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Sexual Subjectivity among Adolescent Girls: Social Disadvantage and Young Adult Outcomes

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A risk framework characterizing teenage sexual activities as dangerous, especially for girls, has dominated research on teenage sexuality. Consequently, girls' sexual subjectivity has been virtually unexamined by large-scale quantitative research. We use the National Longitudinal Study of Adolescent Health to examine teenage girls' expectations of pleasure during intercourse and sexual self-efficacy, reflecting two key components of sexual subjectivity. Our findings indicate that youth from less socioeconomically privileged families report lower expectations than their privileged peers. There are also racial/ethnic disparities: Black-white differences can be explained by class, religion, and regional sexual education variation, but Latina and Asian girls display disadvantages even after controlling for these factors. Using a life-course approach, we show that dimensions of sexual subjectivity offer wide-reaching benefits in young adulthood, spanning multiple domains—including future sexual health, mental and physical health, and socioeconomic standing. We address the implications of our findings for the reproduction of inequality and conceptualizations of sexual risk and well-being.

Female adolescent sexuality is one of the most contentious political and scholarly topics. For nearly 30 years, an abstinence-only approach guided the US government's sexual education programs, despite opposition from advocates for comprehensive education (Irvine 2002; Luker 2006). Underlying this debate, centered on the well-being of girls and young women, are two broad paradigms. One focuses on the risk and harm associated with youth sex; the other emphasizes sexual self-awareness, assertiveness, and knowledge.

Academic research has been organized around similar dimensions. Numerous studies use large-scale survey data to examine risks associated with sexual behaviors and pro-sex attitudes among adolescents (e.g., see Armour and Haynie 2007; Billy et al. 1988; Cuffee, Hallfors, and Waller 2007; Hallfors et al.

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2005; O'Donnell, O'Donnell, and Stueve 2001; Rostosky, Regnerus, and Wright 2003; Sabia and Rees 2008). In contrast, qualitative feminist research focuses on females' expectations of sexual desire and pleasure, as well as confidence and control in sexual decision-making (Bay-Cheng 2003; Fine 1988; Horne and Zimmer-Gembeck 2005; Lamb 2010; Martin 1996; Schalet 2009; 2011a; Thompson 1995; Tolman 1999, 2002). Until recently, these two rich bodies of scholarship—reflecting different methods and/or perspectives—have rarely entered into conversation, limiting the potential for cross-fertilization (Schalet 2009; Tolman and McClelland 2011).

In this article, we use the National Longitudinal Study of Adolescent Health (Add Health) to examine teenage girls' expectations of sexual subjectivity in navigating heterosexual interactions. Our focus on girls mirrors that of existing literature and reflects the fact that girls may face more challenges to sexual subjectivity than boys (Martin 1996; Tolman 2002). We ask: (1) How do adolescent girls from disadvantaged groups differ from their privileged counterparts in expectations of pleasure during sexual intercourse and sexual self-efficacy? and (2) How do these factors affect adolescent girls' future sexual health, mental and physical health, and socioeconomic standing? Our approach builds on a small body of quantitative scholarship challenging a simplistic notion of risks surrounding adolescent sexual intercourse (e.g., Bearman and Brückner 2001; Horne and Zimmer-Gembeck 2005, 2006; Impett, Schooler, and Tolman 2006; McCarthy and Casey 2008; McCarthy and Grodsky 2011; Meier 2007; Pearson 2006).

Background

Over the past century, more young women have joined men in premarital sex. By age 21, 85 percent of men and 81 percent of women report vaginal intercourse, and the mean age at first intercourse has declined and converged at just over 17 (NCHS 2013). Reliable contraception, legalized abortion, and liberalization of sexual attitudes enabled this shift by reducing the physical and social risks of sex and offering young women unprecedented control over their sexuality (Loftus 2001; McLanahan 2004). These changes have played an important role in how female adolescent sexuality is viewed and studied.

The 1990s ushered in an era of concern around a series of what were framed primarily as women's issues. A seven percent rise in teenage pregnancy rates between 1985 and 1990, combined with an increase in sexualized images of girls and young women in the media, fueled public alarm (APA Task Force 2012; Donovan 1998; Hamilton and Ventura 2012; Levin and Kilbourne 2008). This social and political climate, and the involvement of the organized Christian Right, contributed to a marked increase in the federal government's expenditure on abstinence-only education programs (Fine and McClelland 2007; Irvine 2002; Lord 2010; Luker 2006). Between 1996 and 2001, these funding streams grew exponentially, and did not decrease until after 2009 (SIECUS 2010b). The period was also characterized by a research agenda focused on negative consequences of teen sex (see Fine and McClelland 2006; Tolman and McClelland 2011).

Scholars have shown that teenage sex can have harmful effects on young women's sexual health, under certain conditions. For example, the earlier the age of first sex, the greater risk of contracting an STI or experiencing teen pregnancy (Kaestle et al. 2005; Kirby 2002).[1] Youth who engage in their first sex at a non-normative point in the life course may have lower levels of psychological well-being and educational attainment (Frisco 2008; Meier 2007). Relational context also matters: Intercourse within adolescent romantic relationships is not associated with negative educational outcomes, while sex outside this context is (McCarthy and Grodsky 2011). Risks posed by early sexual activity may be salient for black girls, who transition to sexual intercourse earlier, and possibly exacerbated by socioeconomic factors (Miller et al. 1997; Upchurch et al. 1998). Girls whose mothers have less education are also more likely to engage in teen sex (Meier 2003).

Quantitative research on teens' sexual attitudes has occurred mostly within this same risk framework. Positive sexual attitudes, in which there are perceived benefits to having sex (e.g., pleasure), have been framed as risk factors in that they are antecedents to having sex (Cuffee, Hallfors, and Waller 2007; Rostosky, Regnerus, and Wright 2003).[2] In this literature, sexual efficacy is considered protective, to the extent that youth demonstrate the ability to refrain from sex (Kirby 2002).

A risk approach to youth sexuality leaves little room for positive perspectives, narrowing the discourse (Dennison and Russell 2005; Tolman and McClelland 2011). Unlike other risky behaviors (e.g., drug use), it is assumed that sex is healthy for adults; however, it is unclear how girls and young women are expected to achieve a healthy adult sex life if there is no notion of healthy sexual development (Fine 1988; Martin 1996; Schalet 2011a, 2011b; Thompson 1995; Tolman 2002). Many topics are off the table—such as how to confidently navigate and enjoy sexual activities. A risk approach assumes that the most relevant outcomes are adolescent sexual activity, STI contraction, and teen pregnancy. Very little scholarship investigates whether youth sexual behaviors and attitudes shape a broader array of outcomes.

Sexual Subjectivity and Social Disadvantage

In 1988, Fine identified "a missing discourse of desire" surrounding female adolescent sexuality. She, along with others (Debold, Wilson, and Malave 1993; Martin 1996; Thompson 1995; Tolman 1999, 2002), argued that girls are taught to view themselves as sexual objects and targets of male sexual aggression. They noted that girls often view their sexuality with fear or shame, and report sexual activity as something that happens to them.

