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Cognitive-Behavioral Intervention to Enhance Sexual Assertiveness in Women Who Exhibit Premarital Sexual Compliance in the Greater Jakarta Area, Indonesia

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ABSTRACT

Premarital sexual compliance is common among women and is influenced by gender role socialization. Sexual assertiveness reduces the likelihood of engaging in sexual compliance. This study examined the effectiveness of cognitive-behavioral intervention in enhancing sexual assertiveness in women who exhibited sexual compliance. This was a quasi-experimental study conducted with a pretest-posttest nonequivalent control group design. Each group consisted of five participants recruited through purposive sampling. Participants in the intervention group participated in five individual sessions, preceded by a pre-session and followed by a follow-up session. The participants in the control group were given a psychoeducation book to read and had no face-to-face sessions. Analysis was conducted through the comparison of quantitative data measured by the Indonesian version of the Sexual Assertiveness Questionnaire for Women (SAQ-W) scale. Participants' changes in cognition and behavior before and after the intervention were also observed. It was found that cognitive-behavioral intervention successfully enhanced sexual assertiveness in women who exhibited sexual compliance. Participants in the intervention group were able to identify what they wanted and did not want in sexual situations, modify maladaptive thoughts leading to unassertive behaviors, and apply behavioral techniques to facilitate the occurrence of assertive behavior in sexual contexts.

Keywords: Cognitive-behavioral intervention, sexual assertiveness, sexual compliance

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INTRODUCTION

A preliminary study conducted by the authors in February 2017 of 2231 unmarried heterosexual Indonesian women ages 15-43, most of whom were residing in the Greater Jakarta area, found that many women were sexually active prior to marriage (Kristanti, 2017). In all, 45% have had oral sex, 6% have had anal sex, and 34% have had penis-in-vagina sex. Notwithstanding the widespread opinion that premarital sexual activities are pleasurable for both participating parties, around 30-40% of premarital sexual activities occur out of compulsion (French & Neville, 2016; Hickman et al., 2004; Young & Furman, 2008). The most surprising finding is that the majority (89%) of women who engaged in compulsory sexual activities gave their consent to the sexual activity in the absence of any physical violence or verbal threats from the partner, and they did so during a conscious and non-intoxicated state (Kristanti, 2017). This condition, women giving their consent to engage in sexual activities without (or unaccompanied by) the desire to perform those activities, is known as sexual compliance (French & Neville, 2016; Impett & Peplau, 2002; O'Sulivan & Allgeier, 1998).

The high levels of sexual compliance discovered in these women prompt this research to further examine what causes women to agree to get involved in unwanted sexual activities. The socialization of gender roles plays a part in shaping sexual compliance, because women develop identities oriented toward fulfilling other people's needs, maintaining close relations with others, or giving emotional support to others (Hyde & Else-Quest, 2013; Impett & Peplau, 2003; Walker, 1997). The reasoning women employ in sexual compliance is consistent with this concept of gender socialization. Women feel responsible for satisfying their partners' sexual needs, do not want to hurt their partners' feelings or make them feel rejected, want to avoid tensions and conflict, want to feel accepted by their partners, and believe that sexual activities will make their partners love them more and will improve the quality of the relationship (Gavey as cited in French & Neville, 2016; Impett & Peplau, 2002; Kristanti, 2017; Lewin, 1985; O'Sulivan & Allgeier, 1998). The social valuation of virginity is also a strong reason to consent to unwanted sexual relations. Women who lose their virginity before marriage are usually demeaned by stigma and terms such as "broken", "damaged", "cheap", and "easy" (Bennett, 2005). They may find it difficult to risk being left by their partners whom they've already had sex with because they worry that no other man will want to marry them (Kristanti, 2017). Therefore, they may have a tendency to acquiesce to their partners' sexual requests, despite it being against their wishes.

On the other hand, in accepting invitations from their partners to engage in sexual activities, women face another conflict, that incited by religious values in Indonesia, which hold that premarital sex is a sin (Bennett, 2005; Kristanti, 2017). From a religious as well as a cultural point of view,

premarital sex is considered socially deviant, unhealthy, immoral, illegal, and dangerous (Bennett, 2005, 2007; Holzner & Oetomo, 2004). In Islam, the majority religion in Indonesia, premarital sex is called *zina*, an offence punishable by the *shariah,* the Muslim justice system (Bennett, 2005). This internal religious conflict makes women unsure of what they should do in sexual situations. Detecting this uncertainty, men are socially expected to behave according to their sexual script, persistently persuading and seducing until the female partners agree to engage in sexual activity (therefore presenting sexual compliance).

