from the area in the near future (because of the study's longitudinal design).

Before program implementation, youth completed a 15-minute computer-based survey about ARA, sexual behavior, pregnancy risk, and care seeking for sexual and reproductive health. Students received a $10 gift card to thank them for their time. Study procedures were approved by Institutional Review Boards at the Public Health Institute, University of Pittsburgh, and participating school districts.

### *Measures*

Primary predictors for the current analysis included sexual minority status and ARA. Sexual minority status was measured via two items assessing sexual identity and sexual behavior. Sexual identity was measured with the item, "Do you consider yourself: heterosexual/straight, bisexual, homosexual/gay/lesbian, or not sure?" Participants were also asked if they had ever had vaginal, oral, or anal sex, and if so, whether their partners since they started having sex were "women only," "mostly women," "equally men and women," "mostly men," and "men only." A participant was classified as a sexual minority if they *either* identified as lesbian, bisexual, or questioning (i.e., not sure) OR reported having had same-sex sexual contacts. The reference category for this predictor included girls who identified as heterosexual AND had male sex partners only (i.e., "completely heterosexual"). Physical and sexual ARA was measured via three items modified from the Revised Conflict Tactics Scale [17] and the Sexual Experiences Survey [18] including, "In the past 3 months, has someone you going out with or hooking up with" (1) "ever hit, pushed, slapped, choked or otherwise physically hurt you? (including such things as being hit, slammed into something, or injured with an object or weapon)," and (2) "used force or threats to make you have sex (vaginal, oral, or anal sex) when you didn't want to." The third item read: "In the past 3 months, have you had sex with someone you were going out with or hooking up with when you did not want to, because you felt like you did not have a choice, even though they did not use physical force or threats?" Participants who endorsed at least one item were coded as having experienced ARA. Data on the perpetrators were not available.

Outcomes included sexual behavior, sexual risk, pregnancy risk, and care seeking for sexual and reproductive health. Three items assessed whether participants engaged in vaginal, oral, or