Strikingly absent in the narratives they collected was evidence of girls' sexual subjectivity. As Lamb (2010) notes, scholars define sexual subjectivity as girls' ownership over their desire/pleasure (terms that are often used interchangeably). Horne and Zimmer-Gembeck (2005, 28) describe sexual subjectivity as "the perceptions of pleasure from the body and the experience of being sexual." Many point to the importance of sexual agency or efficacy, in which girls "advocate

for [their own] interests in the sexual arena" (Bay-Cheng 2003, 65; Lamb 2010). Feminist scholars are divided as to whether sexual self-efficacy is a feature of sexual subjectivity, but most see them as linked: It is easier to seek and own sexual pleasure if one is efficacious. Martin (1996, 10) even connects owning "the pleasure we get from our bodies" with agency more generally, or "the ability to act in the world and . . . will things and make them happen."

Scholars argue that the sexual subjectivities of girls in disadvantaged social positions are most challenged (Martin 1996; Tolman 2002). This disadvantage may operate, in part, through disparities in access to accurate and positive information about youth sexuality. For example, in the home, more educated parents tend to be better informed and hold less conservative sexual attitudes, which facilitates communication with children (Miller and Whitaker 2001; see also Regnerus 2005). Latina and Asian mothers talk less to their daughters about sex and maintain high levels of surveillance. In contrast, black mothers are most likely to convey sexual information to their daughters (Meneses et al. 2006), perhaps due to a greater perception of need given the early age of intercourse among black girls.

Outside the home, educational and material resources are most limited for black and Latina girls and those from poor or working-class families (Fine 1988; Fine and McClelland 2007). Through the 1990s, these groups were more likely to be clustered in states and schools reliant on abstinence-only education. This programming offered only limited sexual information and discouraged the development of girls' sexual subjectivity. Disadvantaged youth also have limited access to high-quality health care, through which sexual services and information are obtained (Fine and McClelland 2007).

Differences in sexual subjectivity may also exist due to class- and race-based stereotypes of female sexuality. For example, Asian girls and women are often portrayed as an "exotic pornographic fantasy" (Chou 2012, 72), perhaps leading them to exercise caution in sexual expression. Black, Latina, and less privileged youth are likely to be labeled as sexually permissive or "at risk" (Bettie 2003; Collins 2000; López 2003; Tolman 1996). Their bodies and actions are coded as more sexual than those of upper-middle-class white girls (Bettie 2003; Garcia 2012; Wilkins 2008). When girls' sexuality is constructed as a problem to be solved—rather than empowered—they are in a vulnerable position for claiming sexual subjectivity.

Feminist scholars contend that limited sexual subjectivity poses issues for girls and young women. Martin (1996) argues that girls' self-esteem drops at adolescence because they become alienated from their bodies and sexual selves. Debold, Wilson, and Malave (1993, 8) see girls' truncated sexual subjectivities as behind their struggles with depression, appearance, eating disorders, and "other manifestations of psychological distress." Tolman (2002, 21) claims that "*not* feeling sexual desire may put girls in danger and 'at risk' . . . [A girl] then becomes especially vulnerable to the power of others' feelings as well as to what others say she does and does not want or feel." This may make the active choices necessary to prevent unwanted conception and STIs more difficult (see Tolman, Striepe, and Harmon's [2003] theoretical model).

Most work detailing the dangers of limited sexual subjectivity is based on qualitative data and thus may lack generalizability. Horne and Zimmer-Gembeck (2006) develop a quantitative scale to measure female sexual subjectivity, defined around sexual pleasure. They find that higher levels of sexual subjectivity are associated with higher sexual self-efficacy and self-awareness, and lower sexual anxiety (see also Impett, Schooler, and Tolman 2006). Beyond this, there are few attempts to isolate the effects of sexual subjectivity.

Feminist scholars also have concerns about girls' development of authentic subjectivities (Gavey 2012; Lamb 2010; Lamb and Peterson 2011; Peterson 2010). Recent empowerment efforts have treated sexual subjectivity as about individual "girl power" and sexual self-fulfillment, with little attention to social, political, and institutional contexts (Bay-Cheng 2003; Lamb 2010). If pleasure is the primary focus, many problematic forms of sex might be coded as positive. Girls may feel efficacious and in control of potentially objectifying sexual performances, like lap dances and stripping (Lamb 2010). This raises the possibility that what seems like sexual subjectivity might not always offer the benefits posited by feminist literature.

Long-Term Consequences of Sexual Subjectivity

Long-term consequences of girls' sexual subjectivity are virtually unknown. As noted earlier, this is due, in part, to a blind spot in a research tradition focused on predictors and risks of adolescent sex. The studies that exist, largely from a feminist perspective, have not been longitudinal—regardless of method. There is little empirical evidence of how early sexual attitudes and development shape young adult experiences.

We take a life-course approach to sexual subjectivity, highlighting consequences for young adult well-being (Halpern 2010). Adolescent sexual behavior may send youth in different directions, with cascading effects in multiple dimensions of their lives. For example, Meier (2007) shows that the timing of adolescents' first sex influences subsequent mental health. Frisco (2008) demonstrates that features of adolescent sexual behavior are strong predictors of future academic attainment. This broader understanding of how youth sex is linked to indicators of socioeconomic status moves adolescent sexuality research into the realm of stratification. It emphasizes the importance of framing sexual "risk" and advantage more comprehensively.

There is potential for girls' sexual subjectivity to be protective, beyond health benefits. Girls who display sexual subjectivity may be better equipped to engineer sexual interactions in ways supportive of young adult tasks. For example, one threat to female educational achievement is early commitment (Holland and Eisenhart 1990; Martin 1996). Girls and young women may enter relationships in part because they are perceived as the legitimate context for unmarried female sexuality (Crawford and Popp 2003; Risman and Schwartz 2002). Relationships may derail them academically, depleting valuable time, autonomy, and energies (Hamilton and Armstrong 2009). Girls who learn to privilege their

sexual needs may make decisions about how and with whom to have sex that do not hurt their career trajectories.

In what follows, we ask how two features of sexual subjectivity are distributed among adolescent girls, and whether they shape key dimensions of their young adult lives: sexual health, mental and physical health, and indicators of future socioeconomic status. Ideally, we would measure the degree to which girls experienced themselves as sexual subjects in actual sexual encounters. However, it is not necessary to be sexually active in order to demonstrate sexual subjectivity, and—in the initial wave of the Add Health survey—many girls were not. In addition, Add Health (although less than other national data sets) tends to approach youth sexual behavior from a risk model (Tolman and McClelland 2011). Thus, we follow past precedent in assessing sexual subjectivity through attitudinal measures (Horne and Zimmer-Gembeck 2006).

Data, Measures, and Methods

We analyze data from the 1994–2008 National Longitudinal Study of Adolescent Health (Add Health). In 1994–1995, a cluster-based sample of 20,745 seventh through twelfth graders was drawn from a representative sample of US schools. Adolescents completed a face-to-face interview, in which they provided sociodemographic information and details on many aspects of their lives. Sensitive sexual information was collected using audio-CASI technology to ensure reliability and validity.

