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DYADIC PROCESSES WITHIN SEXUAL RELATIONSHIPS

Consent and Contraceptives: An Investigation of Dyadic Processes within Sexual Relationships

A thesis submitted in partial fulfillment of the requirements  
for the degree of Bachelors in Public Health

by

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### Abstract

To form healthy and satisfying sexual relationships, couples must implement effective sexual communication. Prior research mainly focuses on the female perspective when looking at communication about important relational aspects (e.g., sexual consent and contraceptive decision-making), but studies have indicated that sexual decisions are often made by both people in a dyad. To obtain an accurate idea of how dyadic sexual communication functions, both partners' perspectives are needed. We investigated the dyadic practices and satisfaction regarding consent communication and contraceptive decision-making among sexually active dyads ( $N = 37$ ) who were recruited through flyers and an electronic campus newsletter. Dyads individually, as well as simultaneously, completed a web-administered survey in a lab setting. The survey assessed dyad participants' satisfaction with sexual consent communication and contraceptive decision-making. We tested effects of (1) type of consent cue and (2) agreement regarding contraceptive decision-making on these measures using independent sample  $t$ -tests. Satisfaction with consent communication and contraceptive communication were positively correlated. These findings indicate that the more satisfied people were with consent communication in their current relationship, the more satisfied they are with communication about contraceptives. Dyads were generally satisfied with both their consent communication and contraceptive decisions. People who reported using "no response" consent cues at their most recent sexual encounter were significantly less satisfied with consent communication in their relationship. Due to no response consent cues leading to lower satisfaction within the dyad, we recommend teaching and implementing effective communication strategies when communicating consent to facilitate healthy and functional relationships.

*Keywords: consent, contraceptives, relationship, sexual decision-making*

## **Introduction**

### **Sexual Communication**

Sexual communication is a key dyadic process that is vital in the formation of healthy and satisfying sexual relationships among couples (Sprecher & Hendrick, 2004). Research has generally looked at reports from individual participants that are part of a dyad to understand how communication within couples functions. It is important to look at sexual communication as a function of dyadic relationships to better understand if and how it occurs and how it may affect satisfaction with sexual relationships.

Many individuals are nervous or apprehensive to communicate about sexual topics. Babin (2012) found a strong negative relationship between sexual communication apprehension and sexual satisfaction. This association demonstrates that there is a direct relationship between communication and sexual experiences; however, research has also shown that facilitation of sexual conversations can be difficult for couples (Quinn-Nilas et al., 2015). Some couples have a hard time talking about specific subjects regarding sexual activity, while others find the topic in general too daunting. Sexual communication apprehension may be a large barrier to satisfying sexual relationships. One study found that, while some topics of sexual communication were harder for couples than others, the majority of participants answered that it was either “very difficult” or “difficult” to discuss topics such as condom negotiation and interest in sexual activity with their partner (Quinn-Nilas et al., 2015). Findings from the same study indicated that partners find it “very difficult” to ask to use a condom more often than they find it “very difficult” to tell their partner if a certain sexual activity hurts them (Quinn-Nilas et al., 2015). This finding potentially demonstrates a disconnect in how individuals value different sexual

topics (e.g., consent communication and contraceptive decision-making) that could have significant ramifications on their overall satisfaction with their sexual relationship.

Despite people's apprehension to engage in conversations about sexual behavior, successful communication is a key aspect to achieving safe, consensual (Beres, 2010), and satisfying sexual experiences (Davis et al., 2006) with a romantic partner. Green and Faulkner (2005) found that there was a positive relationship between dyadic sexual communication and relationship satisfaction. Poor communication can have the opposite effect, leading to less positive sexual experiences and lower likelihood of sexual communication in the future (Babin, 2012). Faulker and Lannutti (2010) found that unsatisfying communication revolved around sexual decision-making, and these conversations tended to lead to negative relational and sexual effects. Some of these negative outcomes included unwanted sex, not talking about present sexual issues, and unsafe sexual practices (Faulkner & Lannutti, 2010).

Lack of communication regarding contraceptive methods within romantic dyads could lead to unintended pregnancy due to misunderstanding about what methods were being implemented, if any. According to Singh and colleagues (2010), 5.5% of women of reproductive age experience an unintended pregnancy each year. Relationship stability and seriousness have both been shown to be potential predictors of unintended pregnancy (Barber et al., 2010). It is essential to look at contraceptive communication from a dyadic standpoint to compare whether both partners are on the same page about their communication regarding consent and contraceptive methods.