The complexity underlying sexual compliance has manifold implications. At first, women may experience positive feelings, such as satisfaction, happiness, and love as a result of having complied with their partners' needs. The long-term effects, however, are predominantly negative feelings, such as guilt and sinfulness, feeling dirty, being disgusted with oneself, feeling tainted, fearing pregnancy, and feelings of worthlessness, which may affect their psychological state (Christopher, 1988; Kristanti, 2017). Unwanted sexual activity may also have negative health consequences for women, such as, among others, pregnancy-related risks or sexually transmitted diseases, such as HIV/AIDS or cervical cancer. These things may happen because women who engage in unwanted sexual activities tend to feel reluctant to ask for protection or contraceptives (Katz & Tirone, 2009; Liu, 2006; Thiangtham et al., 2010).

One of the solutions that may help women escape the sexual compliance problem is by developing sexually assertive behavior patterns (Carlson & Johnson, 1975; Greene & Navarro, 1998; Morokoff, 2000; Rickert et al., 2002; Schry & White, 2013; Testa & Dermen, 1999). Assertiveness itself is the ability to defend personal rights as well as the ability to express opinions, feelings, and desires directly, without the accompaniment of anxiety or guilt, while still respecting the rights of others (Alberti & Emmons, 1970; Linehan, 1979; Rich & Schroeder as cited in Rakos, 2006). Women who are sexually assertive can behave sexually according to their wishes, in spite of her partner's needs, without feeling guilty or worried. She also knows and is sure of what she wants sexually, the boundaries between the sexual behaviors she is willing and unwilling to do, and can communicate these to her partner. Interventions to increase sexual assertiveness must focus on identifying and testing irrational beliefs systems or a number of traditional norms related to gender and sexuality cognitively believed by women, norms that make them fear losing other people, hurting others' feelings, or that they are behaving too aggressively; then, such interventions must prepare women with the skills needed to perform assertive behaviors (Walker, 1997; Wolfe & Fodor, 1975). The cognitive-behavioral approach responds to this need; it teaches individuals to identify non-adaptive cognitive patterns and how they can create negative emotions. If one changes how one thinks, interprets, and assumes, a shift of

emotions toward positivity can occur, and more adaptive patterns of behavior can be brought out (Kazdin as cited in Dobson & Dozois, 2010; Spiegler & Guevremont, 2010; Westbrook et al., 2011).

The utilization of the cognitive-behavioral approach to increasing assertiveness in women, which includes sexual assertiveness, has gained empirical support (Linehan et al. as cited in Linehan, 1979; Muehlenhard et al., 1989; Wolfe & Fodor, 1977). A controlled, randomized experiment performed by Weindhardt et al. (1998) found that interventions based in cognitive-behavioral techniques were effective for increasing assertiveness in women who were at risk of being infected with HIV. A recent study by Ilkchi et al. (2011) found that cognitive-behavioral therapy could significantly reduce anxiety and increase self-efficacy and assertiveness in anxious female students.

Reflecting on the success of the aforementioned studies, the authors became interested in implementing this strategy and examining the effectiveness of the cognitive-behavioral approach in increasing women's sexual assertiveness in the context of premarital sexual compliance. The intervention carried out in this study was intended to support participants in clearly identifying their sexual boundaries and what they want in sexual situations, identifying and modifying cognitions that inhibit assertive behaviors in the sexual context, and learning behavioral techniques to facilitate the development of assertive behaviors in the sexual context. These aims were achieved through an intervention module developed by the authors, based on several studies of cognitive-behavioral interventions (Jakubowski-Spector, 1973; Linehan, 1979; Muehlenhard et al., 1989; Westbrook et al., 2011; Wolfe & Fodor, 1975), with a few adjustments to address the needs of female Indonesian participants.

MATERIALS AND METHODS

Design

The current study was a quasi-experimental study with a two-group design, measured before, after, and two weeks post intervention (follow-up). Gravetter and Forzano (2012) described this research design as pretest–posttest nonequivalent control group design.

Participant

The participants of this study were ten people (five in the control group and five in the intervention group), with the following criteria: women, aged 18–29 years, unmarried but in a romantic relationship, heterosexual, had engaged in a sexual activity they did not want with their current partners even though they had never experienced physical violence or threats from the partner, and have low scores (≤ 42) in the Relational Sexual Assertiveness (RSA) subscale on the adapted Sexual Assertiveness Questionnaire for Women (SAQ-W; Walker, 2006) instrument.

