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AUTHOR Falbo, Toni; Eisen, Marvin
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ABSTRACT

Little is known about the power strategies adolescents view as effective in influencing an intimate partner to have or avoid having sexual intercourse. These strategies were examined in a pretest survey of 203 adolescents who reported their agreement or disagreement with strategies used to have protected sex or to avoid having sex with a girl/boyfriend. The results indicated that in avoiding sex, adolescents preferred a direct and unilateral strategy; in seeking protected sex, they preferred a direct and bilateral strategy. The unilateral, indirect approach was the least preferred strategy regardless of sexual goal. The findings also showed that gender, age, and ethnicity were significantly related to agreement with power strategy use; minority, female, and younger adolescents agreed more, in general, to all strategies to avoid and to have sex. A posttest survey was completed by 146 adolescents who had completed a Health Belief Model training project designed to train adolescents to use effective strategies in intimate relationships. Posttest results indicated that the project had little influence on the overall preference rankings of strategies. Participants gained in terms of desirable strategies to have protected sex, but were not generally affected in terms of strategies to avoid sexual intercourse. (Data tables describing the strategies assessed, with results, are appended.) (NRB)

Interpersonal Influence Strategies Applied to Sexual Decision-Making of Adolescents

Toni Falbo and Marvin Eisen

Introduction

This study had two purposes. First, the study aimed to uncover the types of strategies adolescents report using in order to influence another adolescent to have protected sexual intercourse and to avoid having sexual intercourse. Previous research on the topic of power in intimate relationships has found that among married couples, shared and active decision-making is positively related to effective fertility planning (Hollerbach, 1980). A recent study (Jorgerson, King, and Torrey, 1980) reported that the female's power within the adolescent dyad was strongly and negatively related to exposure to pregnancy risk. Beyond the Jorgerson et al study, however, little is known about the power strategies adolescents view as effective in influencing an intimate partner to have or avoid having sexual intercourse. This study will explore the power strategies advocated by adolescents and examine gender and other status differences in the reported use of these strategies.

The second purpose of this study was to evaluate the HBM project in terms of its success in training adolescents to use effective strategies in intimate relationships. In general, research results suggest that bilateral (i.e., two-sided) and direct strategies, such as reasoning with the partner, are better than unilateral (i.e., one-sided) and indirect strategies, such as passive withdrawal from the intimate partner (Falbo and Peplau, 1980; Hollerbach, 1980). This study will evaluate the HBM project to determine if

adolescents agreed to using more direct and bilateral strategies and fewer indirect and unilateral strategies after participating in the project.

The power strategy model

The model underlying the data collection and the interpretation of the results was derived from a multidimensional scaling (MDS) of strategy types reported by young adults (Mean Age = 22.5 years) to influence their intimate partner (Falbo and Peplau, 1980). Thirteen such power strategy types were generated from the open-ended survey of power strategies used by 434 dating individuals. These strategy types were evaluated by a group of nine experts and these evaluations served as the basis for the MDS analysis.

The results of the analysis was a two-dimensional model which accounted for 89% of the varian:.. One dimension was labeled Directness and ranged from direct strategies, such as telling your partner what to do, to indirect strategies, such as buttering up the partner. The second dimension was labeled Bilaterality and ranged from two-sided types of strategies, such as reasoning, to one-sided types of strategies, such as growing silent and withdrawing until the partner agrees.

Some types of strategies were considered to be better than others. According to the ratings of experts and the self-reported satisfaction of the people engaged in these intimate relationships, bilateral and direct strategies, such as reasoning, were the best types of strategies. The least desirable types of strategies were unilateral and indirect, such as withdrawal. Bilateral, indirect (e.g., buttering up) and unilateral, direct (e.g., telling) were of moderate desirability.

Further, it was found that people who felt they had more power in their relationship were more likely to report using bilateral than unilateral

strategies. Therefore, the perception of greater power is associated with the use of such strategies as reasoning while the perception of lesser power is associated with more unilateral strategies, such as withdrawal. Interestingly, women in heterosexual pairs were more likely to report using unilateral and indirect strategies; while men were more likely to report using bilateral and direct strategies.