### **Sexual Consent Communication**

Healthy sexual relationships require that both partners communicate their preferences, expectations, and reservations in order to facilitate behaviors that are both wanted and

consensual. Discussion about sexual activity is limited and taboo outside of the context of the romantic dyad, or sometimes even within the relationship itself (Baxter & Wilmot, 1985; Babin, 2012), making it difficult for individuals to be comfortable communicating about sexual behavior and potentially establishing consent (Babin, 2012). For the purposes of this study, we defined consent as *one's voluntary, sober, and conscious willingness to engage in a particular sexual behavior with a particular person within a particular context* (Willis & Jozkowski, 2018). Research on sexual consent needs to examine dyads to better understand how each partner communicates and interprets consent communication because a dyadic approach is currently missing in the literature. Similarly, research should use a dyadic approach to understand whether consent communication is related to satisfaction with consent practices with sexual relationships.

In order to have a healthy sexual relationship, partners should communicate regarding their consent to sexual activity (e.g., Beres, 2007, 2014; Dripps, 1996; Muehlenhard et al., 2016), and how they convey this can vary by person and by couple. Consent can be communicated verbally or nonverbally, directly or indirectly; research suggests that nonverbal consent cues are used most often (Beres, Herold, & Maitland, 2004; Hall, 1998; Hickman & Muehlenhard, 1999; Humphreys, 2007; Muehlenhard et al., 2016). Previous research that examines consent communication among college students found that they were hesitant to communicate explicitly or verbally about sexual consent (Curtis & Burnett, 2017). Another study corroborated this with their finding that students would rather assume consent than directly communicate (Humphreys, 2007). Instead of directly or verbally communicating, many college students prefer to use nonverbal consent cues to communicate with a sexual partner (Beres, Herold, & Maitland, 2004; Jozkowski, Sanders, et al., 2014; Muehlenhard et al., 2016). Nonverbal consent may be in the form of moaning, sexually suggestive body movements or positioning, or undressing (Beres,

2010, 2014; Hickman & Muehlenhard, 1999; Jozkowski, Peterson, Sanders, Dennis, & Reece, 2014). Beres' (2007) review of studies on sexual consent found that sexual history can have an effect on how consent is communicated, but studies addressing this are limited. Similarly, the previous studies on consent cue styles are all individual based, so a dyadic approach is also lacking in existing studies.

People's perceptions of consent cues may affect what type they choose to implement. In one study, students struggled to communicate about consent because they deemed it to be awkward or had adopted the societal construct that talking about sex was not okay (Curtis & Burnett, 2017). Some students felt that explicitly talking about sexual consent may ruin the mood and make the encounter less enjoyable (Foubert, Garner, and Thaxter, 2006, p. 366). This may also look different as relationship status or sexual history changes, and because the previous studies are looking at individual responses they are not able to assess perceived norms of consent communication within the dyad.

Research shows that relationship status with a sexual partner can change how consent communication functions within the dyad, specifically altering what type of consent cues are normative in that relationship (Beres, 2010, 2014; Humphreys & Brousseau, 2010; Humphreys & Herold, 2007; Muehlenhard et al., 2016). Humphreys (2007) found that people identified explicit consent communication as being more important in casual relationships than in committed relationships. In this study, participants identified scenarios depicting more committed relationships as being more consensual and acceptable (Humphreys, 2007). Similarly, some feel that it is more acceptable or more likely for consent to be assumed in a committed relationship because of a previous sexual history with that partner (Muehlenhard et al., 2016). The sexual history inherent to many committed relationships may make nonverbal or less direct

consent communication more likely (Marcantonio, Jozkowski, & Wiersma-Mosley, 2018), especially when looking at behaviors lower on the sexual hierarchy such as genital touching or oral sex (Humphreys, 2007; Jozkowski et al., 2014). Over time partners may become more familiar with each other's consent cues that are most frequently used so they can more easily identify them without having to communicate verbally. Sex is expected to be consensual in dyadic relationships, and often this leads to assumed consent for every sexual encounter within the dyad (Muelenhard, 2016) Therefore, we examined couples' satisfaction regarding consent communication within their relationship.

### **Contraceptive Use and Decision-making**

Similarly, most of the existing literature regarding contraceptive use focuses on women's experiences alone and not those of a dyad (Upadhyay et al., 2016; Wildsmith et al., 2015). This is likely because women are typically seen as responsible for contraceptive method use. Most extant studies focus on women's contraceptive choices, identifying women as having a better understanding of hormonal contraceptives (Wildsmith, Manlove, & Steward-Streng, 2015). However, one study found that male partners may have the most influence when it comes to dyadic decisions regarding contraceptive method (Vasilenko et al., 2015). Previous studies have yet to address both partners' perceptions toward the communication about contraceptive decisions in that relationship, even though research shows that decisions about contraceptives are not made by either individual party but by the romantic dyad as a unit (Kusunoki & Upchurch, 2011).