Ethics

Approval of this research was obtained from The Ethics Committee of the Faculty of Psychology at Universitas Indonesia. Informed consent was read, discussed, and signed by the first author and the participants.

Procedure

The authors contacted the respondents of the preliminary study matching the participant criteria of the current study, invited them to participate in this study, and sent them a proposal for participation in the research through the webpage survey.ui.ac.id. Potential participants were informed that they would fill out a questionnaire that would serve as a screening tool (SAQ-W). Their scores were recorded as the pre-test. If their scores matched the requirements for becoming a participant, they were contacted to join the cognitive-behavioral intervention (being placed into the intervention group). If their scores did not match the criteria or they were not willing or unable to join the intervention for any other reason, they were placed into the control group, receiving a psychoeducational book on sexual compliance and sexual assertiveness developed by the authors. Eight weeks after the pre-test, both the intervention group and the control group were asked to fill out the same measurement (SAQ-W) that would serve as a post-test. Two weeks after the post-test, both groups were also asked to fill out a follow-up measure (SAQ-W).

Measure

The adapted version of the Sexual Assertiveness Questionnaire for Women (SAQ-W) instrument, developed by Walker (2006), was used to measure participants' sexual assertiveness. The SAQ-W uses a 5-point-scale (1 = strongly disagree; 5 = strongly agree) to measure how suitable the 30 statements on sexual assertiveness are to the participant's condition. There are four factors in the SAQ-W: RSA, Sexual Confidence and Communication Assertiveness (SCCA), Commitment-Focused Sexual Behavior, and Sex-Related Negative Affect. Among these four factors, Walker (2006) identified the first factor (RSA) (including items such as "*I go along with what my partner wants sexually, even when I'm uncomfortable*"; "*I engage in sexual behavior when I don't really want to because I'm afraid my partner might leave me if I don't*") and the second factor (SCCA) (including items such as "*I don't really know what I want sexually*"; "*I lack confidence in sexual situations*") as the two main components of sexual assertiveness. RSA refers to the extent of female assertiveness affected by the focus on the partner and the partner's sexual needs. Women with high RSAs behave as they wish sexually, regardless of their partners' requests, without feeling guilty or worried. However, women with low RSAs tend to prioritize and comply with their partners' sexual requests, even when she wants something else. Moreover, SCCA illustrates the extent of women's awareness of their own desires and

sexual needs and how well they are able to communicate it to their partners. Following Walker, the authors will only use two factors (subscales) in this current study, namely, the RSA, which consists of 14 items, and the SCCA, which consists of 7 items.

The adaptation of SAQ-W involved translation, back-translation, psychometric testing, and the development of a norm. In a trial conducted among 681 female respondents who are unmarried but have been in a romantic relationship, it was found that the RSA as well as the SCCA subscales are both reliable (Cronbach's alpha = 0.929; 0.729) and valid according to the criterion validity procedure. The criterion used for the validity procedure was whether or not the respondents had experienced compulsory sexual activities. The norms for the RSA subscale are that scores between 14 and 42 indicate low relational sexual assertiveness, while scores between 43 and 70 indicate high relational sexual assertiveness. The norm for the SCCA subscale are that scores between 7-21 indicate low sexual confidence and communication, while scores between 22-35 indicate high sexual confidence and communication. The norms were validated by conducting the chi-square test to the expectancy tables obtained by those cut-off scores. The cut-off scores were determined using the theoretical means of the two subscales.

Course of Treatment

A cognitive-behavioral intervention is a psychological intervention that emphasizes and elaborates on cognitive, emotional, and behavioral processes to help clients overcome complicated problems (Westbrook et al., 2011). Based on a review of several cognitive-behavioral intervention programs for assertiveness, a few techniques are found to be commonly exercised to manage assertiveness in women (Jakubowski-Spector, 1973; Linehan, 1979; Muehlenhard et al, 1989; Wolfe & Fodor, 1975). These techniques were used to increase sexual assertiveness in women in this study and were placed in a series of intervention sessions, summarized as in Table 1.

