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POSTDOCTORAL STUDIES**

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**Girl Power/Boy Power :
Positive Sexual Health Outcomes and the Gendered Dynamics of Power in Adolescent Heterosexual
Relationships**

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**Girl Power/Boy Power: Positive Sexual Health Outcomes and the Gendered
Dynamics of Power in Adolescent Heterosexual Relationships**

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**Thesis submitted to the Faculty of Graduate and Postdoctoral Studies
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Abstract:

Power, how it is defined, embodied and expressed by individuals is central to how those individuals will behave in and perceive their relationships. This dissertation is based on a study focusing on the issues of power and positive sexual health outcomes within adolescent heterosexual relationships from a Population Health perspective that attends to selected social determinants of health. Specifically, this dissertation examines how power is conceptualized, understood and measured in the context of adolescent heterosexual relationships and how power influences the outcomes of these relationships. An explicit concentration is placed on positive outcomes while maintaining a consideration of negative outcomes as key factors in the achievement of sexual health for adolescents.

Both qualitative interviews and a quantitative cross-sectional survey were used to explore these issues with a convenience sample of self-defined heterosexual youth between the ages of 14 and 20 who primarily self-identified as Caucasian. Results show that power is overwhelming conceptualized as negative, with some adolescents denying that they have or exercise power. The embodiment of power is perceived to be gendered. 'Powerful girls' are critiqued in a way that 'powerful guys' are not. Young men and women described expressing power in their relationships in generally positive fashions. A minority of young men described expressing power in dominant ways while a minority of young women described using their sexuality as a means of expressing power.

The quantitative measurement of relationship power as measured by a modified version of the Sexual Relationship Power Scale (Pulerwitz, Gortmaker, & DeJong, 2000) revealed lower scores for young men as compared to young women. Regression analyses revealed that for both males and females an experience of physical or verbal violence from a partner in the past year was negatively associated with scores on the SRPS and communication within the most recent relationship was positively associated with scores on the SRPS. High rates of positive sexual health outcomes such as, sexual self-efficacy, satisfaction, sexual assertiveness and communication were seen.

Findings, as well as limitations of this study, point to the need for more research on issues of power, equity, gender and positive sexual health outcomes.

Introduction

Power – a simple word with complex meanings. Power is embedded in all aspects of our social political and personal lives. At the most intimate level, power is embedded in our sexual relationships. This dissertation is based on a study focusing on the central issues of power and positive sexual health outcomes within adolescent heterosexual relationships from a Population Health perspective that attends to the social determinants of health. Specifically, this dissertation examines how power is conceptualized, understood and measured in the context of adolescent heterosexual relationships and how power influences the outcomes of these relationships. An explicit concentration is placed on the positive sexual health outcomes of these relationships while maintaining a consideration of negative sexual health outcomes as key factors in the achievement of sexual health for adolescents. Moreover, the links between the various social determinants of health as mediators of power and resultant inequities are made whenever possible. These links acknowledge that the social determinants of health, for example, income and ethnicity intersect with power structures to create inequities in adolescent heterosexual relationships. Finally, the focus on adolescent heterosexual relationships brings to the forefront the social construction of masculinity and femininity, and the ways in which power is realized in and through these constructions.

Globally, research has shown that power intersects with the social determinants of health within adult and adolescent heterosexual relationships to influence positive and negative sexual health outcomes (Blanc, 2001). However, the focus of this research has overwhelmingly been on negative sexual health outcomes and the risks inherent in such heterosexual relationships. This negative orientation is justified by the enormous challenges posed by rapidly rising rates of sexually transmitted infections, including HIV, and continued disparities in sexual health between and among men and women (Canadian Federation of Sexual Health, 2007).

I claim that lost in this research about power, adolescence, gender and heterosexuality are the positive aspects of sexual health, including the positive ways in which power is understood and expressed

within adolescent heterosexual relationships. Sexual health has long been defined positively by international organizations such as The World Health Organization:

"A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, 2004, p.3)".

Researchers have established that gendered power dynamics, including pressures to conform to rigid norms of heterosexuality which emphasize power inequities, are related to the social determinants of health and negative sexual health outcomes (Wingood & DiClemente, 2002). Yet, there is little information about how or if gendered power dynamics are linked to positive sexual health outcomes. It is unclear, for example, whether power, understood and expressed as equity within adolescent heterosexual relationships, may lead to positive sexual health outcomes. A Population Health perspective allows for a more nuanced approach to the ways in which the concepts of gender and power are tied to positive as well as negative sexual health outcomes and to the social determinants of health at a personal and societal level.