One study found that new relationships or casual "hookups" are less likely to include an effective contraceptive, while longer relationships are more likely to be concerned with preventing a pregnancy (Upadhyay et al., 2016). Other studies suggest that more casual partners

are more likely to use condoms, while committed partners are more likely to use a hormonal method of contraceptive (Kusunoki & Upchurch, 2011). Yet another study reported conflicting evidence that cohabiting adults in a committed heterosexual relationship were less likely to use a contraceptive method of any kind (Wildsmith et al., 2015). This demonstrates a discrepancy in existing literature regarding contraceptives and how they are used by romantic dyads.

Young adults in dyadic relationships may have already transitioned away from condoms, but if relationship conflict causes them to question their future with their partner they may not make the switch to or continue use of longer acting hormonal methods (Manlove et al., 2014). This demonstrates a scenario where instability and lack of communication in a relationship can increase the chance of unintended pregnancy and decrease the chance of effective contraceptive use (Miller, 1973). Previous studies have noted that dyads who communicate about contraception are more likely to use some form of contraception (Manlove et al., 2003; Widman et al., 2006). As frequency of sex within the relationship increases, however, there is a negative association with condom use or dual method use, suggesting that dyads do not consistently use condoms later in the relationship (Kusunoki & Upchurch, 2011). This pattern could be due to increased comfort within the relationship and less concern regarding STI prevention, or it could be due to fear of asking to continue using condoms as that may be perceived as a sign of mistrust within the relationship. If this is the case, discussing social stigma regarding condom use with romantic dyads could increase the likelihood that they would continue consistent use.

To assess satisfaction with contraceptive decision-making, it is important to examine the attitudes between both people in a relationship. When asking individual participants, Frost and Darroch (2004) found that 30% of participants agreed with the statement that “it doesn’t matter if someone uses a birth control method or not.” This is a very clear example of why dyadic

communication is essential, because while they asked one partner the other partner could think that contraceptives are extremely important but have not communicated this within the context of their dyad and thus an unintended pregnancy could result. Research on contraceptive use needs to examine the role of the dyad to better understand whether types of contraceptive methods are related to satisfaction with contraceptive practices within sexual relationships.

### **Present Study**

The present study examined people's satisfaction with communication in their relationship—especially about consent and contraceptives. Previous research has indicated that communication has significant effects on both sexual consent and contraceptive use, so examining how it functions within a romantic dyad is key to understanding the role of communication. We will define romantic dyad within this study as *any committed intimate two-person relationship*. A dyadic approach to looking at sexual communication regarding consent and contraceptive decision-making is currently missing in the literature, making it difficult to know how both partners interact to make decisions or communicate effectively. In this study, we investigated (1) if relationship length is associated with satisfaction with consent and contraceptive communication, (2) if satisfaction with consent and contraceptive practices are correlated, and (3) how actual practices regarding sexual consent communication and contraceptive decision-making influence satisfaction with these practices.

H1a: People who have been in their relationship longer will be more satisfied with their consent communication in the context of their sexual relationship.

H1b: People who have been in their relationship longer will be more satisfied with their contraceptive communication in the context of their sexual relationship.

H2: Satisfaction with consent communication will be positively correlated with

satisfaction with contraceptive decision-making.

H3a: Because people perceive verbal consent cues to be awkward and mood-killing, people who used nonverbal consent cues at their most recent sexual encounter will be more satisfied with consent communication in the context of their sexual relationship.

H3b: People who agreed more with their partner regarding contraceptive decision-making will be more satisfied with contraceptive communication in the context of their sexual relationship.

## Method

### Participants

To be eligible for this study, participants had to be (1) sexually-active, (2) in a monogamous dyadic relationship, (3) between the ages of 18 and 35, and (4) be able to come into the research lab to complete the survey. We define “sexually active” for the purposes of this study as having participated in at least one sexual behavior (i.e., oral intercourse, vaginal-penile intercourse, anal intercourse) with their partner within the course of their monogamous relationship. The final sample includes 37 romantic dyads (two individuals who identify as romantic partners), for a total of 74 participants ages 18-39. The average age of the participants was 22.43 ( $SD = 3.87$ ). A majority (66.2%) of participants identified as entirely heterosexual (i.e., females who selected “only attracted to males” or males who selected “only attracted to females”) while 37.8% of the sample identified somewhere else on the spectrum (i.e., “mainly attracted to males but occasionally females” or “equally attracted to both males and females”). When broken down by gender, 50% of women identified as entirely heterosexual while 87.9% of men identified this way. The race most participants identified with was white (87.8%). Detailed sociodemographic characteristics for the sample are in Table 1.