All interventions for the participants in the intervention group were conducted by the first author, who served as the therapist. First, the therapist conducted a pre-session to build rapport and perform the initial interview. In the first session, psychoeducation on sexual compliance was conducted, including the definition of sexual compliance, the concept of consent and desire, and information on men's sexuality, as well as the reasons commonly expressed by Indonesian women for consenting to unwanted sexual activity. Next, the participants were counseled to help them identify pros and cons themselves when engaging in sexual activities they do not actually want. Using the two-column technique, participants were able to weigh and decide which items from the two sides (pros and cons) were more important to them, so that they could formulate sexual boundaries with their partners.

In the second session, the participants received psychoeducation on sexual assertiveness, covering the definition of sexual assertiveness as well as the

Table 1
Cognitive-behavior intervention program for increasing sexual assertiveness

Contact	Description of activities
	Measuring SAQ-W for pre-test
Pre-session	Rapport building and completion of personal information, initial interview, explanation of program, and completion of informed consent.
1st Session	Psychoeducation on sexual compliance, counseling about internal conflicts and setting boundaries regarding sexual activities the client is willing and not willing to do.
2nd Session	Psychoeducation on sexual assertiveness, psychoeducation and counseling to help client identify factors that are hindering them from behaving sexually assertive, discussion of case formulation.
3rd Session	Introducing the ABCDE technique, cognitive restructuring and assigning homework, psychoeducation on the overt component in assertiveness.
4th Session	Writing of script to be assertively communicated to partner, role-play of script and assigning homework.
5th Session	Sessions recap, planning the next steps to be more sexually assertive, measuring SAQ-W for post-test, termination.
Follow-up	Progress monitoring, measuring SAQ-W for follow-up, delivering results (comparing pre-test and post-test results), filling out the evaluation form regarding the intervention program and therapist.

differences between submissive, assertive, and aggressive behavior. Through psychoeducation and counseling, the participants were informed of the factors that may hinder women from becoming assertive and became more aware of the beliefs they have held that have blocked them from behaving assertively. A discussion of case formulations based on the cognitive-behavioral framework was also conducted. All five participants felt that this discussion helped them better understand the source of their sexual compliance and consequently learnt what they could do to be more sexually assertive.

In the third session, the ABCDE (A= activating event/antecedent; B = belief; C = emotional and behavioral consequences; D = disputing irrational thoughts and beliefs; E = cognitive and emotional effects of revised beliefs) technique for recognizing and disputing unhelpful thoughts was introduced. Participants were asked to think of a time when they found it difficult to refuse an invitation to engage in a sexual activity they did not wish to do (A), as well as identify thoughts and feelings that hindered them from behaving assertively in that situation (B and C). After that, participants were asked to dispute their thoughts (D), that is, to think of new thoughts that could help them to be more assertive in the given situation (E). Participants then continued practicing their disputes by making a table. In the table, participants were asked to identify negative thoughts that had hindered them from being sexually assertive, describe the socialization of gender roles that incited those previous thoughts, and dispute these with their own thoughts through cognitive restructuring. Participants were given homework, namely to continue working on their table. In

general, all five participants felt that the cognitive restructuring process helped them to develop a different perspective for looking at their problem, also equipping them with tools they could use to escape their vicious thought cycle. Table 2 reports an example of the cognitive restructuring process performed by one of the participants.

Table 2
An example of the cognitive restructuring process done by one participant

Old thought	Gender role socialization	Dispute
"I have been doing sexual activities as a routine in my relationship, therefore it is my responsibility to always satisfy him [my partner]."	"It is the wife's responsibility to cater to her husband's needs. I feel that he is my future husband, so I must keep doing the sexual activities even though I do not want to do them."	"I do not have to serve him all the time. When I do not feel comfortable, then he must respect my wishes."

At the end of the third session, psychoeducation was given on the principles of assertive communication as per Rakos (2006), including: (1) content, that an assertive statement must contain the desire, affect, and opinion of the subject, be direct, specific, and respectful, and use an I-statement; (2) paralinguistic elements, that an assertive message must be delivered firmly with moderate response latency and duration; (3) non-verbal behavior, that an assertive message must be delivered with constant eye contact but not rigidly, a sincere facial expression that is also serious, the use of hand gestures and flexible arms, and a relaxed and attentive posture; and (4) interaction skills, that is, timing, initiation and persistence, and the ability to control stimuli.