The HBM Project

The HBM project which generated these data was developed around the Health Belief Model. As applied to the adolescent pregnancy area, this model consists of four components, consisting of perceptions of: (1) the seriousness of pregnancy, (2) one's susceptibility to pregnancy (or impregnating someone), (3) the benefits of contraception, and (4) the barriers to contraceptive use.

One would expect that a desired outcome from training teens about adolescent sexuality would be to associate perceptions regarding the seriousness of and susceptibility to pregnancy with greater agreement with power strategy use in general. Likewise, it would be desirable to have strong and positive associations between agreement with power strategy use to have only protected sex and perceptions regarding the benefits of contraception. In contrast, it would be logical to expect positive associations between perceptions of the barriers to contraception and agreement to use power strategies to avoid having sex; while negative correlations between perceived barriers and agreement to use power strategies to have only protected sex.

Additional signs of a positive outcome for teens who engaged in the project would be an increase in agreement with the use of desirable power strategies, such as reasoning, and a decline in agreement with the use of undesirable power strategies, such as withdrawal. More generally, a desirable

outcome of participation in the project would be an increase in the adolescents' agreement with all desirable strategies to have or avoid having sexual intercourse.

Method

Subjects: Two hundred and three adolescents (126 females, 77 males) ranging in age from 12 to 18 years participated in the pre-test survey before participation in the HBM program. Of these, 45% were Anglo, 28% Black, and 28% were Hispanic. The post test survey was completed by 146 adolescents.

Procedure: As part of one section of the pre and post test, eight items were included to measure agreement with power strategy use. Four items were devoted to assessing strategies used to avoid having sex with a girl/boyfriend. Four items were devoted to assessing strategies used to have only protected sex with a girl/boyfriend. The items were written so as to reflect each quadrant of the Falbo and Peplau (1980) two-dimensional model. That is, one item represented bilateral and direct strategies; one item represented unilateral and direct strategies; one item represented unilateral and indirect strategies; and one item represented bilateral and indirect strategies. The specific items appear in Table 1 and the adolescents responded to them in terms of a 5-point rating scale ranging from strongly agree to strongly disagree with the mid-point being not sure.

Since the rest of this symposium is devoted to describing and evaluating the curriculum of the training program, little about this will be described here. The curriculum did provide the opportunity for participants to think about and rehearse strategies they would use to avoid having sex or to have only protected sex. Unfortunately, the types of strategies encouraged or discouraged by the trainers were left up to the judgment of the individual

trainers and to the spontaneous statements of the participants within each group. The trainers were not specifically trained to teach the adolescents to use or to avoid using particular strategies.

The post test survey also included items which combined to form scales measuring the four components of the Health Beliefs Model. Because these scales are described elsewhere, they will not be described further here.

Results

Pretest Data. As you can see from Table 1, the most preferred strategy for avoiding sex differed from the most preferred strategy for having sex. In avoiding sex, adolescents preferred a direct and unilateral strategy; while in seeking protected sex, adolescents preferred a direct and bilateral strategy. However, regardless of sexual goal, the unilateral and indirect strategy was the least preferred.

Table 1 also indicates that participation in the training program had little influence on the overall preference rankings of strategies. Only two out of the eight comparisons of pre and post ranks showed any change.

Table 2 presents the correlations between three individual difference variables and ten variables representing power strategies. The first eight power strategy variables represent the responses to the eight items presented in Table 1. The additional two variables represent the combined agreement scores of all strategies used to avoid sex and all strategies used to have sex.

These correlations indicate that gender is significantly related to agreement with power strategy use, especially those strategies to avoid having sex. Overall, these correlations suggest that female adolescents agree more than male adolescents with all types of strategies used to avoid having sex.

The only significant association between gender and a strategy to have sex concerns the indirect-unilateral strategy (withdrawal). Here, too, females agree to using it more than do males.

Age was significantly related to the use of the indirect and unilateral strategies, regardless of sexual goal. This means that younger adolescents were more likely to agree to the use of withdrawal than were older adolescents. The correlations between age and the combined strategy scores indicated that, in general, younger adolescents agree with the use of all strategies more than did older adolescents, especially to strategies to avoid sex.