## **Procedure**

The procedure for our study was approved by our university's Institutional Review Board before any data were collected. We recruited participants using both flyers and a campus-wide newsletter that is emailed to students daily. Interested students emailed the research assistant, and those who met all participation criteria were invited to schedule an appointment to come into the research lab and take the study at the same time as their partner. The survey was created to take approximately 30 minutes, and participants were scheduled a minimum of 45 minutes apart to allow enough time for them to comfortably respond to the survey. A researcher met with the dyad as they came into the lab to complete the in-person survey. Each computer was assigned a random identification number before entry to ensure that the survey was anonymous. The research assistant then brought in the dyad and distributed consent forms to both parties which were explained and signed before beginning the study. Participants were seated at their respective computers with their backs toward each other. They were instructed to silence their phones and place them on the desks. Then the research assistant explained the instructions for completing the survey to ensure that the participants received identical information on how the study would function. The researcher sat in the lab space while the survey was conducted online through Qualtrics Survey software in order to eliminate the possibility of participants communicating their answers to each other.

Both members of the dyad participated in the survey separately without access to each other's answers or knowledge of their partner's responses in any way. By participating simultaneously, participants were in the exact same environmental conditions, which allowed for the most comparable answers possible. The desks in the lab were turned to face opposite walls so

the individual's environment was more private, and blinders were added to keep the screens out of view of the research assistant. The survey consisted of both open and closed-ended questions to measure various constructs of sexual communication and satisfaction regarding consent and contraceptives. Upon completing the study, participants were each monetarily reimbursed \$10 cash for their participation. Finally, the participants were debriefed regarding the purpose of the study and asked to not disclose the questions on the survey to other possible participants; they were then directed out of the research lab.

## Measures

**Sociodemographic characteristics and sexual behavior.** The survey started with asking participants sociodemographic questions including their age, race, sexual orientation, relationship status and length, and student status. Relationship length was measured continuously in months. The survey then provided participants with a list of contraceptive methods and asked them to indicate which they had used with their partner, with participants selecting multiple if necessary within the context of their relationship (i.e., male condoms and birth control).

**Satisfaction with consent communication.** Participants responded to 25 questions about their consent communication and satisfaction within their current relationship. These items were adapted from the Sexual Communication Apprehension Scale (Babin, 2012). For the purposes of their study, Babin defined sexual communication apprehension as fear or anxiety associated with either real or anticipated communication with a sexual partner about sexual topics. Participants answered these questions on a 6-point Likert-type scale, with response options ranging from *strongly agree* (1) to *strongly disagree* (6). In the present study, these items demonstrated good internal consistency (Cronbach's  $\alpha = .943$ ). For a complete list of these items, see Appendix 10. For most measures "strongly agree" was the most positive response with a smaller number of

items requiring reverse scoring to properly indicate receptiveness toward communication as being positive or negative. Lower scores indicate more positive feelings toward sexual communication within the dyad.

**Sexual consent communication cues.** Consent cues were measured with the item *Which of the following behaviors did you do to show your partner that you were willing to engage in vaginal intercourse?* Participants were prompted to select the consent cues most recently used by both themselves and their partners. Direct verbal cues were identified with the response option *I used direct verbal cues, such as saying "I want to have sex"*. Indirect verbal cues were identified with the response option *I used indirect verbal cues (like hints), such as saying something in a sexy voice or asking my partner to get a condom, or saying yes to something they said*. Direct non-verbal cues were identified with the response option *I used direct non-verbal cues, such as moving my partner's hands towards my genitals or just starting to have sex, or nodding my head agreeing to something they said*. Indirect non-verbal cues were identified with the response option *I used indirect non-verbal cues, such as making eye contact or touching my partner's arm, back, or legs*. No response cues were identified with the response option *I let the behavior happen without resisting or stopping it*. For an itemized list of these measures see Appendix 12.

**Satisfaction with contraceptive communication.** Participants responded to 23 questions about their contraceptive communication and satisfaction within their current relationship. These items were adapted from the Student Communication Satisfaction Scale (Goodboy et al., 2009) and the Relationship Assessment Scale (Hendrick, 1988). These measures were adapted to assess satisfaction and communication regarding contraceptive use within sexually active dyads. We excluded measures which did not fit within the study parameters and rephrased questions when necessary to make them about contraceptive choices. Participants answered these questions on a

7-point Likert-type scale, with response options ranging from *strongly agree* (1) to *strongly disagree* (7). Lower scores indicate more positive feelings toward sexual communication within the dyad. In the present study, these items demonstrated good internal consistency (Cronbach's  $\alpha = .955$ ). For a complete list of these items, see Appendix 11.

**Contraceptive decision-making.** To measure how people decided on contraceptive use within their current sexual relationship, participants answered *How was your contraceptive method decided?* Response options included *I decided*, *My partner decided*, or *We decided together*. We created a score to reflect whether each person in a relationship agreed on how contraceptive use was decided in their relationship. Participants were marked as having agreed if (1) they both selected *We decided together* or (2) one selected *I decided* and the other selected *My partner decided*.

## **Analysis**

To test the associations between relationship length, satisfaction with consent communication, and satisfaction with contraceptive decision making, we conducted Pearson's  $r$  correlations, because each of these variables was continuous. To test whether (1) type of consent cue used affected satisfaction with consent communication and (2) dyadic agreement in contraceptive decision making affected satisfaction with contraceptive decision making, we conducted independent samples  $t$ -tests, because the predictor variables were dichotomous and the outcome variables were continuous. All tests were conducted using SPSS 25 at an alpha level of .05.