This dissertation is based upon a study I designed to investigate the gendered dynamics of power within adolescent heterosexual relationships in a Canadian urban setting using a two-phase multi-method study. The study recruited adolescents between the ages of 14 and 20, who self-identified as heterosexual and could read and write in English from two settings, a public sexual health clinic and undergraduate university classes in Ottawa. The first phase of the study involved interviews at the public sexual health clinic and the second phase used a cross-sectional survey of adolescents at both the clinic and the university.

In phase one the interviews explored how adolescents defined and expressed power in their heterosexual relationships and how they understood the concept of sexual health. A total of 35 adolescents were interviewed, 13 males and 22 females. On average the youth were 18.5 years old with an age range of 15-22. The majority of the participants self-identified as white, were born in Canada, were currently in school and were sexually active.

In phase two the survey included quantitative measures of power, positive (e.g., satisfaction, communication) and negative (e.g., sexually transmitted infections) sexual health outcomes and various indicators of the social determinants of health (e.g., income, ethnicity). A total of 353 females and 101 males participated in the survey. The average age of the males in this phase was 19 years and females 18 years. As with phase one the majority of the participants were born in Canada and self-identified as white with the remaining participants identifying several different ethnicities. The majority of the survey participants were sexually active (71.9%, females; 74.9% males), currently in school, and lived with both of their parents.

To describe the participants throughout the dissertation I use the terms youth, young people, young men and women, and adolescents interchangeably. The United Nations variously uses the term “adolescents” for those aged 10-19 years, “youth” for those aged 15-24 years and “young people” for those aged 10-24 (Bearinger, Sieving, Ferguson, & Sharma, 2007). Due to the significant overlap in these categories, I adopted to use the various terms interchangeably.

The phrase “self-identified as heterosexual” is used to indicate those who selected on either the survey or qualitative data form that they were heterosexual. To self-identify means that the individual chooses to understand him/herself as heterosexual. However, self-identifying as heterosexual does not necessarily mean that the individual engages only in opposite sex activities. Men who have sex with men (MSM) have traditionally been a hard to reach population because they often identify as heterosexual but also engage in same sex activities. In this project, heterosexual was defined as being sexually attracted to opposite sex partners. Participants were offered the following response categories to identify their sexual orientation: 1) bisexual (attracted to both same and opposite sex partners), 2) homosexual, gay or lesbian (attracted to same sex partners); 3) heterosexual (attracted to opposite sex partners); 4) I’m not sure. The term heterosexual relationships is also used throughout the dissertation to refer to a sexual relationship between a male and female. Both the survey and the interviews asked specifically about heterosexual relationships and how the respondents behave in these relationships. In Chapters 1 and 2, three women who self-identified as bisexual but were currently in heterosexual relationships were included in the analysis, the rationale for this decision is found in the respective chapters. In Chapters 3

and 4 only those individuals who self-identified as heterosexual were included in the survey analysis. Nevertheless, some participants also reported that they engaged in same sex activities. Research suggests that adolescents may experiment with same and opposite sex behaviours and identities in the process of determining their sexual orientation (Saewyc et al., 2004), these results may be indicative of this.

Rationale

The rationale for this study is threefold. First, I believe that the proliferation of sensationalized social messages about “girl power” has distorted our understanding of the gendered power dynamics of adolescent heterosexual relationships. Second, concern over young people’s sexual health has intensified simultaneously, due to rising rates of sexually transmitted infections and the HIV epidemic (Canadian Federation for Sexual Health, 2007; UNAIDS, 2008). Third, while these trends in sexually transmitted infections may signify that the sexual health of young people is on the decline, the singular research focus on negative sexual health outcomes has created a gap in our knowledge of the positive aspects of youths’ sexual health (Aggleton & Campbell, 2000; Canadian Federation for Sexual Health, 2007; Russell, 2005).

For example, research on HIV infection has revealed the importance of gendered power dynamics to the heterosexual transmission of HIV and to negative sexual health outcomes in young men and women. For young women, inequities in heterosexual relationships mean fewer options to negotiate the terms of those relationships, thereby often leading to unplanned pregnancies, violence, sexually transmitted infections, or HIV infection. For young men, inequities in heterosexual relationships are exacerbated by a society in which hegemonic forms of masculinity that legitimize dominance of men over women are highly valued (Connell, 2005). Reports from practitioners working with young men detail that the pressures to conform to hegemonic forms of masculinity may lead to violence, risk taking behaviours, incarceration and suicide (Population Council, 2001). Researchers have also detailed the negative consequences for both women’s and men’s health of the interplay between power, gender and