During the fourth session, the intervention progressed into the behavioral component. Participants were asked to write a role-play script communicating their sexual boundaries to their partners in an assertive manner. They were asked to refer to the sexual boundaries they set on the first session and then write them according to the principles of assertive communication that were given to them on the third session. The therapist gave feedback on the script, and the participants were then asked to communicate their script to their "partners," who they imagined was sitting across from them in an empty chair. The therapist also asked the participants to imagine the responses that their partners would give and ask them to reply to those responses until an agreement on sexual boundaries in their relationship is made. In general, all five participants performed the activity well and they reported feeling readier to behave assertively to their partners. As homework, they were asked to assertively deliver their points regarding sexual boundaries to their partners and evaluate their own performance on an evaluation sheet.

In the fifth session, the homework was discussed and the sessions to date were summarized. The therapist asked the participants to mention the important points from the first session to the last and helpful ideas they had gleaned, as well as the changes

they felt before and after the intervention. The therapist also helped participants make a concrete plan for the things they could do to be more sexually assertive. In the follow-up session, the therapist discussed the improvements experienced by the participants after termination and also asked them to give feedback about the intervention. Figure 1 below summarized the participant recruitment procedure.

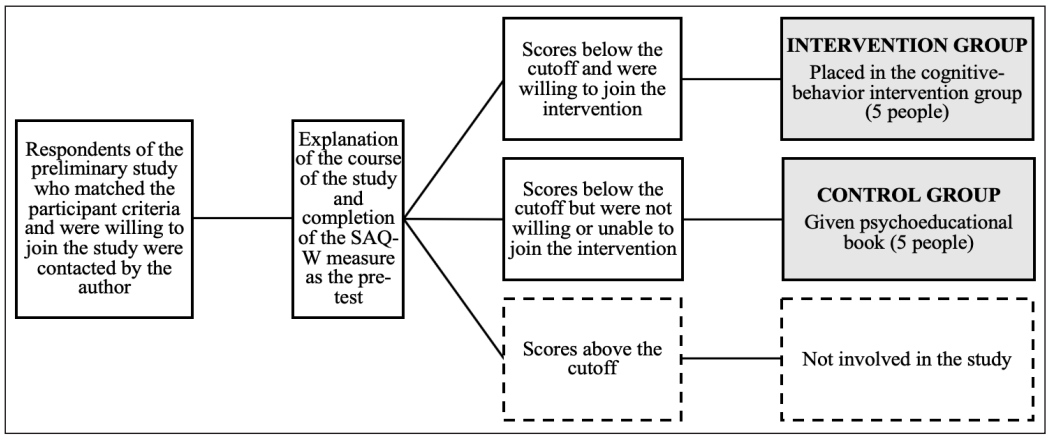

Figure 1. Participant recruitment procedure

RESULTS

The results of the study are presented based on changes on the RSA and SCCA subscales. In general, both the intervention and control groups experienced increases in RSA, but the intervention group experienced greater improvement. In Figure 2 and 3, which show the changes for each participant in each groups, the increases that occurred in the intervention group can be seen to be more uniform compared to those of the control group. Figure 4 shows that for intervention group, all participants successfully improved their RSA scores in great strides from low to high, whereas in the control group, there were participants who had great and small improvements, and one even maintained a low RSA score.