## **Results**

### **Descriptive Statistics**

People were generally satisfied with their communication with their partner regarding consent ( $M = 1.91$ ,  $SD = .81$ , range: 1-4.77) and contraceptives ( $M = 1.84$ ,  $SD = .82$ , range: 1-4.61). Results indicated gender had no significant influence on satisfaction with communication about consent within the relationship,  $t(71) = -.846$ ,  $p = .400$ . This indicates that women ( $M = 1.85$ ,  $SD = .80$ ) and men ( $M = 2.01$ ,  $SD = .82$ ) were equally satisfied with communication in their relationship. Results indicated gender also had no significant influence on satisfaction with communication about contraceptives within the relationship,  $t(71) = -1.202$ ,  $p = .233$ . This indicates that women ( $M = 1.71$ ,  $SD = .66$ ) and men ( $M = 1.93$ ,  $SD = .92$ ) were equally satisfied with communication in their relationship.

Participants were most likely to report using a variety of methods of communication regarding consent strategies. Participants reported that they used explicit verbal ( $N = 43$ , 58.1%), explicit nonverbal ( $N = 41$ , 55.4%), implicit verbal ( $N = 36$ , 48.6%), and implicit nonverbal ( $N = 40$ , 54.1%) consent cues at similar rates, while no response was much lower ( $N = 14$ , 18.4%). Participants reported that their partners used explicit verbal ( $N = 40$ , 54.1%), explicit nonverbal ( $N = 40$ , 54.1%), implicit verbal ( $N = 39$ , 52.7%), and implicit nonverbal ( $N = 36$ , 48.6%) consent cues at similar rates, while no response was much lower ( $N = 18$ , 24.3%).

While responses between couples on contraceptive decisions were generally similar, there was some discrepancy on who made the decision regarding method choice with 60.6% of women saying that they and their partner decided on a contraceptive method together and 75.8% of men saying the same. The most commonly used contraceptive methods by participants in this study were male condoms ( $N = 64$ , 86.5%), birth control pills ( $N = 52$ , 70.3%), and withdrawal ( $N = 47$ , 63.5%). We found that 62.7% of people who used birth control pills did so at least most of the time; 48.9% and 40.7% used withdrawal and male condoms at this rate, respectively.

Emergency contraception was used by some participants ( $N = 15$ , 20.3%) but none reported using it most of the time or always. Detailed contraceptive method responses and consistency are in Table 2.

### **Hypothesis 1**

The range of relationship length for the dyads was 3 to 109 months, with the average relationship length of 37.76 months ( $SD = 26.92$ ). Length of relationship was not associated with people's satisfaction regarding communication about consent,  $r = -.059$ ,  $p = .617$ . Length of relationship also was not associated with people's satisfaction regarding communication about contraceptives,  $r = -.074$ ,  $p = .530$ . These non-significant correlations indicate that being in a relationship longer did not make partners more satisfied with their consent or contraceptive communication with their partner.

### **Hypothesis 2**

Satisfaction with consent communication and contraceptive communication were positively correlated,  $r = .34$ ,  $p = .039$ . The more individuals within a dyad was satisfied with their consent communication, the more satisfied they were with their contraceptive communication.

### **Hypothesis 3**

People who reported that they used "no response" consent cues at their most recent sexual encounter with their current partner were significantly less satisfied with consent communication in their relationship,  $t(72) = -2.11$ ,  $p = .039$ . "No response" consent cues were identified with the item "I let the behavior happen without resisting or stopping it". None of the other consent cues at the event level were significantly associated with participants' general satisfaction with consent communication in their current relationship (Table 3). Further, none of

the consent cues that participants perceived their partners using were associated with consent communication satisfaction (Table 4).

Whether people disagreed regarding the decision-making process about their contraceptive method did not significantly influence people's satisfaction with communication about contraceptives in their relationship,  $t(51.33) = 1.61, p = .113$ . This indicates that partners who agreed ( $M = 1.71, SD = .63$ ) and those who disagreed ( $M = 2.03, SD = 1.00$ ) were equally satisfied with communication in their relationship.

### **Discussion**

In this study, we found a positive correlation between consent communication and contraceptive communication. Participants generally communicated with their partners about both topics and were satisfied with their communication on both topics. Communicating verbally, nonverbally, explicitly or implicitly all led to generally the same satisfaction with consent communication. Those who consented without using any response signal were significantly less satisfied. While these findings are exploratory, they suggest that research looking at the dyad may be a fruitful avenue to understand communication strategies and satisfaction in couples.