masculinity (Courtenay, 2000; Jewkes, 2002; Robinson, 2005; Santana, Raj, Decker, La Marche, & Silverman, 2006). Power inequities in heterosexual relationships are also tangled up with other markers of power in society, namely the social determinants of health. Despite consistent concern over negative sexual health outcomes among adolescents it is acknowledged that the development of sexual relationships is a key aspect of human development (Haffner, 1995; Satcher, 2001) and is very common; globally, rates of pre-marital sexual experience among adolescents vary between lows of 1% to highs of over 70% (Bearinger, Sieving, Ferguson, & Sharma, 2007). In the United States, Finer (2007) reports that the majority of adults have engaged in pre-marital sexual relationships during their adolescence. Yet, our understanding of adolescent sexual health, in terms of positive sexual health outcomes is sparse. As Tolman (1999) contends, positive sexual health includes the experience of intimacy, meaningful relationships, love and safety. It consists of more than the avoidance of sexual intercourse and negative sexual health outcomes.

I suggest that these findings require a closer look at the gendered dynamics of adolescent heterosexual relationships to consider the possibility that adolescent heterosexual relationships may result in negative as well as positive outcomes that challenge traditional gender inequities.

Objectives

The study upon which this dissertation is based had three objectives:

- 1) To investigate how young people understand, define and experience positive sexual health;
- 2) To investigate how young people understand and experience the gendered dynamics of power;
- 3) To investigate associations between the social determinants of health, positive and negative sexual health outcomes and the gendered dynamics of power.

Methodological Rationale

In order to address the stated objectives, I used both qualitative and quantitative methods. Interviews with male and female adolescents were employed in the first qualitative phase and a cross-sectional survey was used in the second, quantitative phase. The decision to use a multi-method approach for this study was driven by the nature of the study's objectives; the complexity of the issues of gender, power and positive sexual health; and the particularities of Population Health research.

Interviews were important to ground the study in the experiences of young people and contextualize the findings as much as possible. The complexity of the issues of gender, power and positive sexual health demanded a qualitative component to help flesh out how young people understood the concepts. The strength of qualitative methods is their ability to address abstract concepts in an open format (Patton, 1990). Due to the limited research on young people's understandings of power and gender within heterosexual relationships, particularly when young men are concerned, the main contribution of the qualitative phase was to ground the dissertation in young people's own experiences and realities and to add this perspective to the literature. Because in the second quantitative phase I decided to use an existing quantitative measure of power (Sexual Relationship Power scale), a scale that had previously been untested with males, interviews were also important to determine congruence between the concepts of the scale and the adolescents' views on power within heterosexual relationships. Finally, in order to examine the final objective and determine possible associations between variables the use of statistical methods that demanded quantitative data were needed. In summary, the choice of multiple methods was driven primarily by the research objectives and by the corresponding strengths of each method in addressing the objectives.

Second, because this dissertation is based in a program of Population Health research and endeavoured to make a contribution to this field it was felt that a multi method approach would best facilitate reaching this goal. Population Health research is intended to be critical, theory and evidence-based and increasingly adopts mixed-methods approaches (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005). Moreover, Population Health is concerned both with the conceptualization and

measurement of health outcomes (Kindig & Stoddart, 2003) necessitating the use of both qualitative and quantitative methods of inquiry. Since this is a Population Health dissertation which aims to both understand and measure issues of gender, power and positive sexual health outcomes and their relation to the social determinants of health both qualitative and quantitative methods were employed.

Literature Review

I conducted an extensive review of Canadian and international literature to situate the issues of gender, power, adolescent sexual health and the social determinants of health. The review used multiple methods including hand and database searching, reference checking and consultation with experts. The review spans the fields of Population Health and Health Promotion, Women's Studies, and Sociology.

The research on adolescent sexual activity is generally concentrated on heterosexual intercourse and the primary measures of risk reduction within these encounters namely, condom use, contraception and abstinence. As a result, the majority of statistics on adolescent sexual health highlight these measures. These statistics are summarized to help situate heterosexual adolescents by describing their sexual behaviours, particularly as they relate to risk. For example, based on data from the 1996 Canadian National Public Health Survey (NPHS) Maticka-Tyndale (2001) reported that 70% of young women and 81% of young men reporting condom use at last intercourse. Conversely, more recent Canadian data from the 2003 Canadian Community Health Survey (CCHS) reveals that only 30% of sexually active Canadian youth reporting multiple partners used a condom at last intercourse with lack of condom use being more common among older adolescents (44%, 20-24 years; 33%, 18-19years; 22%, 15-17years) (Statistics Canada, 2005). Similarly, Maticka-Tyndale (2001) reporting from the 1996 NPHS states that condom use is generally higher among younger adolescents and is more common with casual sexual partners.