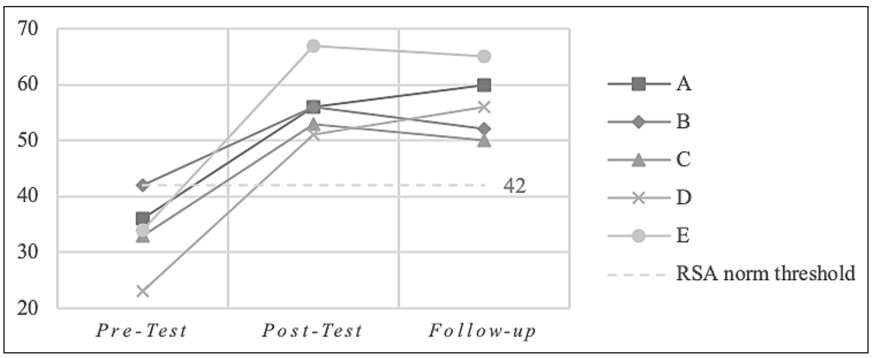

Figure 2. RSA changes in the intervention group

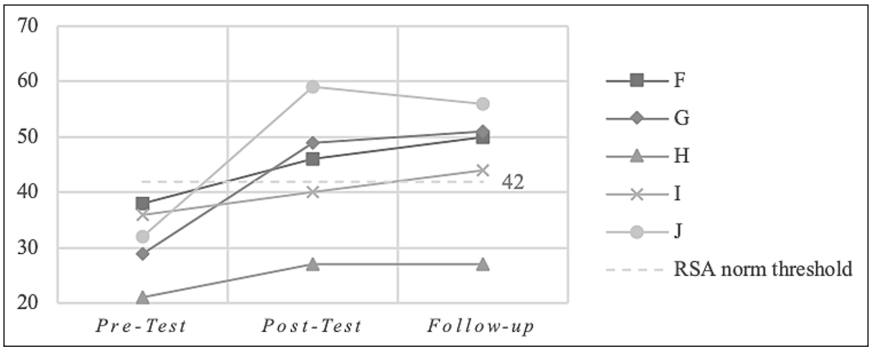

Figure 3. RSA changes in the control group

In general, both intervention and control group experienced improvements in their SCCA scores; however, the intervention group experienced greater improvement than the control group. In the pre-test, the SCCA scores of the control group were higher than those of the intervention group's, but in the post-test and follow-up, the SCCA scores of the intervention group exceeded the control group's scores as shown in Figure 5.

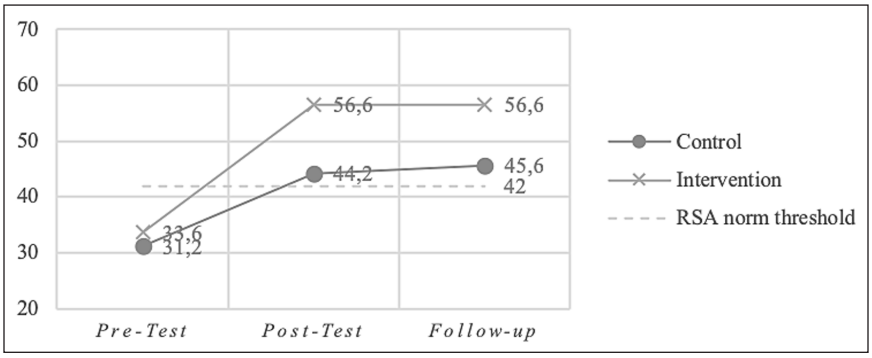

Figure 4. Comparison of RSA changes between the intervention and control group

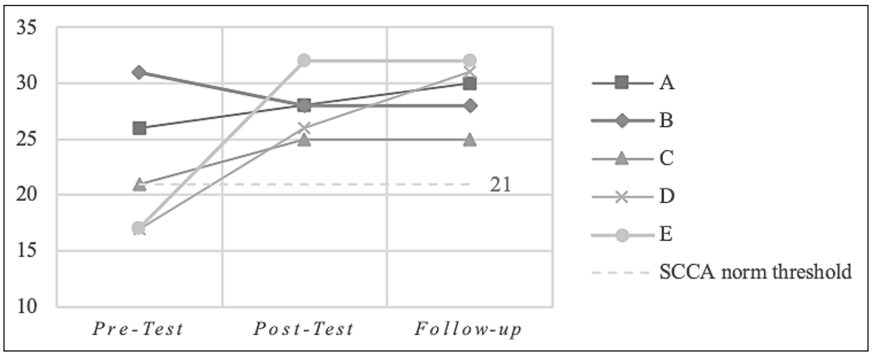

Figure 5. SCCA changes in the intervention group

Figure 6 and 7 illustrate changes experienced by each participant in each group. Although one participant in the intervention group showed a decrease in SCCA, in the end, all the participants in the intervention group had high SCCA scores. Meanwhile, in the control group, there was still one participant who had a low SCCA score relative to the norm.