While increased relationship length was expected to be a predictor of increased satisfaction, being in a relationship longer did not affect how satisfied people were with their consent communication or contraceptive communication in the context of their sexual relationship. While our study found that consent satisfaction was consistent, we did not address wantedness of the encounter, which may play a heavier role in longer relationships. Prior research suggests that relationship status may change how people perceive consensual sexual encounters with regards to wantedness. Individuals may not want to disappoint their partner or

disrupt a happy point in their relationship, so might be more willing to engage in an unwanted behavior and still consent to it (Basile, 1999; Brousseau 2011; Impett & Peplau, 2003; Peterson & Muehlenhard, 2007). Knowing this, participants may have reported satisfaction with consent communication at equal rates but may be consenting as a function of other factors in their relationship, which may change the context of that consent. This suggests that communication with a partner regarding what an individual may want or not want to engage in at a given time may be a fruitful avenue for further research as it could relate to the development of satisfying and healthy relationships.

Relationship length also did not have any significant effect on satisfaction with communication regarding contraceptive decisions, indicating that even early on, partners were discussing what methods they would use. Our results contradict previous findings from Quinn-Nilas et al. (2015), who suggest that talking about sex and contraceptive use is extremely difficult for dyads. Not only did participants in our study indicate that they had conversations about contraceptives with their partner, but their satisfaction was a result of feeling that they had meaningful and productive conversations about contraceptives and were heard in those conversations by their partner. This demonstrates a higher quality of conversations about contraceptives than one may typically expect, especially among college age students or shorter term relationships.

Prior studies suggest that relationships are most satisfying with effective communication strategies (Beres, 2010; Bridges, Lease, & Ellison, 2004; MacNeil & Byers, 1997; Menard & Offman, 2009). We found that sexual communication satisfaction was positively correlated with communication within that relationship. Satisfaction with consent communication was positively

correlated with satisfaction with contraceptive decision-making, potentially suggesting an increase in overall comfort with sexual topics.

Participants reported that both they and their partner equally used a variety of consent cues to communicate their sexual consent. This differs from previous studies that found that committed relationships are more likely to use nonverbal or indirect consent cues (Marcantonio et al., 2018). Dyads in our study generally had high satisfaction with their communication strategies regarding consent regardless of what cues were used, and most participants felt that their last sexual experience with their partner was consensual. These results indicate that dyads were generally on the same page when it came to how they were communicating about sexual consent. The only consent cue that significantly affected satisfaction was that where an individual reported that they had used “no response” cues, or allowed a behavior to happen without resisting or stopping it. Consent cues that a participant reported their partner used had no effect on the participant’s own satisfaction. This suggests that consent satisfaction may be more of an internal process rather than something perceived through the actions of a partner. An individual may be more satisfied with their consent communication when they feel they have effectively communicated what they want versus basing their satisfaction on how well their partner communicated.

Dyads were also satisfied with their contraceptive decision-making and communication. Some dyads agreed on who made the decision regarding what contraceptive method would be implemented and some disagreed, but people who agreed with their partner regarding contraceptive decision-making were not any more satisfied with their contraceptive communication than those who disagreed on contraceptive decision-making. Overall responses within dyads were similar when selecting contraceptive methods, and most indicated that they

had previously had conversations with their partner about what method they would implement. The most common forms of contraceptives used within the dyad were male condoms ( $N = 64$ ), birth control pills ( $N = 52$ ), and withdrawal ( $N = 47$ ). Only 14 participants always used their chosen method of contraceptive, with the majority of participants selecting some level of inconsistency. This response pattern may be less concerning for dyads who use two methods together, for example birth control pills and male condoms, if they are not always using male condoms. However, of the individuals who reported using birth control pills only, 62.7% reported consistent use. This corroborates prior research that suggests that contraceptives are often used inconsistently (Frost & Darroch, 2008; Upadhyay, Raifman, & Raine-Bennett, 2016). Dyads were generally satisfied with their communication regarding contraceptives. Most dyads reported the same contraceptive method, so they both know what is being used in their relationship to either prevent pregnancy, STI's, or both. This contradicts previous research in which dyadic responses were inconsistent and showed a lack of communication (Vasilenko et al., 2015). Knowing what method is being used is an important first step in establishing equal responsibility for contraceptives within a dyad, potentially leading to higher satisfaction when one feels supported in not having to make contraceptive decisions alone.