Evidence of Canadian adolescents' sexual behaviour is also found in the more recent national survey by the Canadian Association for Adolescent Health (CAAH) which is based on data from a national online survey conducted in 2005. This research found that the teens surveyed had three sexual partners

on average, 24% did not use any protection at last intercourse, 38% reported engaging in casual sex and 16% believed that their sexual partners had other sexual partners while dating them. Furthermore, 68% of the teens in this study reported having oral sex and 26% considered sexual abstinence to include oral sex (CAAH, 2006).

Related to the research focus on risk reduction behaviours are the statistics on negative sexual health outcomes such as sexually transmitted infections and unplanned pregnancies. Canadian data from the 2003 CCHS indicate that those who had first intercourse at an earlier age were more likely to have multiple partners and more likely to report having had a sexually transmitted infection (Statistics Canada, 2005). Overall, the CCHS (2003) also revealed that approximately 4% of 15-24 year olds reported having been diagnosed with a sexually transmitted infection; this is most likely an underestimate due to the lack of symptoms for many sexually transmitted infections (Statistics Canada, 2005). Increased risk for sexually transmitted infections is often related to the use of oral contraceptives and the subsequent abandonment of barrier methods of protection such as condoms. Data from the Canadian Youth, Sexual Health and HIV/AIDS Study (2003 data) indicates that approximately 39% of grade 9 female students and 54% of grade 11 female students report using the birth control pill at last intercourse (SIECCAN, 2004). Health Canada data from 2002 on the prevalence of sexually transmitted infections among Canadian youth is summarized in a report by the Sex Information and Education Council of Canada (SIECCAN, 2004). This report indicates that rates of gonorrhoea are highest among male and female 15-24 year olds and females account for approximately 75% of reported Chlamydia rates which have risen 25.1% from 1992 to 2002 and rates of human papillomavirus are also highest among Canadian women under age 25 (SIECCAN, 2004). Pregnancies among young women have declined steadily in Canada over the past 20 years and as a result the abortion rate has also declined (Canadian Federation for Sexual Health, 2007). However, the ratio of abortions to live births among this age group has remained stable giving an indication that the number of unplanned pregnancies is unchanged (Canadian Federation for Sexual Health, 2007). Canada does not collect data on unplanned pregnancies specifically but this ratio and data from the 2002 Canadian contraceptive survey that indicates that 28% of women report

experiencing an unplanned pregnancy gives an estimate of the number of these events (Fisher & Black, 2007).

It is evident that in Canada data on negative sexual health outcomes such as sexually transmitted infections and teen pregnancy are routinely collected, but there is little information on the factors that contribute to these outcomes. Data on the gendered dynamics of adolescent relationships, behaviours other than sexual intercourse and the circumstances that feed rising sexually transmitted infection rates are limited (Maticka-Tyndale, 2001).

Reasons behind rising rates of sexually transmitted infections, particularly for young women, may be due in part to stereotypical beliefs about gender, sexuality and condom use. For example, 21% of women aged 15-24 surveyed as part of the 1998 Canadian Contraceptive Study reported that it would be difficult to get their partner to use condoms, 36% believed that with only one partner condoms were not needed for the prevention of sexually transmitted infections, 69% felt it was embarrassing to buy condoms and 46% felt that condoms made sex less enjoyable for their male partners (Fisher & Boroditsky, 2000). These findings may account for the difficulties that young women have negotiating condom use. It is important to note that this national survey did not include young men, reinforcing the standard notion that protection against pregnancy and sexually transmitted infections are solely a young woman's responsibility.

Furthermore, young women from an Ontario study report that they have been taught that their sexual desires are mild compared to those of males and that they were responsible for controlling their own sexual urges as well as those of males. Common double standards were also noted in this study; females stated that girls were subject to "bad reputations" for having multiple partners while their male counterparts were not. Male participants reported being upset at their portrayal as only interested in sex and not in relationships. Both male and female students stated that they felt pressure to engage in sexual activity, males most often from other male friends and females from boyfriends and female friends (DiCenso et al., 2001).

Research from Alberta points to further possible reasons behind rising rates of negative sexual health outcomes. Tsui and Nicoladis (2004) report that before their first experience of sexual intercourse

men and women (age range 17-38 years, mean 19.4 years) were most unlikely to discuss sexually transmitted infections, possible pregnancy and the emotional impact of intercourse (32-40%) but were more likely to discuss condom use (63-73%) and other methods of birth control (48-58%). This study also found that 56% of young men and 54% of young women found their first experience of sexual intercourse emotionally satisfying and only 35% of young women compared to 62% of young men reported being physically satisfied (Tsui & Nicoladis, 2004).

In contrast to work outlining the negative sexual health outcomes associated with adolescent sexual activity, a few researchers have begun to focus their attention on positive and protective sexual health outcomes (Aggleton & Campbell, 2000; Dennison & Russell, 2005; Horne & Zimmer-Gembeck, 2005; Russell, 2005; Smiler, 2008; Smiler, Ward, Caruthers, & Merriwether, 2005; Tolman, 2006).