Add Health is not without limitations, as we discuss below. However, it is the most comprehensive, nationally representative survey on adolescent sexuality, and thus offers the greatest potential to step outside a risk framework (Dennison and Russell 2005). Add Health also follows respondents from adolescence through young adulthood, reinterviewing nearly three-quarters of Wave 1 respondents in 2001–2002—when most were aged 19 to 24—and again in 2007–2008—when they were 24 to 32. Longitudinal design allows us to analyze the potentially enduring effects of adolescent sexual subjectivity.

Our sample includes unmarried adolescent females who were at least 15 at the time of Wave 1, to whom Add Health administered questions regarding sexual activity.[3] We also focus on females likely to engage in heterosexual sexual activity. This is necessary, as several items refer to "intercourse," which Add Health narrowly defines as "when a male inserts his penis into a female's vagina."[4] Although Wave 1 does not ask respondents to self-report sexual identification, it does include the following questions: "Have you ever had a romantic attraction to a male?" and "Have you ever had a romantic attraction to a female?" We take a broad approach, excluding only girls who simultaneously answered "no" to the first question and "yes" to the second.[5] Omitting cases with missing values in sampling weights, 6,808 girls met the sample criteria. Missing values in explanatory variables are imputed using multiple imputation by chained equations ($m = 20$) (Royston, Carlin, and White 2009).

A total of 6,416 female respondents are available for separate analyses that predict our two key measures of sexual subjectivity (discussed below), as cases

missing on these variables are dropped. Because we examine nine discrete young adult outcomes, we allow each outcome to have its own estimation sample. This approach maximizes the available information, and preserves disadvantaged youth in the sample, who are more likely to be missing on outcome indicators.

Expectations of Sexual Pleasure and Self-Efficacy

Table 1 reports the wording and coding for all variables. As discussed earlier, the feminist literature associates sexual subjectivity with experiencing sexual pleasure and demonstrating sexual self-efficacy. Wave 1 of Add Health includes a single question regarding sexual pleasure, buried in the "Motivations to Engage in Risky Behaviors" module. Respondents are asked to what extent they agree with the following statement: "If you had sexual intercourse, it would give you a great deal of physical pleasure."

This is the only measure of sexual pleasure in a large-scale national survey of adolescents, and thus offers the best available information. Given the political and social climate in the 1990s, it is perhaps surprising that such a measure exists at all. The measure, however, has serious limitations. It asks respondents to consider pleasure only in the context of intercourse, as defined by Add Health. As sex researchers have demonstrated, manual or oral stimulation significantly increases the likelihood of female orgasm (Bancroft 2002; Richters et al. 2006). Girls may also fear first intercourse, assuming it will be painful; however, as Martin (1996) notes, these assumptions may be—in and of themselves—indicators of limited sexual subjectivity. Below, we refer to this measure as expectations of pleasure during intercourse.

Add Health's Wave 1 sexual efficacy module focuses on birth control use—one of many ways girls can exercise sexual agency. Practicing safe sex and preventing pregnancy are often tasks girls face alone; they may even encounter sexual stigma for doing so (Garcia 2012; Tolman 2002). Assuming a hypothetical partner, respondents are asked: (1) If you wanted to use birth control, how sure are you that you could stop yourself and use birth control once you were highly aroused or turned on? (2) How sure are you that you could plan ahead to have some form of birth control available? (3) How sure are you that you could resist sexual intercourse if your partner did not want to use some form of birth control? We measure self-efficacy with a composite variable of these items ($\alpha = .630$).

Outcomes in Young Adulthood

We examine nine young adult outcomes, grouped into three categories: sexual health, mental and physical health, and indicators of future socioeconomic status. These indicators are drawn from Waves 3 and 4.

We include four measures of sexual health. In Wave 3, respondents who have had vaginal intercourse in the past 12 months are asked to indicate how often they used some form of birth control, and specifically, how often they used a condom. We also report a positive STI result for a chlamydia, gonorrhea, and trichomoniasis assay administered by Add Health in Wave 3. This measure is

Table 1. Description of Variables in the Analyses

PANEL A. Variables from Wave 1, 1994–1995		
Variable descriptions	Question wording/coding	Mean
Expectations of pleasure during intercourse	If you had sexual intercourse, it would give you a great deal of physical pleasure. 1 = strongly disagree; 5 = strongly agree	3.10
Sexual self-efficacy	Composite scale from 3 items: (1) If you wanted to use birth control, how sure are you that you could stop yourself and use birth control once you were highly aroused or turned on? (2) How sure are you that you could plan ahead to have some form of birth control available? (3) How sure are you that you could resist sexual intercourse if your partner did not want to use some form of birth control? 1 = very unsure; 5 = very sure	4.33
Early sexual intercourse[a]	Derived from age of sexual debut from Waves 1, 3, and 4	.51
Race/ethnicity[a]	Racial/ethnic self-identification in five categories: 0 = white; four dummies for black, Latina, Asian, and other minorities.	–
Highest parental education[a]	Years	13.46
Family income[a]	Thousands of dollars	44.12
Adolescent's age	Years	16.93
Frequency of religious attendance[a]	In the past 12 months, how often did you attend religious services? 1 = never; 4 = once a week or more	2.68
Average GPA[a]	Average GPA from English, math, social studies, and science (1 = D; 4 = A)	2.77
Mother has a paid job[a]	1 = yes; 0 = no	.68
Parental structure	Categorical: 0 = single-parent families; two dummies for two-biological-parent and two-other-parent families	–
Private school	1 = yes, 0 = no	.05
Urban school	1 = yes, 0 = no	.26
Region	Categorical: 0 = Northeast; three dummies for West, Midwest, and South	–

PANEL B. Outcome Measures in Young Adulthood, Waves 3 to 4, 2001–2008		
Variable descriptions	**Question wording/coding**	**Mean**
WAVE 3		
Frequency of using birth control[b]	On how many of these occasions of vaginal intercourse in the past 12 months did you or your partner use some form of birth control or pregnancy protection? 0 = none; 4 = all	2.71
Frequency of using a condom[b]	On how many of these occasions did you or your partner use a condom? 0 = none; 4 = all	1.50
Positive STI results	Positive assay results for chlamydia, gonorrhea, or trichomoniasis	.06
WAVE 4		
Teen pregnancy (before age 20)	Derived from the pregnancy table file data in Wave 4 (yes = 1)	.26
CES-D Depression Scale	CES-D depression scale constructed by Add Health based on the following five items: During the past seven days, (1) you were bothered by things that usually don't bother you; (2) you could not shake off the blues, even with help from your family and your friends; (3) you had trouble keeping your mind on what you were doing; (4) you felt depressed; and (5) you felt sad. Higher scores = more depressive symptoms	2.79
General health	In general, how is your health? 1 = poor, 5 = excellent	3.65
Number of close friends	How many close friends do you have? Close friends include people whom you feel at ease with, can talk to about private matters, and can call on for help. 1 = none; 5 = 10 or more friends	3.08
Years of schooling	Years	14.38
Personal income	Thousands of dollars	30.57

Source: National Longitudinal Study of Adolescent Health, 1994–2008

Note: All mean values are restricted to heterosexual female respondents who were at least 15 years old in Wave 1 and are adjusted by survey sampling design. Unweighted *N* for sexual pleasure expectations, sexual self-efficacy, and all control variables = 6,416. Unweighted *N*s for outcome variables in Waves 3 and 4 vary from 4,021 to 5,999, depending on the missing data in the outcome.