The significant correlations between ethnicity and power strategy use were all positive indicating that the minority adolescents agreed more with these strategies than did Anglo adolescents. An inspection of the relevant mean scores indicate that Black and Hispanic adolescents responded similarly and both differed from the Anglos' mean. The correlations indicate that regardless of sexual goal, minority adolescents agreed more with the use of the indirect and unilateral strategy (withdrawal). Further, the significant and positive correlations between the two combined strategy scores and ethnicity indicate that minority adolescents, like female and younger adolescents, agreed more, in general, to all strategies to avoid and to have sex.

Posttest Data: In order to determine if training based on the Health Belief Model was associated with the adolescents' agreement with power strategies, correlations between the posttest scores measuring the components of the Health Belief Model and the posttest scores measuring power strategy agreement were computed. The results are presented in Table 3. The scale measuring the seriousness of pregnancy was unrelated to any of the power

strategy variables. The susceptibility scale was significantly correlated with only one of the 10 power strategy variables. The scale measuring the perceived benefits of contraception was positively and significantly related to eight out of the 10 power strategy variables, especially those dealing with strategies to have protected sex. Finally, the scale measuring the perceptions of greater barriers to contraception was positively and significantly related to the indirect-unilateral strategy (withdrawal) regardless of sexual goal. In contrast, the barriers scale was negatively related to the use of indirect-bilateral strategies (tell them that you love them) regardless of sexual goal and to the direct-unilateral strategy (telling) to avoid having sex. This means that greater perceptions of barriers to contraception are negatively related to telling the partner what is wanted, but positively related to the use of passive withdrawal as a means of influencing the girl/boyfriend.

Pre-Posttest Change: In order to determine whether the adolescents changed their agreement with power strategy use following participation in the HBM program, ten repeated measures analyses were conducted. These were conducted on the pre and post test ratings of the eight power strategies and the two combination scores reflecting the agreement with all strategies to have or avoid having sex.

The results are signalled in Table 1. The presence of a * after the posttest mean indicates that a significant repeatedness factor was obtained. Of the four strategies to avoid having sex, only one changed significantly: direct, unilateral, $F(1,143)=5.92$, $p<.02$. In contrast, agreement with all four strategies to have sex changed significantly. Compared to the pretest ratings, adolescents increased in their agreement with the use of (telling) direct, unilateral, $F(1,143)=18.45$, p .0001, (reasoning) direct, bilateral, $F(1,143)=11.49$, $p<.001$, and (tell them you love them) indirect, bilateral,

$F(1,143)=24.54$, $p<.0001$, strategies. The adolescents decreased in their agreement with the use of the (withdrawal) indirect, unilateral strategy, $F(1,143)=15.10$, $p<.0001$.

The results regarding the two combination scores reflected the results with the eight strategies. That is, the combined strategies to avoid having sex did not change significantly; whereas, the strategies to have sex did, $F(1,143)=17.46$, p .001. The means suggest that agreement with strategies to have protected sex increased after participation in the program.

Discussion

This study succeeded in exploring the strategies adolescents perceive to be effective in avoiding or having sex. Although this sample is not totally representative of adolescents across the U.S., the sample was heterogeneous in terms of the gender, age, and ethnicity of the participants. Therefore, the strategy preferences expressed by this sample and the gender, age, and ethnicity differences found here may reflect the patterns of power strategy use generally found among those U.S. adolescents willing to participate in such a program.

These results suggest that the most agreed with strategies to have protected sex were reasoning with the partners and telling them that you love them and that you had to use birth control. The most agreed with strategies to avoid sex were simply telling the partner you're not ready to have sex and also telling them that you love them but that you're not ready to have sex. Regardless of sexual goal, the least preferred strategy was not paying attention to the partner.

Overall, females agreed more than males with all strategies especially those to avoid having sex. This finding is consistent with the stereotype of females being the limit setters in sexual encounters (McCormick, 1979). However, based on the stereotype of males being the sexual initiator, one would expect boys to agree more to strategies to have sex, and this was not found in this sample. Perhaps this disparity is due to the earlier social maturation of girls in that they have already internalized the cultural expectations for their gender while the adolescent boys of this sample had not.