Widdice and colleagues (2006) report that when asked of the hypothetical benefits of sexual intercourse, 76% of adolescents reported only one positive outcome. The majority of outcomes were framed as risk avoidance such as "not getting pregnant", "not getting an STD, HIV or AIDS" but some were more positively orientated such as "fun, pleasure, positive feelings and emotions" and relationship improvement. Gender differences were found - more girls reported relationship improvement than boys. Boys were more likely to report "increased social standing", "fun, pleasure and positive feelings and emotions" as compared to girls. It is important to note that only 18.3% of the males and 9.7% of the females surveyed in this study reported a previous experience with vaginal intercourse, which was the only sexual activity reported on in the study (Widdice, Cornell, Liang, & Halpern-Felsher, 2006).

These findings are consistent with literature that shows that young women are more concerned with their male partners' needs and are less likely than their male partners to report positive outcomes of sexual intercourse (Fine & McClelland, 2006). Yet these findings are inconsistent with research that suggests that young men lack concern about the emotional aspects of sexual intercourse (Narring, Wydler, & Michaud, 2000; Sprecher & Sedikides, 1993). Smiler (2008) also describes young men whose cited reasons for dating are relational and emotional as opposed to the stereotypical notion that a desire for sex is the primary motivator for young men to enter relationships.

Horne and Zimmer-Gembeck (2005) examined young women with varying levels of sexual experience and questioned whether those levels were associated with several positive outcomes. The researchers found that young women with more sexual experience reported higher amounts of sexual agency and "sexual subjectivity" compared to their less experienced peers. Sexual subjectivity was an indicator that captured concepts such as sexual body esteem (feeling sexually attractive), entitlement to, and experience of, sexual pleasure and the ability to reflect upon one's sexual behaviour and experiences (Horne & Zimmer-Gembeck, 2005). This research points to the positive implications of sexual activity for young women and questions the notion that sexual activity is uniformly bad for young women.

In addition to examining positive outcomes of sexual activity, some researchers have begun to investigate factors that may protect young people against negative sexual health outcomes. The primary focus of these studies is on abstinence as a healthy and protective option for young adolescents who may not yet have the skills to ensure healthy sexual relationships. For example, Chawning and colleagues (2001) report that abstinence among young female Native American adolescents was associated with scholastic achievement whereas for young men, abstinence was associated with self-efficacy (including ability to refuse sexual advances) and the belief that their friends did not use drugs. Research from the Caribbean also shows that scholastic achievement, including a strong connection to school, was the strongest predictor of not having had intercourse among youth aged 10-18 years (Blum & Ireland, 2004).

In an effort to understand positive sexual health, Tolman and colleagues explored aspects of adolescent girls' sexual development in the United States. They believe these aspects are responses to the patriarchal society in which we live (Impett & Tolman, 2006; Impett, Schooler, & Tolman, 2006; Tolman, 1999; Tolman, Striepe, & Harmon, 2003). Some of the aspects that they have tested empirically include: "inauthenticity in relationships", body objectification, belief in traditional ideologies and norms of femininity, sexual self-concept, sexual self-efficacy and sexual agency. "Inauthenticity in relationships" reflects a central tenet of traditional femininity in which young girls silence their own needs in favour of their male partners thereby potentially increasing their risk of unwanted sexual activity, sexually transmitted infections and HIV infection. Body objectification refers to the disengagement of young girls from their bodies' such that they self-objectify their bodies. Sexual self-concept is a measure of a girl's

evaluation of her own sexual feelings and actions while sexual agency is an indication of a girl's ability to ensure self protection in heterosexual relationships. Sexual self-efficacy is the self-belief that one can act based on their own sexual needs, desires and interests. It was found that "inauthenticity in relationships" was associated with less frequent use of hormonal contraception and body objectification was associated with less condom use (Impett et al., 2006). Girls with lower sexual agency and acceptance of their sexuality (sexual self-concept) were found to have more traditional beliefs about femininity and were more likely to compromise themselves in heterosexual relationships (Tolman, 1999). A related finding from Horne and Zimmer-Gembeck (2005) reveals that young women with higher levels of sexual subjectivity report more condom use self-efficacy and thus may be more likely to successfully negotiate protection within a heterosexual relationship.