[a]To preserve cases, multiple imputations ($m = 20$) for missing cases are used in multivariate analyses.

[b]Respondents with no vaginal intercourse in the past 12 months are excluded from analyses.

preferable over self-reports of seeking medical help, as it is unclear if individuals who go to the doctor for treatment actually have higher rates of STI contraction or are demonstrating more responsible behavior.[6] We also utilize the Wave 4 pregnancy table data to construct a measure of teenage pregnancy, in which respondents who reported becoming pregnant before age 20 were coded as 1.

Three variables from Wave 4 assess mental and physical health. Mental health is measured by a five-item Depression Scale (CES-D) constructed by Add Health. Higher scores indicate more depressive symptoms. General health is assessed by self-report, in which personal health is rated from poor (1) to excellent (5). Given that social ties are a strong predictor of mental and physical health (Seeman 1996), we include a measure of close friends with whom respondents "feel at ease with, can talk to about private matters, and can call on for help."

Finally, we include two important indicators of future socioeconomic success from Wave 4. We measure educational attainment with years of schooling. Personal income is assessed in thousands of dollars.

Explanatory Variables

We code respondents who had sexual intercourse at or before age 16 as 1, and others as 0. This indicator captures sexual activity before the average age at first sex for females (17.1 years; NCHS 2013), as transitioning with one's peers is not associated with negative outcomes (see Meier 2007).[7] With the inclusion of early sexual intercourse as an explanatory factor, we separate out the effects of having early sex from expectations of pleasure during intercourse or self-efficacy. That is, while they might be related, we consider each as having distinct effects.

We consider two primary dimensions of disadvantage. Race/ethnicity is measured by adolescents' racial self-identification in Wave 1. Respondents were asked to select from five racial categories: white, black, American Indian or Native American, Asian or Pacific Islander, and other. They also answered the question "Are you of Hispanic or Latino origin?" Using this information, we constructed five categories: white, black, Latina, Asian, and other.[8] Measures for social class of origin include highest parental education in years of schooling and annual family income in thousands.

We also include other potential determinants of girls' sexual subjectivity from the Wave 1 data. Age is measured in years. Average religious attendance in the past 12 months is coded from 1 (never) to 4 (once a week or more). For a measure of academic achievement, we use the respondents' average letter grades from the previous academic year coded on a four-point scale. Nontraditional family structure and women's employment are associated with feminist attitudes (Bolzendahl and Myers 2004). Thus, we include dummy variables for two-biological-parent and two-other-parent households, with families headed by a single parent or a guardian as the reference group. Mother's employment is assessed using the question "Does she [resident mother] work for pay?" (1 = yes, 0 = no). Finally, measures of school context are considered, including indicators of private and urban status as well as region.[9]

Analytical Strategies and Statistical Methods

Our analyses proceed in two stages. First, we focus on predictors of female adolescents' expectations of pleasure during intercourse and sexual self-efficacy. Our initial models examine the relationship between race/ethnicity and our dependent variables of interest. In a second model, we add markers of family social class, and in a third, early sexual intercourse. Finally, we include all explanatory variables.

In a second stage, we examine the long-term implications of expectations of pleasure during intercourse and self-efficacy for young adult well-being. We use OLS, binary logit, and ordinal logit, and conceptualize these models under the framework of the generalized linear model (GLM). The GLM framework works well here, as we are interested primarily in whether our two measures of sexual subjectivity are significant predictors of our outcome variables. All analyses control for explanatory variables and are adjusted by the sampling design of Add Health.

Results

Table 2 reports the weighted means for expectations of pleasure during intercourse and sexual self-efficacy by selected sociodemographic characteristics.[10] All continuous variables are divided into quartiles.

Racial/ethnic differences in expectations of sexual pleasure and self-efficacy are notable. Black and Latina girls report significantly lower expectations of pleasure during intercourse than white girls ($p < .05$). With regard to self-efficacy, Latina and Asian girls have lower expectations than whites ($p < .05$). These findings suggest a racial advantage in sexual subjectivity for white adolescent females.

A similar story is apparent with social class. As parental education increases, so do expectations of pleasure during intercourse and self-efficacy. There is a significant difference between the lowest and highest educational quartiles for both attitudinal measures, and some differences between middle groups and the highest quartile. There is a sizable gap in positive attitudes between those in the bottom and lower-middle income quartiles with those whose parents earn the most.

As table 2 indicates, early sex is positively associated with expectations of pleasure and self-efficacy. This is not surprising, as girls who expect intercourse to be pleasurable may be more likely to engage in it (see Rostosky, Regnerus, and Wright 2003) and/or those with more sexual experience may view intercourse as more pleasurable (Horne and Zimmer-Gembeck 2005). Feminist research also suggests that greater sexual experience boosts girls' sexual agency and confidence in navigating sexual interactions (Horne and Zimmer-Gembeck 2005; Impett, Schooler, and Tolman 2006). Notably, although black girls and those from less privileged families are more likely to engage in first sex at age 16 or younger (confirmed in supplemental analyses; see also Miller et al. [1997]; Upchurch et al. [1998]), they do not appear to enjoy the corresponding benefits.

Table 2. Weighted Means of Teenage Girls' Expectations of Pleasure during Intercourse and Sexual Self-Efficacy by Selected Characteristics

	Expectations of pleasure during intercourse[a]	Sexual self-efficacy[a]
All	3.10	4.33
Race		
White[†]	3.14	4.36
Black	2.99*	4.33
Latina	2.87*	4.06*
Asian	3.01	3.95*
Other minority	3.15	4.37
Parental education		
Lowest quartile	2.97*	4.26*
Lower-middle quartile	3.12*	4.35
Higher-middle quartile	3.18	4.34*
Highest quartile[†]	3.28	4.43
Family income		
Lowest quartile	3.01*	4.27*
Lower-middle quartile	3.05*	4.29*
Higher-middle quartile	3.12	4.36
Highest quartile[†]	3.20	4.39
Early sexual intercourse		
Yes	3.23*	4.37*
No[†]	2.96	4.29
Adolescent's age		
Lowest quartile	2.88*	4.22*
Lower-middle quartile	3.05*	4.30*
Higher-middle quartile	3.21	4.42
Highest quartile[†]	3.26	4.40
Frequency of religious attendance		
Never[†]	3.25	4.38
Less than once a month	3.19	4.37
Once a month or more	3.08*	4.32
Once a week or more	2.95*	4.27*
School performance by GPA		
Lowest quartile	3.12	4.22*
Lower-middle quartile	3.07	4.29*
Higher-middle quartile	3.12	4.39