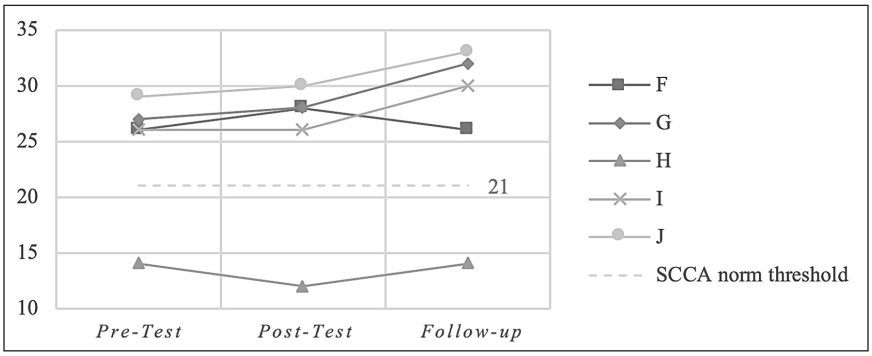

Figure 6. SCCA changes in the control group

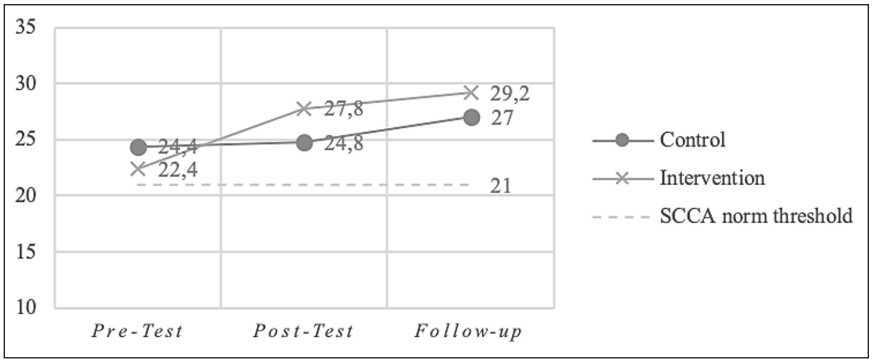

Figure 7. Comparison of SCCA changes between the intervention and control group

Other than changes in RSA and SCCA scores, participants in the intervention group also showed several qualitative changes, which are: (1) becoming able to identify their sexual wishes and boundaries ("At this point, I think I am comfortable to limit my sexual activity [with my partner] to kissing and hugging only. I don't want to have sexual intercourse, and I know that video sex call is also not for me"); (2) feeling confident enough to communicate those sexual boundaries to their partners ("I think now I know where I stand and I am ready to talk about it with my partner"); (3) being able to identify and modify thoughts that have been hindering them from behaving assertively in the sexual context ("I think I used to have a tendency to think of the worst, 'what if he leaves me', and such.' Now I think if I already expressed my objection to his sexual request and he doesn't respect my wishes, it's not on me … Wow, why didn't I think

about it this way sooner?!"); and (4) being able to assertively express refusal or sexual boundaries to their partners ("I feel like in our relationship, we have done some sexual activities that I am actually not comfortable with … I know that it is important for you, but honestly, it made me feel as I am living in a sin and it's not for me … I want us both to feel equally comfortable in pursuing this relationship forward").

DISCUSSIONS

There are a few points worth discussing. First, to the surprise of the authors, the control group also experienced an increase in sexual assertiveness, especially in the RSA subscale, although its quantity is not as great as that of the intervention group's and not all participants in the control group experienced a substantial increase. This finding indicates that psychoeducational books can also help participants improve their sexual assertiveness and can be used as a simple alternative intervention if face-to-face intervention cannot be performed.

The impact of cognitive-behavioral intervention on the two subscales of sexual assertiveness (SAQ-W), which are RSA and SCCA, is also a point to consider. An interesting pattern was found, which is that the RSA scores only increased if the individual already had high SCCA scores. In other words, before a person can behave assertively according to their wishes in a sexual situation, they need to be quite sure of their sexual boundaries and feel confident enough to express them. A real example of this notion can be seen among the participants of the control group. The four of them who experienced an increase in RSA at the post-test had SCCA scores high above the norm from the beginning. This means that when an individual is already certain of her sexual desires and boundaries, then information from a psychoeducational book is sufficient to help her be more sexually assertive. Another support for the SCCA as a possible mediator to RSA changes is found in the authors experience when conducting the intervention for the intervention group. The authors felt that it was much harder to deliver intervention sessions to participants with low SCCA scores than it was to deliver them to those with high SCCA scores. Therefore, the authors suggest that future research systematically examine the role of SCCA as a mediator between the intervention and RSA.

During the follow-up, an interesting result was found in changes in sexual assertiveness scores, compared between both groups. The RSA scores of the control group continued to improve, whereas the scores of the intervention group were stagnant. This may be explained by the principle of regression toward the mean (Gravetter & Wallnau, 2013), which states that individuals with extreme scores will tend to get lower scores nearer to the mean when next measured. This decrease in score was not caused by any deterioration in the participant, but is more a statistical fact of life. This is what happened to the participants in the intervention group. Meanwhile, the control group did not experience very large increases in their scores, so their pre-test

scores were not extreme. They generally showed increases of scores and did not show any regression toward the mean for the next measurement. Moreover, the participants in the intervention group were instructed to do several tasks within a limited period of time; meanwhile, participants in the control group were not instructed to do so. It is possible that they had their own pace in progressing with the information given in the psychoeducational book. Therefore, they could still continue to process the information even after the period of intervention had ended, which would explain why their RSA scores continued to increase.