Some studies that focus on positive sexual health outcomes address only behaviours such as condom use, abstinence and monogamy (Hutchinson, Sosa, & Thompson, 2001; Upchurch & Kusunoki, 2004) but without addressing the gendered power relations inherent in these behaviours. In one study, the young women identified several behaviours, beyond simply condom use, that they used to protect themselves from sexually transmitted infections including: abstaining from or postponing intercourse, getting tested for sexually transmitted infections and HIV, choosing partners they believed were safe, talking about sexual histories and practicing monogamy (Hutchinson et al., 2001). However, this study did not ask young men what they did to protect themselves or what positive actions they took. This study also only focused on sexual intercourse, and did not examine why some women were more successful at implementing these behaviours than others. A similar approach was taken by Upchurch and Kusunoki (2004) who equated protective behaviour with condom use only and again only sampled females despite drawing their data from a national survey of adolescents that included males. This approach reinforces the notion that young women are the gate keepers of sexual encounters and negates the role of young men in heterosexual relationships (Gahagan & Rehman, 2004; Pulerwitz & Dworkin, 2006).

Social Determinants of Health

Social and income inequalities have been shown to affect population health adversely (CSDH, 2008; Wilkinson & Pickett, 2006). The interaction between the social determinants of health, power and sexual health is an important, yet understudied aspect of population health in Canada. A specific challenge I faced in writing this dissertation is translating the social determinants of health to adolescent experience. Notably, in Marmot and Wilkinson's (1999) seminal publication on the social determinants of health, adolescents are not mentioned once. Moreover, Canadian data on the influence of the social determinants of health on adolescent health outcomes is limited and employs multiple methods and measures.

Data from the 2000/2001 CCHS indicates that adolescents' self-rated health varies by income group, 78% of adolescents in the highest income households (\$60,000-\$80,000 or more) reported very good or excellent health compared to 64% in the poorest households (\$30,000 or less). Further, adolescents from households where at least one parent had postsecondary education also reported their health to be very good or excellent significantly more often than adolescents from households in which parents are less educated (Tremblay, Dahinten & Kohen, 2003). Moreover, research from the Canadian Institute for Health Information (CIHI, 2005) indicates that Canadian youth who have close ties with their families, schools, peers and communities tend to be healthier and have higher self-esteem.

Research on sexual health specifically has shown that earlier initiation into sexual activity, riskier sexual practices, sexually transmitted infections, and adolescent pregnancies tend to be higher among youth in lower socioeconomic groups (Health Canada, 1999; Singh, Darroch, & Frost, 2001). In Canada lower education at the individual level is associated with early sexual intercourse and lower rates of contraception use (Health Canada, 1999). Gender specific trends also exist; for young boys having a poor relationship with their parents or coming from a low-income family were significantly associated with early intercourse, these factors were not associated with early intercourse for girls (Statistics Canada, 2005).

Langille and colleagues (2004), using regression analysis, discovered several characteristics of Nova Scotia communities that predicted a higher probability of teenage pregnancy. Communities that were characterized by a higher proportion of single parent families (possibly a proxy for low income), persons of Native or Black ethnicity and more women in the workplace were associated with a higher probability of teenage pregnancy (Langille, Flowerdew, & Andreou, 2004). Studies from the United States that used secondary data analysis also found that relationships between sexual health outcomes and the social determinants of health exist (Cubbin, Santelli, Brindis, & Braveman, 2005; Zierler et al., 2000).

American data reveal that rates of sexual intercourse and early sexual intercourse are higher among ethnic minority adolescents and adolescents of lower socioeconomic status (Kotchick, Shaffer, Forehand, & Miller, 2001). This trend could be indicative of a number of the social determinants of health at work including income/poverty, education and access to health services. It is important to note that the social history of race, ethnicity and immigration in Canada and the United States is distinct from each other and thus findings may be deemed to be country specific. For example, Canadian data reveal that adolescents from non-white ethnic groups who are not born in Canada have significantly lower rates of early intercourse and teen pregnancy (Singh et al., 2001). Research by Maticka-Tyndale (2001) confirms that teens who are having sex earlier than their peers are generally not in school, are from lower income families and are Canadian born. When we consider teens who report multiple partners we see a similar trend; they are generally from low income families and are not in school (Maticka-Tyndale, 2001).

Smylie and colleagues (2006) report on the influence of social capital on risk behaviours, including sexual intercourse, number of sexual partners, and unprotected intercourse. Data from this study were drawn from the 1996/1997 cycle of the National Population Health Survey (NPHS). Factors that were indicative of social capital included language spoken, Canadian birth, frequency of contact with friends and neighbours, volunteer experience, living arrangement and household composition (e.g., both parents, number of siblings), religiosity, labour force participation, in/out of school, and team sport participation. For both males and females, race and income were significant predictors of risk behaviour. For males, the effect of income decreased when family structure was added and for females the effect of ethnicity decreased when immigrant status (Canadian birth) and language were added. Regression

analysis revealed that the various social capital indicators explained between 3.8% and 7.3% of the variance in risk behaviours for males and females. The authors entered the various indicators in different combinations depending on the theory of social capital used and the indicators that were deemed important according to this theory. For males the social capital indicators accounted for a higher percentage of the variance in risk behaviours than race, income and province of residence combined, for females, the social capital indicators accounted for an equal amount of the variance in risk behaviours (Smylie, Medaglia, & Maticka-Tyndale, 2006).