Continued

Table 2. continued

	Expectations of pleasure during intercourse[a]	Sexual self-efficacy[a]
Highest quartile[†]	3.07	4.41
Other minority	3.12	4.22
Mother has a paid job		
Yes	3.12	4.35*
No[†]	3.05	4.28
Family type		
Single parent or a guardian	3.13	4.33
Two other parents	3.11	4.35
Two biological parents	3.06	4.32
Region		
West	3.12	4.28
Midwest	3.15	4.34
South	2.98*	4.31
Northeast[†]	3.25	4.39
Attend a private school		
Yes	3.30	4.29
No	3.08	4.33
Attend a large school		
Yes	3.13	4.33
No	3.06	4.33
Attend an urban school		
Yes	3.05	4.24*
No[†]	3.11	4.36

Source: National Longitudinal Study of Adolescent Health, 1994–1995
Note: Analyses are restricted to female adolescents likely to engage in heterosexual activity who were at least 15 years old in Wave 1 and are adjusted by survey sampling design unweighted ($N = 6{,}416$).
[a]Responses range from 1 to 5. High values indicate more positive sexual pleasure expectations and more sexual self-efficacy.
[†]Indicates reference category.
*Indicates significance difference at the .05 level.

In supplemental analyses, we divide the sample into girls who had early sex and those who did not. In both groups, black and Latina girls report lower expectations of pleasure during intercourse than whites, and Latina and Asian girls score lower on sexual efficacy. Across our split samples, class patterns also appear for both parental education and income, although income differences are more pronounced among those who did not engage in early sex. These patterns

suggest that minorities and those from less privileged families consistently display lower expectations than similarly experienced peers.

Other differences in table 2 are notable. Older youth report higher expectations of pleasure and self-efficacy. Youth who report higher levels of religious attendance indicate significantly lower levels of both sexual subjectivity components (see also Rostosky, Regnerus, and Wright 2003). For expectations of pleasure during intercourse, there is regional variation: Residents in the South—an area with more traditional gender and sexual attitudes and limited sexual education (Bolzendahl and Myers 2004; SIECUS 2010a)—report less positive attitudes than those in the Northeast. With regard to self-efficacy, academically achieving girls have higher expectations. They may perceive that they have much to lose by contracting an STI or having an unwanted pregnancy, motivating agency in birth control use (Garcia 2012). Girls with working mothers also display greater self-efficacy—perhaps due to maternal transmission of feminist attitudes regarding premarital sex, abortion, and gender roles (Bolzendahl and Myers 2004). Finally, there is an urban disparity in self-efficacy (see Tolman 2002).

These initial findings suggest that disparities in expectations of pleasure during intercourse and self-efficacy are organized around racial, ethnic, and class lines. Below, we turn to multivariate analyses to determine whether these differences can be explained by explanatory variables.

Multivariate Analyses

Expectations of pleasure during intercourse

Model 1 of table 3 indicates that black and Latina girls, as opposed to white girls, have significantly lower pleasure expectations ($p < .01$ and $p < .05$, respectively). A significant difference between blacks and whites (but not Latinas and whites) remains in model 2, with the introduction of measures for social class, and model 3, in which early sexual intercourse is added. In model 4, which includes controls for religious attendance and region of the country, there is no statistically significant difference between whites and blacks.

These findings suggest that many racial/ethnic disparities in expectations of pleasure during intercourse are maintained through socioeconomic, religious, and regional policy factors. Among Latinas, low levels of parental education relative to other racial/ethnic groups may limit the transmission of sexual information in the family. Blacks have high levels of religious attendance and are heavily represented in the South—the region where abstinence-only programming enjoyed the most support (see SIECUS 2010a). Both these factors likely pull down the pleasure expectations of black girls in previous models, but are accounted for in model 4.

Asian girls display a different pattern. The disparity in expectations for pleasure during intercourse first reaches significance in model 2, when accounting for parental social class. In model 3, with the addition of early sexual intercourse, it does not reach significance. This is due to the fact that Asian girls are significantly less likely to have teen sex, which is associated with a reduction in

Table 3. Ordinal Logit Coefficients for Adolescent Girls' Expectations of Pleasure during Intercourse

	Model 1		Model 2		Model 3		Model 4	
	B	S.E.	B	S.E.	B	S.E.	B	S.E.
Black	–.286	(.100)**	–.206	(.097)*	–.232	(.097)*	–.144	(.115)
Latina	–.483	(.194)*	–.240	(.176)	–.168	(.172)	–.183	(.149)
Asian	–.261	(.135)	–.271	(.129)*	–.154	(.124)	–.299	(.116)*
Other minorities	.000	(.153)	.036	(.154)	.038	(.157)	.010	(.148)
Highest parental education			.075	(.016)**	.083	(.016)**	.087	(.016)**
Family income			.001	(.001)	.001	(.001)	.001	(.001)
Early sexual intercourse[a]					.546	(.072)**	.536	(.074)**
Adolescent's age							.270	(.028)**
Frequency of religious attendance							–.126	(.032)**
Average GPA in high school							–.031	(.048)
Mother has a paid job							.033	(.080)
Two-biological-parent family							–.156	(.068)*
Two-other-parent family							–.177	(.079)*
Attend a private school							.366	(.147)*
Attend an urban school							–.038	(.092)
West							–.063	(.114)
Midwest							–.151	(.108)
South							–.359	(.105)**

(Continued)

Table 3. continued

	Model 1		Model 2		Model 3		Model 4	
	B	S.E.	B	S.E.	B	S.E.	B	S.E.
τ_1	–2.531		–1.488		–1.108		2.749	
τ_2	–1.414		–.363		.028		3.905	
τ_3	.687		1.764		2.186		6.135	
τ_4	2.572		3.661		4.100		8.097	
F-value	3.72		5.79		15.04		16.39	

Source: National Longitudinal Study of Adolescent Health, 1994–1995

Note: $N = 6{,}416$. Standard errors are in parentheses. All coefficients are adjusted by survey sampling design and multiple imputations for missing cases in controls ($m = 20$). White, single parent or a guardian, and Northeast are reference categories.

[a]Age of first sex is derived from Waves 3 and 4.

** p < .01 * p < .05 (2-tailed)

pleasure expectations that, when controlled for, mitigates the difference. However, in model 4, with a fuller array of social-class-related controls (e.g., private school), a significant difference in comparison to white girls is once again apparent ($p < .01$).

Class disparities are robust and mirror those noted in table 2. As models 2, 3, and 4 indicate, teens with parents who have higher levels of education report higher expectations of pleasure during intercourse ($p < .01$).[11] In model 4, we also see that youth who attend a private school—a benefit typically available only to wealthy families—display higher pleasure expectations ($p < .05$).