### **Implications**

While most consent cues used resulted in satisfying sexual communication, those who used “no response” consent cues were significantly less satisfied with their sexual communication regarding consent. This indicates that there may be a lack of effective communication within these dyads, or a disconnect in how partners are perceiving their consent communication. Couples should aim to communicate about how they want to give or get consent to facilitate a satisfying sexual relationship. Identifying discrepancies in couples' communication

strategies or satisfaction with that communication will indicate areas where education and intervention could be necessary help to increase satisfaction within sexual relationships. While most participants were also satisfied with their contraceptive communication and decision-making, some reported inconsistent method use. This suggests that while participants may have been satisfied with their contraceptive communication, they may not be communicating accurately or effectively about it since some dyads are not implementing their method consistently. If both partners were able to effectively communicate about contraceptives and how to properly use them, their methods should be used correctly and consistently in order for them to be satisfied with their contraceptive decisions. More education regarding proper use of contraceptives may be necessary to give both partners the knowledge to communicate effectively about contraceptives so that dyads are not only communicating but communicating good information. Overall, our findings suggest that couples' satisfaction with their relationship may improve from effective sexual communication regarding consent and contraceptive decisions.

### **Strengths, Limitations, and Future Directions**

Recording responses in an identical environment from both partners eliminated the risk of variance in responses due to environmental factors, and having them take the study simultaneously with a researcher present eliminated the possibility of them communicating their responses while completing the survey in the hopes that they would be more honest when their responses were confidential. This was just a single study and used a smaller sample from a college campus, so it is recommended that researchers continue the dyadic approach to studying consent to better understand how it functions both across and within partners.

The study being in-person rather than a survey link sent out resulted in lower participation, but potentially higher validity because researchers were supervising the

participants so they may have paid more attention to the questions or answered them more thoughtfully than they would have in a more casual setting or at their home. The lower participation may also potentially be due to increased difficulty for potential participants to access the survey since they had to have transportation to the research lab. These findings are exploratory and a larger sample would have brought more statistically significant results to the surface, but it is important to note that the study had statistically significant findings even with a smaller sample size, demonstrating support for this method of data collection. Additionally, the study was advertised using flyers that required individuals to indicate interest in participating. This could lend itself to those who are more comfortable discussing sexuality participating, meaning that there could be dyads who are less satisfied with their communication and less comfortable talking about sexuality that were not willing to seek out participation in the present study. In the future, researchers could look into other ways of recruiting participants that could better include a more diverse group when it comes to comfort regarding sexual topics. It would also be relevant to include a question scaling individuals' comfort talking about sexuality to quantify if this phenomenon is actually present in the sample, or blind the purpose of the study on recruitment materials.

While most couples selected the same contraceptives from the list of methods, an important follow up would be to look at whether they both understand what the chosen method is and how it works. While they may both know what the method is, there may be some discrepancy in participation with understanding the method that leaves female partners more likely to feel on their own in making contraceptive choices, which would explain the difference in responses of "I decided" versus "we decided together", with more females putting the prior and more males thinking the latter. Future studies should look into whether dyads who

communicate more with their partner are communicating accurate information regarding contraceptive strategies. It is important to not only promote frequent communication but accurate and meaningful communication.

### **Conclusion**

It is important to understand that communication regarding sexual behavior is something that is developed over time, with comfort regarding sexuality and comfort within the dyad all playing a role. This study provides some support that communicating consent rather than just accepting a behavior can have a positive effect on relationships, which could lead to healthier and better communication overall about consent and contraceptives among dyads. This indicates support for the importance of dyadic communication and increasing comfort with talking about sexual topics. Healthy and satisfying sexual relationships are less likely to occur without teaching and destigmatizing effective and confident sexual communication.

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Table 1

*Sociodemographic Characteristics of the Sample (N = 74)*

	N	%
Sex		
Female	40	54.1
Male	33	44.6
Other	1	1.4
Sexual orientation		
Entirely hetero	49	66.2
Not entirely hetero	25	37.8
Race		
White	65	87.8
Hispanic	8	10.8
Native American	4	5.4
Asian	4	5.4
Black	4	5.4
Middle Eastern	1	1.4
University status		
First year	6	8.1
Second year	10	13.5
Third year	17	23.0
Fourth year	14	18.9
Fifth+ year	3	4.1
Graduate	11	14.9
Non-degree	1	1.4
Not a student	12	16.2

Table 2

*Contraceptive Method Use and Consistency*

Type of Contraceptive	N	%	Use at least most of the time	%
Male condom	64	86.5	26	40.7
Female condom	4	5.4	0	0.0
Withdrawal	47	63.5	23	48.9
Birth control pill	52	70.3	32	62.7
Birth control patch	1	1.4	0	0.0
Vaginal ring	2	2.7	1	50.0
Birth control shot	4	5.4	0	0.0
Spermicide	1	1.4	0	0.0
Hormonal IUD	8	10.8	n/a	n/a
Non-hormonal IUD	6	8.1	n/a	n/a
Hormonal implant	9	12.2	n/a	n/a
Diaphragm	0	0.0	n/a	n/a
Natural family planning	4	5.4	0	0.0
Female sterilization	2	2.7	n/a	n/a
Male sterilization	1	1.4	n/a	n/a
Emergency contraception	15	20.3	0	0.0
None	1	1.4	n/a	n/a
I don't know	0	0.0	n/a	n/a