In summary, the research that links adolescent health and sexual health outcomes to the social determinants of health generally deals with issues of education, race/ethnicity, parental/household income, immigrant status, family, peer and school relationships. Many of these social determinants of health are measured in different ways. For example, income may also include a measure of parental occupation or education and the measurement of social capital as a unique social determinant of health may overlap other social determinant of health indicators.

Gendered Dynamics of Power

Power inequities in heterosexual relationships have negative outcomes for both men and women. Women who report more power in their heterosexual relationships are more likely to use, or say they intend to use, condoms and report higher sexual self-efficacy (Blanc, 2001; Bowleg, Belgrave, & Reisen, 2000; Gutierrez, Oh, & Gillmore, 2000; Kershaw et al., 2006; Pettifor, Measham, Rees, & Padian, 2004; Pulerwitz, Amaro, DeJong, Gortmaker & Rudd, 2002; Pulerwitz, Gortmaker, & DeJong, 2000). The level of completed education among adult women has been shown to be directly related to power in heterosexual relationships, condom use and communication about HIV risks (Pulerwitz et al., 2000; Saul et al., 2000). In addition, women who report having less power than their male partners or who claim that their partners are dominant within their relationships are less successful in negotiating safer sex and tend to report lower self-esteem (Buysse & VanOost, 1997; Galliher, Rostosky, Welsh, & Kawaguchi, 1999; Soet, Dudley, & Dilorio, 1999). In contrast, one study reported that women with higher power scores reported

less consistent condom use (Harrison, O'Sullivan, Hoffman, Dolezal, & Morrell, 2006). Findings from research with girls indicates that those who adhere to conventional or traditional views of femininity tend to have romantic ideas about heterosexual relationships that prescribe limits to their power within those relationships (Holland & Ramzanoglu, 1992; Holland, Ramazanoglu, Sharpe, & Thomson, 1998; Tolman, 1999). Without power in their heterosexual relationships women are positioned as objects of men's desires and this lack of power makes safer sex negotiation near impossible (Kippax, Crawford, Waldby, & Benton, 1990).

Qualitative research reveals that young women do not perceive themselves to be in control of their heterosexual relationships and are "acted on" rather than actors (Allen, 2003). Young women also report having less power than their male partners (Gutierrez et al., 2000). Conversely, researchers have found evidence of young women who resist stereotypes of passive femininity, speak of their sexual desires, and use power and control as a means of expressing desire (Allen, 2003; Allen, 2003b; Rosenthal, Lewis, & Cohen, 1996). Young women report having control over how often to have sex, with whom and when, contraceptive use and discussions of sexual history (Allen, 2003; Levy, Otis, Samson, Pilote, & Fugere, 1997). Pulerwitz and Dworkin (2006) also describe women who resist traditional power dynamics within their heterosexual relationships, often due to previous experiences with power inequities. Women have also reported that in spite of their feminist beliefs about power and sexual agency, these beliefs often don't translate well into practice (Allen, 2003; Miles, 1993).

In her study of young women's first experiences of sexual intercourse, Thomson (1995) reported that many found the experience unpleasant, painful and disappointing. Yet some described it as positive and pleasurable. The young women who reported a positive experience described relationships that were characterized by equity, affection and with partners who recognized their needs and desires. Thomson describes these young women as responsible and powerful, meaning not passive or subordinate. Notably, they made up only 3% of her sample of 400 young women (Thompson, 1995).

Allen (2003b) concluded as a result of her New Zealand qualitative research that male power is "...simultaneously contested and negotiated in ways which afford women a measure of agency" (p.235) but, contends that male power in heterosexual relationships is not easily disrupted. Agency can be

defined as the ability to act or make a choice. Agency is distinct from power which is viewed as a structural force supported by various mechanisms within a given society. Research with women over the age of 30 confirms the persistence of male power and that this power continues to make it difficult for women to practice safer sex with a male partner (Maxwell & Boyle, 1995).

Coercive or violent sexual experiences are reported by both young men and women and are an obvious consequence of abuse of power in all relationships. An American study focused on dependency in adolescent (aged 11-19 years) heterosexual relationships reported that 24% of females and 16% of males reported unwanted sexual activity and 38% of females and 19% of males reported that they could not say no when their partner wanted to engage in sexual activity (Kalof, 1995). This study also reported that for Black females, belief in equitable gender roles and higher levels of self-confidence decreased participation in unwanted sexual activity but for Black males, belief in these roles decreased intimacy in their sexual encounters (Kalof, 1995).