Models 3 and 4 corroborate patterns established earlier. Girls who experienced intercourse at age 16 or younger are significantly more likely to report higher levels of expectations for pleasure during intercourse. We also see that as age increases, so do pleasure expectations. Those who attend religious services more frequently report lower expectations, as do girls living in the South versus the Northeast. Although not apparent in table 2, when controlling for class disadvantages associated with single-parent families, youth from two-parent family types report lower expectations of pleasure during intercourse. This may be due to the fact that divorced adults are significantly more likely to hold feminist views on premarital sex (Bolzendahl and Myers 2004)—potentially increasing the likelihood of communicating positive sexual views to their daughters.

Table 4. Regression Coefficients for Adolescent Girls' Sexual Self-Efficacy

	Model 1		Model 2		Model 3		Model 4	
	B	S.E.	B	S.E.	B	S.E.	B	S.E.
Black	–.035	(.036)	–.003	(.036)	–.006	(.036)	.015	(.037)
Latina	–.305	(.072)**	–.232	(.071)**	–.221	(.071)**	–.210	(.070)**
Asian	–.418	(.111)**	–.421	(.111)**	–.405	(.109)**	–.460	(.107)**
Other minorities	.004	(.056)	.018	(.054)	.017	(.054)	.029	(.055)
Highest parental education			.020	(.005)**	.021	(.005)**	.016	(.005)**
Family income			.001	(.000)*	.001	(.000)*	.001	(.000)*
Early sexual intercourse[a]					.077	(.027)**	.094	(.027)**
Adolescent's age							.077	(.012)**
Frequency of religious attendance							–.028	(.014)*
Average GPA in high school							.089	(.016)**
Mother has a paid job							.024	(.034)
Two-biological-parent family							–.039	(.034)
Two-other-parent family							–.021	(.039)
Attend a private school							–.064	(.089)
Attend an urban school							–.071	(.038)
West region							–.027	(.059)
Midwest region							–.082	(.053)
South region							–.078	(.043)
Constant	4.364	(.023)**	4.058	(.072)**	4.002	(.073)**	2.679	(.235)**
F-value	5.75		7.65		7.48		10.07	

Source: National Longitudinal Study of Adolescent Health, 1994–1995
Note: $N = 6{,}416$. Standard errors are in parentheses. All coefficients are adjusted by survey sampling design and multiple imputations for missing cases in controls ($m = 20$). White, single parent or a guardian, and Northeast are reference categories.
[a]Age of first sex is derived from Waves 3 and 4.
** $p < .01$ * $p < .05$ (2-tailed)

Sexual self-efficacy

In model 1 of table 4, we see that Latina and Asian girls have significantly lower expectations of self-efficacy than whites ($p < .01$). The difference persists across all four models. Notably, there are no significant differences between blacks and whites in any models. This is consistent with previous research on the flow of sexual information in the home—where black girls are advantaged, even over whites, and Latina and Asian girls are disadvantaged (see also Garcia 2012; Meneses et al. 2006).

Model 2 adds indicators for social class of origin. Again, we see a significant positive effect of parental education on sexual self-efficacy that persists in models 3 and 4 ($p < .01$). Models 3 and 4 indicate a few additional patterns. There is the expected positive effect of early sex, with those who engaged in intercourse before or at age 16 displaying higher expectations of sexual efficacy. Older youth also anticipate greater sexual self-efficacy. Girls who attend religious services regularly have lower self-efficacy expectations, and students with higher GPAs report higher levels.[12]

Predicting Young Adult Outcomes

In this section, we determine how expectations of pleasure during intercourse and self-efficacy shape girls' future well-being. In table 5, we take a broad perspective, looking at nine measures from Waves 3 and 4 across three domains: sexual health, mental and physical health, and indicators of future socioeconomic status. All analyses include explanatory variables.

Sexual health

Young women who reported high expectations of sexual pleasure during intercourse are no less likely to use birth control or condoms and no more likely to test positive for an STI or to have experienced a teen pregnancy. When looking at sexual self-efficacy, we see similar findings for birth control use. More importantly, early self-efficacy is positively linked to greater frequency of condom use ($p < .05$). Girls who report higher expectations of sexual self-efficacy are also significantly less likely to report becoming pregnant before age 20 ($p < .05$). These findings suggest that neither component of girls' sexual subjectivity puts them at greater sexual risk. If anything, expectations of self-efficacy are beneficial for sexual health. This is consistent with the theoretical model presented in Tolman, Striepe, and Harmon (2003).

Mental and physical health

There is strong evidence that later mental and physical health benefits accrue to girls with more positive sexual attitudes. Youth with higher expectations of pleasure during intercourse report more close friends ($p < .01$), who can be a positive resource for mental and physical health (Seeman 1996). Girls who report greater self-efficacy have significantly lower scores on the CES-D Depression Scale, report better general health, and have a greater number of close friends ($p < .01$, with the exception of general health at $p < .05$). Combined, these results are highly

Table 5. Effects of Adolescent Girls' Expectations of Pleasure during Intercourse and Sexual Self-Efficacy in Young Adulthood

	Sexual risk and health				Mental and physical health			Indicators of future socioeconomic status	
	Frequency use birth control[a]	Frequency use a condom[a]	Positive STI results	Teen pregnancy	CES-D Depression scale	General health	Number of close friends	Years of schooling	Personal income
Expectations of pleasure during intercourse	.026	–.042	–.050	.096	.022	.017	.102**	.134**	.214
Sexual self-efficacy	.062	.120*	.048	–.123*	–.193**	.086*	.172**	.081	1.556*
N	4,021	4,025	4,933	5,999	5,998	5,999	5,930	5,999	5,765
F-value	14.683	8.881	10.156	26.077	7.372	9.300	19.148	73.862	15.807
Age range of outcome measure	19~24	19~24	19~24	before 20	24~32	24~32	24~32	24~32	24~32
Model	Ordered logit	Ordered logit	Binary logit	Binary logit	Linear regression	Ordered logit	Ordered logit	Linear regression	Linear regression

Source: National Longitudinal Study of Adolescent Health, 1994–2008
Note: All coefficients are adjusted by survey sampling design and multiple imputations for missing cases in the control variables ($m = 20$). Control variables include race, parental education, family income, early sexual intercourse, age, religious attendance, high school GPA, mother's employment, family structure, private school attendance, urban school attendance, and region.
[a]Respondents with no vaginal intercourse in the past 12 months are excluded from analyses.
** $p < .01$ * $p < .05$ (2-tailed)

supportive of claims posited by the feminist literature (Debold, Wilson, and Malave 1993; Martin 1996; Tolman 2002; Tolman, Striepe, and Harmon 2003).

Indicators of future socioeconomic success

In many ways, this dimension seems the most removed from girls' early sexual expectations. Yet, as noted earlier, to the extent that adolescent sexuality is linked to critical decisions about educational and career trajectories, the ability to navigate for one's own interests in the sexual sphere might well be protective of socioeconomic standing. We find supporting evidence: Girls who have higher expectations of pleasure attain more years of schooling ($p < .01$), even controlling for family socioeconomic background. Furthermore, those who report higher self-efficacy as girls earn higher levels of personal income as young adults ($p < .05$). These findings suggest the importance of sexual subjectivity for women's life chances.