The next finding to be discussed concerns the part of the intervention the participants felt was most beneficial: the activity about the dysfunctional thought cycle and the creation of disputes. This appreciation of a standard tool of cognitive-behavioral therapy shows that the cognitive-behavioral approach is indeed the right approach to address the sexual compliance issue.

Furthermore, the probable long-term effects of the intervention should be discussed. A limitation of this study is that follow-up was done only two weeks post termination, although findings did show that the effect of the intervention was relatively stable during this two-week period. However, there may not have been enough important incidents in this period to test whether the improvement in sexual assertiveness of the participants can be maintained in the long run. One of the things that may increase the likelihood of the intervention having a more stable long-term effect would be for the setting of sexual boundaries were to be done gradually. Some participants in this study set sexual boundaries that are a long way off from the usual sexual activity they have performed with their partners, such as limiting the sexual activity to a light kiss when the two usually have sexual intercourse. During the intervention process, their partners can accept the new setting of sexual boundaries; however, a long-term evaluation is yet to be done to review whether the participants or partners continues to act according to the sexual boundaries. Based on this consideration, it would perhaps be better if the setting of sexual boundaries were done gradually, starting with assertive refusal of sexual advances. After the participants become comfortable with expressing refusal, they can then try to set the sexual boundaries that they are truly comfortable with.

This study is not immune to several limitations, which can be addressed in future studies. The first concerns the use of a control group that may not have the same characteristics as the intervention group. The authors have made sure that the RSA mean of the intervention group was equal to that of the control group, but no measurement was made and no variables were identified for factors that could have influenced the results of the study. Another limitation of the study is the lack of a control group that received no treatment. In this study, the control group was given a psychoeducational book as the authors' form of accountability for the

participants of this study, and this gesture could already be considered as a simple intervention. According to Gravetter and Forzano (2012), this limitation makes it impossible to identify time-related effects, which may have jeopardized the internal validity of the study. Based on this limitation, we suggest that future researchers utilize a wait list control group. With regard to the content of the cognitive-behavioral intervention itself, there are a few points that can be added to improve the benefits felt by the participants such as among others, information regarding sexual health or the use of contraceptives because women who show sexual compliance tend to also not be assertive in asking the use of protection (Katz & Tirone, 2009; Liu, 2006; Thiangtham et al., 2010).

Methodologically, future studies can be done with larger samples so the impact of the intervention can be generalized and statistical testing can be done to prove the effectiveness of the intervention. Also, before placing participants into intervention or control groups, researchers should identify and measure external variables that may affect relationships between the independent and the dependent variables. The results of this study would be even more valid if the control group were completely left alone or not given any treatment; one solution for this would be to use a waitlist control group system. Moreover, to monitor the long-term effects of the study, more follow-up sessions can be held at 3 months, 6 months, or 1 year after termination. Future studies can also systematically explore the hypothesis of the SCCA as a mediator to RSA changes using a large sample size.

On a more practical note, the authors can reproduce and disseminate the psychoeducational book with an easy conscience because it was found to have helped increase assertiveness in women who show sexual compliance. When explaining the course of the cognitive-behavioral intervention, it would be better if the setting of sexual boundaries were done gradually, as demonstrated in the previous discussion. Beyond this, it is important for there to be future studies that include the topic of sexual health and the use of contraceptives in the intervention module. For instance, a psychoeducation could be performed on the dangers of performing sexual activities without protection, the right to use contraceptives, and the types of contraceptives available, with a follow-up where participants report on mentioning the use of contraceptives as they establish their sexual wishes and boundaries with their partners.

CONCLUSIONS

Interventions using a cognitive-behavioral approach can increase sexual assertiveness in women who show premarital sexual compliance. The increase caused by the intervention is greater than obtained by just reading a psychoeducational book. Participants involved in cognitive-behavioral intervention experienced positive changes, not only quantitatively, as measured by

the RSA and SCCA subscales, but also in evident qualitative changes. Participants became more able to identify their sexual boundaries and what they want out of sexual situations, identify and modify thoughts that may hinder them from acting assertively in sexual contexts, and use behavioral techniques that can facilitate the appearance of assertive behavior in sexual contexts.

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