Table 3

*Types of Consent Cues Reported by Participant at Most Recent Sexual Encounter*

Self-consent cues	M	SD	<i>t</i>	df	<i>p</i>
Explicit verbal					
Yes	1.94	.79	-.36	72	.718
No	1.87	.84			
Implicit verbal					
Yes	1.98	.85	.80	72	.424
No	1.83	.77			
Explicit nonverbal					
Yes	1.86	.77	.63	72	.529
No	1.98	.86			
Implicit nonverbal					
Yes	2.04	.89	-1.55	72	.125
No	1.75	.69			
No response					
Yes	2.31	.92	-2.11	72	.039*
No	1.82	.76			

Table 4

*Types of Consent Cues Participant Reported Their Partner Using at Most Recent Sexual Encounter*

Partner consent cues	M	SD	<i>t</i>	df	<i>p</i>
Explicit verbal					
Yes	2.00	.792	-.99	72	-.187
No	1.81	.828			
Implicit verbal					
Yes	1.91	.872	-.01	72	.990
No	1.91	.744			
Explicit nonverbal					
Yes	1.88	.808	.29	72	.771
No	1.94	.821			
Implicit nonverbal					
Yes	2.03	.938	-1.18	72	.243
No	1.80	.658			
No response					
Yes	2.15	.941	-1.44	72	.154
No	1.83	.755			

## Appendix

### *Satisfaction with Consent Communication*

*6-point Likert-type scale, "strongly agree" to "strongly disagree"*

1. I am calm and relaxed when communicating with my partner about sexual issues.
2. While participating in a conversation with my partner about sex, I get nervous.
3. Talking with my partner about sex makes me feel uncomfortable.
4. Engaging in sexual communication with my partner makes me nervous.
5. Ordinarily I am very tense and nervous in conversations about sex with my partner.
6. While talking with my partner about sex, I feel very relaxed.
7. I have no fear of speaking up in a conversation about sex with my partner.
8. Generally, I am comfortable communicating with my partner about sexual issues.
9. My thoughts become confused and jumbled when I communicate with my partner
10. I feel calm when I think about talking with my partner about our sex life.
11. Thinking about talking with my partner about our sex life leaves me with an uneasy feeling.
12. I feel anxious when I think about communicating with my partner about the sexual aspects of my life.
13. Ordinarily I am very calm and relaxed in conversations about sex with my partner.
14. I feel nervous when I think about talking with my partner about the sexual aspects of our relationship.
15. I am afraid to speak up in conversations about sex with my partner.
16. I face the prospect of talking with my partner about sex with confidence.
17. I worry when I think about talking with my partner about our sex life.
18. I feel anxious when I think about talking to my partner about condom use.
19. The idea of initiating a conversation with my partner about safer sex practices makes me nervous.
20. I am comfortable talking to my partner about condom use.
21. Talking with my partner about protecting ourselves against sexually transmitted infections makes me feel uncomfortable.
22. Thinking about asking my partner if he or she has been tested for sexually transmitted infections makes me nervous.
23. I have no fear of telling my partner about what I dislike during sex.
24. I feel anxious when I think about telling my partner what I dislike during sex.
25. Thinking about talking with my partner about what I do not like during sex leaves me with an uneasy feeling.

*Satisfaction with Contraceptive Decision-Making*

7-point Likert-type scale, “strongly agree” to “strongly disagree”

1. My partner makes an effort to satisfy questions I have about our contraceptive use
2. I get a sense of well-being when I communicate with my partner about our contraceptive use
3. I dislike when my partner and I talk about our contraceptive use
4. My conversations with my partner about our contraceptive use are valuable
5. When I talk to my partner about our contraceptive use, I feel like it’s a waste of time
6. Talking with my partner about our contraceptive use leaves me feeling like I accomplished something
7. My partner and I have worthwhile conversations about our contraceptive use
8. I wish my partner was better at communicating with me about our contraceptive use
9. I wish my partner and I had more productive conversations about our contraceptive use
10. My partner tends to dominate our conversations about our contraceptive use and does not allow me to get my point across
11. My partner and I effectively communicate our contraceptive use
12. My partner genuinely listens to me when I talk to them about our contraceptive use
13. My partner is aware of the contraceptive method(s) being used in our relationship
14. My partner and I agree on what contraceptive method to use
15. My partner and I make time to talk about our contraceptive use
16. I am happy with the contraceptive method(s) that my partner and I use
17. I am upset with the contraceptive method(s) that my partner and I use
18. I am satisfied with the contraceptive method(s) that my partner and I use
19. The contraceptive method(s) my partner and I use makes me wish I wasn't in my current relationship
20. My partner and I communicate about our contraceptive use better than the average couple
21. My partner meets my expectations for communicating about contraceptive methods
22. There are problems with how my partner and I communicate about our contraceptive use
23. One of the bigger problems in my relationship is our contraceptive method(s)