The only gender differences in the strategies to have sex concerned the females' greater agreement with the use of withdrawal, the least desirable strategy. Note also that age and ethnicity were correlated significantly with agreement to use withdrawal. That is, younger and minority adolescents were more likely to agree with not paying attention to their partner as a means of either avoiding or having sex. Taken together, these results suggest that lesser status (female, younger, or minority) is associated with the use of withdrawal as a means of influencing others. Since withdrawal is the most passive and least desirable of all the strategies considered in this study, this suggests that lesser status is associated with the use of the most passive and least desirable strategies to have or avoid having sex.

This "lesser status" interpretation can be further extended to the finding that females, younger adolescents, and minorities were somewhat more likely to agree to all strategies, regardless of their sexual goal. The consistency and size of the correlations between gender, ethnicity age, and the two scores reflecting combined agreement with power strategy use suggest a general association between being of lesser status and greater agreement with strategy use. It is likely that these lesser status individuals are aware

that they have less power in general to influence people and therefore, they need to compensate for this by "trying harder" -- that is, exhibiting greater agreement with all strategies in general.

The evaluation component of this study presents a mixed picture of the outcomes of the fertility control. In terms of the Health Belief Model, agreement with power strategies after participation in the program was generally unrelated to the adolescents' perceptions of the seriousness of or their susceptibility to pregnancy. However, the scale measuring the benefits of contraception was positively and significantly correlated with most of the eight power strategies, especially those to have protected sex. Given this, it appears that this scale reflects a more active orientation to avoiding sex or using contraception and that agreement with strategies to have or avoid having sex is associated with this more active orientation to sexual encounters.

One might argue that these consistently positive correlations indicate a response bias--all subjects simply agreeing with any statement on this section of the survey. To counter this argument, it should be noted that the power strategy variables were generally unrelated to the two Health Beliefs components reflecting seriousness and susceptibility, and that the fourth component, barriers to contraception, had positive and significant correlations with some power strategy variables and negative and significant correlations with other power strategy variables. Specifically, perceptions of greater barriers to contraception was positively and significantly related to agreement with withdrawal as a means to avoid or have sex. As suggested previously, agreement with withdrawal can be regarded as reflecting a passive and undesirable choice. Since perceptions of greater barriers to contraception is an undesirable perception, the correlation suggests that undesirable perceptions regarding contraception are associated with agreement with undesirable

power strategies. In contrast, perceptions of fewer barriers to contraception was associated with three out of the four strategies which involved telling the partner something to achieve the sexual goal. That is, adolescents who perceived fewer barriers to contraceptive use agreed more with telling the partners they loved them, and that they had to use contraception or that they were not ready to have sex. Thus, the more the adolescents perceived barriers to contraception, they agreed more with the most passive and least desirable strategies. The less these adolescents perceived barriers to contraception, the more they agreed to use a more active and desirable strategy.

The mixed picture regarding the success of the HBM project continued through the results of the analyses of the changes in power strategy agreement. The adolescents who completed the program increased significantly in their agreement with the more desirable strategies to influence a partner to have protected sex. Further, and importantly, these adolescents decreased significantly in their agreement with the least desirable strategy to have protected sex. However, participation in the HBM program had little significant impact on the adolescents' agreement with strategies to influence their partners not to have sex. These results suggest that participation in the program brought about desirable changes in the adolescents' strategies to have protected sex, but brought about little change in the adolescents' strategies to avoid sexual intercourse.

Conclusion: This study represents an exploration into the value of the inclusion of power strategy training in programs aimed at reducing the incidence of pregnancy among adolescents. Overall, these results indicate that agreement with the use of specific strategies with intimate partners is

related to the individual characteristics of the adolescent and to components of the Health Belief Model. The results suggest that lesser status, in terms of being female, younger, or minority, is associated with agreement with the use of the least desirable power strategies. Special training devoted to empowering these groups with desirable strategies to avoid sexual intercourse or having only protected sexual intercourse is needed.

In terms of the HBM program, the participants gained in terms of desirable strategies to have protected sex, but were not generally effected in terms of strategies to avoid sexual intercourse. More attention needs to be paid tc these strategies to avoid sex in future uses of this curriculum.