Discusssion

A risk framework, in which teenage sexual intercourse is defined as dangerous—especially for girls—has dominated the research on teenage sexuality. Sexual pleasure and sexual efficacy do not fit easily into this framework. "Positive" sexual attitudes are even viewed as a liability, given their association with sexual intercourse (Cuffee, Hallfors, and Waller 2007; Rostosky, Regnerus, and Wright 2003). Consequently, girls' sexual subjectivity has been virtually unexamined in large-scale quantitative research.

We provided a systematic assessment of teenage girls' expectations of pleasure during intercourse and self-efficacy in heterosexual interactions—reflecting two key components of sexual subjectivity outlined in feminist scholarship. Our findings indicate that many disadvantaged youth display lower levels of sexual subjectivity than their advantaged peers. Class differences are consistent and robust across all models. Racial and ethnic differences are more nuanced: Any differences in pleasure expectations for black and Latina girls as compared to whites are due to socioeconomic, religious, and regional policy factors. However, controlling for these same factors reveals lower pleasure expectations for Asians. Throughout the analyses, Latina and Asian girls show lower expectations of sexual self-efficacy.

We found that these components of girls' sexual subjectivity predicted young adult well-being across three key dimensions. The sexual health of young women was not harmed by higher expectations for pleasure during intercourse, and those with high expectations of sexual self-efficacy were more likely to report later condom use and avoid teenage pregnancy. Girls' higher expectations of self-efficacy were significantly linked to better young adult mental and physical health. Greater pleasure and self-efficacy expectations were associated with having more close friends, who may serve as a health resource. Those with higher expectations of pleasure were more likely to attain higher levels of education, and greater self-efficacy was associated with higher levels of personal income as young adults.

When combined, the evidence is supportive of claims posited by feminist scholars. We find wide-reaching benefits of sexual subjectivity, across multiple

domains and well into the life course. Below, we address the implications of these findings for the reproduction of inequality and conceptualizations of sexual risk and well-being.

Sexual Disadvantage and Stratification

Sexual subjectivity, to the extent that it predicts female young adult well-being, can be considered a resource. Like many valuable resources, it is not equally available to everyone. Disadvantage falls along the lines of established inequities, and may play a role in sustaining them.

Feminist research starts from the premise that the sexual subjectivities of girls and young women are uniquely challenged, due in part to their subordinate position in relation to boys and young men (Debold, Wilson, and Malave 1993; Martin 1996; Thompson 1995). Although not the focus of this paper, it is worth noting that there is a large gender difference in expectations of pleasure during intercourse. Only 30.12 percent of girls agreed or strongly agreed that sexual intercourse would give them "a great deal of physical pleasure." More than double this number of boys (62.28 percent) in a similarly constructed sample did. Girls and women often enter into sexual interactions where their pleasure comes second (Armstrong, England, and Fogarty 2012; Tolman 2002).

Among girls, sexual disadvantage is linked to marginalized status. Less privileged, minority females, especially in the South, have limited expectations of pleasure and self-efficacy. This finding is striking, as it maps onto dimensions of sexual education programming in the United States, particularly at the turn of the 21st century (see SIECUS [2010a] state profiles). Impoverished communities, with high concentrations of poor and minority youth, were most likely to adopt abstinence-only programming in order to access federal dollars (Fine and McClelland 2006). The results of this study are consistent with evidence documenting the failure of abstinence-only programming to meet its goals (e.g., see Trenholm et al. 2008)—as well as the costs of poverty and limited access to secular healthcare on girls' sexual subjectivity (Fine and McClelland 2006, 2007).

Our findings also suggest that some marginalized youth encounter barriers to self-efficacy in the home, where—in lieu of effective public health programming—much sexual information is transmitted. In this regard, those with less educated parents are disadvantaged. We also find low levels of sexual self-efficacy among Asian and Latina girls, whose mothers may transmit little sexual information and maintain high levels of surveillance (Garcia 2012; Meneses et al. 2006). When youth have to work around parents, rather than with them, their ability to safely and confidently make sexual decisions may be compromised (Dutra, Miller, and Forehand 1998; Hutchinson 2002; Schalet 2011b); this may be especially true for girls (McNeeley et al. 2002).

Class and racial/ethnic differences in sexual subjectivity, however, are attributable not only to disparities in the flow of sexual information. Girls from less privileged families, many of whom are non-white, may find it harder to escape sexual stigma and enact femininities that are less subject to sanction (Armstrong

et al. 2014; Bettie 2003; Garcia 2012). Damaging cultural stereotypes, such as the fetishization of Asian girls' bodies and sexuality, also take a toll on sexual subjectivity (Chou 2012).

The extent to which youth sexuality not only reflects but contributes to stratification processes is more readily apparent in research on young adult sexuality—particularly in studies of dating and assortative mating (e.g., Schwartz and Mare 2005)—than in research on teenage sexuality. Certainly, scholars have documented the link between age at first birth and young women's educational attainment (Frisco 2008). Outside this relationship, however, teen sexuality often gets narrow treatment, with most emphasis placed on the important—but not singularly so—issues of early transition to sex, STI transmission, and teen pregnancy. Our work highlights the ways in which teen sexuality contributes to broad processes of inequality that unfold over the life course.

We show that sexual subjectivity is not only stratified—it may play a role in stratifying. Early expectations of pleasure during intercourse and self-efficacy have cascading effects into adulthood. Girls who feel empowered to navigate interactions that are personally pleasurable may be able to resist gendered pressures that damage their mental and physical health and limit their educational and career progress (Hamilton and Armstrong 2009; Holland and Eisenhart 1990; Martin 1996; Tolman 2002). As Martin (1996) suggests, sexual subjectivity may translate into greater agency and self-advocacy. It may foster girls and young women's abilities to make decisions based on their needs, rather than those of others. Consequently, sexual subjectivity itself is a socioeconomic advantage, and helps sustain existing racial, ethnic, and class disparities in life chances.

The links between girls' sexual subjectivity and a variety of young adult outcomes suggest that more holistic policies are in order. The presence of sexual health clinics, access to birth control, communication about sexuality, and emphasis on sexual pleasure cannot be framed only as important for girls' sexual health—but as investments in their future economic security, mental and physical health, and social integration. Often policy approaches are isolated to one particular institution or cause. However, this research suggests the importance of broad coalitions, and recognizing the ways that important features of young adult well-being may be interconnected through youth sexuality.

Redefining Sexual Risk and Well-Being

Currently, much debate surrounding teenage sexuality is framed in either/or language and defines teenage sexual activity as risky. Either teens engage in sexual activity—and are thus at risk—or they do not (Schalet 2011a). This obscures the fact that there are more and less healthy and safe ways for youth to interact sexually. As the limitations of the Add Health data suggest, this discourse even constrains the collection of information necessary to answer such questions.