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Table 1

Eight Power Strategies Items: Mean Pre- and Post-Test Scores With Preference Ranks (in parentheses)

	Pre-test Mean (N=203)	Post-test Mean (N=146)	
Goal: To Avoid Sex			
1. If I didn't want to have sex with my girlfriend/boyfriend, I would simply tell her/him that I'm not ready to have sex. (Direct-Unilateral)	4.33 (1)	4.49 (1)	*
2. If I didn't want to have sex with my girlfriend/boyfriend, I would stop paying attention to her/him until she/he agreed to stop trying to have sex with me. (Indirect-Unilateral)	2.82 (4)	2.64 (4)	
3. If I didn't want to have sex with my girlfriend/boyfriend, I would reason with her/him until she/he thought my way. (Direct-Bilateral)	3.71 (3)	3.61 (3)	
4. If I didn't want to have sex with my girlfriend/boyfriend, I would tell her/him that I loved her/him, but that I'm not ready to have sex. (Indirect-Bilateral)	4.28 (2)	4.27 (2)	
• Total: All Strategies to avoid sex	15.13	15.01	
Goal: To Have Sex			
5. If I wanted to have sex with my girlfriend/boyfriend, I would just tell her/him to use birth control. (Direct-Unilateral)	3.19 (3)	3.66 (3)	*
6. If I wanted to have protected sex with my girlfriend/boyfriend, I would stop paying attention to her/him until she/he agreed to use birth control. (Indirect-Unilateral)	2.98 (4)	2.51 (4)	*
7. If I wanted to have sex with my girlfriend/boyfriend, I would reason with her/him until she/he agreed to use birth control. (Direct-Bilateral)	3.63 (1)	3.88 (2)	*
8. If I wanted to have sex with my girlfriend/boyfriend, I would tell her/him I loved her/him and that we had to use birth control. (Indirect-Bilateral)	3.54 (2)	4.00 (1)	*
• Total: All strategies to have sex	13.34	14.05	*

*p<.05

Table 2

Correlations Between Ten Power Strategy Variables and Three Characteristics of of the Respondent: Pre-Test Only (N=203)

	Characteristics		
	Gender	Age	Ethnicity
Goal: To Avoid Sex			
1. Direct-Unilateral	-.34*	.07	-.03
2. Indirect-Unilateral	-.15*	-.20*	.17*
3. Direct-Bilateral	-.15*	-.05	.12[b]
4. Indirect-Bilateral	-.34*	-.09	.01
Goal: To Have Sex			
5. Direct-Unilateral	-.06	.10	.09
6. Indirect-Unilateral	-.32*	-.23*	.28*
7. Direct-Bilateral	-.06	-.09	.04
8. Indirect-Bilateral	.02	-.02	-.04
9. Total: To Avoid Sex	-.26*	-.19*	.13*
10. Total: To Have Sex	-.16*	-.12[b]	.16*

Note: Gender is coded 1=female; 2=male. Age is measured in months. Ethnicity is coded 1=Anglo, 2=Black, 3=Hispanic. *$p < .05$

Table 3

Correlations Between Ten Power Strategy Variables and the Four Components of the Health Beliefs Model: Post-Test Only (N=146)

Power Strategies	HBM Components			
	Seriousness	Susceptibility	Benefits	Barriers
Goal: To Avoid Sex				
1. Direct-Unilateral	-.01	.13[b]	.19*	-.29*
2. Indirect-Unilateral	.07	-.03	.20*	.27*
3. Direct-Bilateral	-.02	.12[b]	.13[b]	.13[b]
4. Indirect-Bilateral	.01	.10	.20*	-.38*
Goal: To Have Sex				
5. Direct-Unilateral	-.03	.16*	.40*	.05
6. Indirect-Unilateral	.02	-.04	.08	.28*
7. Direct-Bilateral	.04	.12[b]	.40*	-.05
8. Indirect-Bilateral	-.03	.02	.32*	-.22*
9. Total: To Avoid Sex	.03	.11	.32*	-.03
10. Total: To Have Sex	.00	.10	.44*	.05

Note: High scores indicate greater agreement. *P < .05, [b].05 < p < .10