An either/or risk framework also leads to oversights in our understanding of causal factors predicting negative sexual health outcomes. Just as an early transition to intercourse increases the likelihood of STI contraction or teen pregnancy

(Kaestle et al. 2005; Kirby 2002), so does a reduced or absent sexual subjectivity. Both fall disproportionately on the shoulders of disadvantaged youth. Educational efforts emphasizing the risks of sexual activity may reduce their sexual subjectivities, inadvertently contributing to the outcomes that policies seek to prevent.

The Obama administration has taken steps away from abstinence-only education. Two of three major federal discretionary funding streams for such programming were eliminated—although substantial funding under Title V remains (SIECUS 2010b, 2012). New efforts highlight the importance of evidence-based programming, increased access to contraceptive and reproductive care, community mobilization, and reaching diverse populations. It is too early to know their effects. However, it is notable that the President's Teen Pregnancy Prevention Initiative is still framed in negative terms: "At risk youth" are identified, and the primary goal is to "reduce teen pregnancy and associated risk factors"—at least in part by "increasing the percentage of youth who abstain" (CDC 2013).

A broader definition of sexual well-being more easily reveals the structural roots of sexual disadvantage. Poverty and limited socioeconomic resources exacerbate negative outcomes associated with teen sexuality, including limited sexual subjectivity, early transition to sex, STI transmission, and teen pregnancy. Here, cross-national work showing the influence of economic, political, and cultural factors on teen sexuality is instructive. Higher rates of poverty, more limited access to birth control, and cultural notions framing teen sex as problematic lead American youth—especially the marginalized—to experience higher rates of pregnancy and abortion than British, Canadian, Dutch, French, and Swedish youth (Darroch, Frost, and Singh 2001; Schalet 2011a, 2011b; Singh, Darroch, and Frost 2001).

We are far from alone in calling for a reconceptualization of sexual well-being. Indeed, the World Health Organization advocates that we move beyond "the absence of disease, dysfunction, or infirmity" and promotes "pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (WHO 2004, 3). A large body of feminist literature takes a similar stance (e.g., Allen 2011; Bay-Cheng 2003; Fine and McClelland 2006; Lamb and Peterson 2011; Schalet 2009, 2011a). We offer a test of sexual subjectivity theory with nationally representative data.

This study is heavily influenced by a life-course approach to teen sexuality. (Halpern 2010). We show that early sexual subjectivity creates ripples in the lives of youth, sending them on different sexual, mental and physical health, and educational pathways. Multiple intersecting domains that researchers, somewhat artificially, parcel apart are affected. From this perspective, what counts as a risk factor is far more comprehensive. Limited sexual subjectivity arguably poses its own set of risks—and is concentrated in already marginalized populations.

Challenges for future research are both empirical and theoretical. As the data limitations of this study suggest, new data-collection efforts are required. Add Health's narrow focus on heterosexual vaginal intercourse precludes the investigation of sexual subjectivity in a broad array of sexual interactions. For girls and young women, this means not investigating the sexual activities through which

they may derive the most physical pleasure. In addition, alongside attitudinal measures, sexual subjectivity would ideally be measured behaviorally—and reflect specific sexual relationships. This means confronting teenage sexuality directly, and acknowledging that both pleasure and self-efficacy are potentially desirable features of sexual interactions.

The design of Add Health also excludes LGBT youth as subjects worthy of study. Some research indicates that girls who do not identify as heterosexual face unique barriers to sexual subjectivity (Bay-Cheng 2010; Fine and McClelland 2006; Garcia 2012), while other work suggests greater sexual subjectivity on the part of young lesbians (Thompson 1995). Currently, these questions are unanswerable. Also, in testing theories of sexual subjectivity—which revolve almost exclusively around females (for an exception, see Martin [1996]), we opted to focus on girls. As Giordano, Longmore, and Manning (2006) note, research on boys' sexuality is notably scarce. New theories of sexual subjectivity will require us to think about female and male sexuality in concert, broaden the range of sexual activities investigated, and embed youth in specific interactional, romantic, and sexual contexts.

Notes

1. Cross-national research, however, points to contraceptive use as a more important explanatory factor (Darroch, Singh, and Frost 2001).
2. This research operationalizes "positive" in a different way than feminist scholars (see Tolman and McClelland 2011), viewing, for instance, items that ask youth if intercourse makes them less lonely and more attractive to the opposite sex as "positive emotions," alongside expectations of sexual pleasure (see Rostosky, Regnerus, and Wright 2003).
3. A total of 7,515 females met these criteria and had valid values for age. In Wave 2, respondents who were younger than 15 at Wave 1 received the same items. Given the number of cases missing on outcome variables, including them in analyses adds only between 731 and 1,341 cases. Sampling weights for Waves 1 and 2 are also different, and this cannot be taken into account. Supplemental analyses using both Waves 1 and 2 indicate that patterns are consistent either way. Thus, we take the more cautious approach in using only respondents who answered these questions in Wave 1.
4. Such a definition categorically excludes sexual interactions between individuals of the same sex. It reflects a privileging of heterosexuality in how youth sexual activity is addressed (Bay-Cheng 2010; Fine and McClelland 2006).
5. A narrower definition, excluding all of those who say "no" to having a romantic attraction to a male, reduces the sample by over 1,000 cases. The Wave 3 sexual orientation self-identification item indicates that over 95 percent of excluded individuals will identify as "straight" or "mostly straight." Thus, we opt for a broad approach. Regardless, results are consistent across sample specifications.
6. Respondents can still refuse the Add Health test. In supplementary analyses, we coded all refusals as 1, along with respondents who had a positive result. Results remain unchanged.
7. Other cut-points produced similar results, as did a measure of whether respondents had sex by Wave 1. None of these measures are necessarily ideal. Using age-based cut-points introduces temporality issues for some respondents in the first—although

not the second—stage of analyses. The Wave 1 measure does not take into account age variation at the time the survey was fielded. Consistency across measures, however, suggests that results presented here are robust.

8. There are three strategies for coding the Latina category. We coded those who answered yes to the Hispanic/Latino item and "other" to the race question as Latina. One could also code all who choose Hispanic/Latino as Latina, regardless of how they answered the race question. Finally, race and ethnicity could be assessed separately with a Latina dummy. Our approach recognizes that some, but not all, youth may view their ethnic status as a lived racial category (Brown, Hitlin, and Elder 2006). All three approaches yield consistent patterns.
9. In supplementary analyses, we include the Wave 1 measure "Were you ever forced to have sexual intercourse against your will?" and the Wave 3 measure "[Before you were in the 6th grade], how often had one of your parents or other adult caregivers touched you in a sexual way, forced you to touch him or her in a sexual way, or forced you to have sexual relations?" Neither measure was significant in predicting the sexual subjectivity components, and did not change the patterns for the young adult outcomes.
10. Unweighted analyses show consistent patterns.
11. Additional analyses suggest that the correlation between family income and parental education attenuates the effects of the two indicators; as a result, the direct effect of family income is mitigated. Results for self-efficacy in table 4 display similar patterns.
12. There is a marginally significant regional difference ($p < .10$), with youth who live in the South reporting lower expectations of sexual self-efficacy. Lack of access to comprehensive sexual education in this region likely plays a significant role (SIECUS 2010a).

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