The social construction of masculinities leads men to believe that they must be in control and exercise power (Blanc, 2001; Jensen, 2007). Research from diverse populations in the United States and Brazil has shown that men who hold traditional views of masculinity are more likely to perpetrate violence against their partners, have unprotected sex, have STIs, and have multiple sexual partners (Blanc, 2001; O'Sullivan, Hoffman, Harrison, & Dolezal 2006; Pulerwitz, Barker, Segundo, & Nascimento, 2006; Santana et al., 2006; Shearer, Hosterman, Gillen, & Lefkowitz, 2005). Male power is reported to be the critical factor in whether condoms are used or not (Bruhin, 2003). In fact, research from South Africa found that heterosexual relationships that are characterized as having high levels of male power are associated with HIV infection (Dunkle et al., 2004). Moreover, in one study of South African men, those who held more traditional views of masculinity reported agreeing to unwanted sex with their partners (Harrison et al., 2006). By contrast, other studies from the United States and Switzerland report more condom use with men who perceived themselves to be dominant or powerful (Bruhin, 2003; O'Sullivan et al., 2006). Men who have not graduated from high school were significantly more likely to endorse traditional ideas about masculinity such as "it is essential for a man to get respect from others" and "men are always ready for sex" (Santana et al., 2006).

In one study with young South African men it was reported that those with more egalitarian sexual scripts (belief in value of shared behavioural guidelines for men and women) were found to use condoms less consistently in their primary relationships and young men in this study with low power scores reported fewer sexual partners (Harrison et al., 2006). Intervention research from Brazil and India has shown that when men move towards more equitable gender role beliefs their risk for HIV and sexually transmitted infections is lowered, they report less violence, fewer partners and more condom use (Pulerwitz et al., 2006; Verma et al., 2006). Pulerwitz and Dworkin (2006) also describe men who resist traditional gender norms and reject the notion that power over sexual decision making and lack of condom use are important to masculinity. In addition, American men who believe that there is equitable power in their heterosexual relationships report higher levels of relationship satisfaction (Sprecher & Felmee, 1997).

Researchers have called for more involvement of males in research on sexual health and specifically investigation into the effects of gender, power, and masculinity on sexual health (Amaro & Raj, 2000; Bowleg, 2004; Gahagan & Rehman, 2004). It is important to note that the majority of the research on power and young men's sexual health comes from developing countries or from the United States and thus the findings may not apply to Canadian young men when the unique influences of ethnicity and culture are considered.

This literature review has highlighted key findings concerning the interrelated issues of positive sexual health and the gendered dynamics of power within heterosexual relationships taking into consideration the social determinants of health. Few studies have examined these issues using multiple methods of inquiry and a minority have included young men in their samples. To summarize, in a review of the research on power and sexual health Blanc (2001) detailed the following gaps in our understanding: 1) few quantitative studies attempt to examine the link between gender-based power dynamics and sexual and reproductive health outcomes; 2) gendered power relations are rarely measured, hence it is difficult to establish relationships with outcomes and; 3) a general lack of common definitions of power in the context of sexual relationships. These gaps adequately describe the existing

literature as reviewed above and the places in which this dissertation endeavours to contribute to the knowledge base.

Conceptual Framework

The conceptual framework for this dissertation draws from multiple disciplines and perspectives to situate the interrelated issues of gender, power, adolescent sexual health and the social determinants of health. Feminist theories of the social construction of masculinity, femininity and heterosexuality are used to explore the gendered dynamics of power within adolescent heterosexual relationships and positive sexual health. Theories about power from the public health, feminist and sociological literature are also used. Concepts of equity and the social determinants of health from Population Health underpin the framework and act as a contextual web that links all aspects.

Researchers have provided evidence that power is key to sexual health outcomes in heterosexual relationships (Blanc, 2001; Wingood & DiClemente, 2002). Studies on power and sexual health generally approach power as inequitable and coercive and examine the influence of this power on negative sexual health outcomes such as violence and HIV infection. This dissertation approaches power and sexual health positively and endeavours to understand whether equity, operationalized as shared power, has similar effects on positive sexual health outcomes, such as satisfaction and communication as we have seen with negative outcomes.

The work of several researchers who explore sexual health from a positive perspective shapes the conceptual approach to positive sexual health employed in this dissertation (Aggelton & Campbell, 2000; Horne & Zimmer-Gembeck, 2005; Robinson, Bockting, Rosser, Miner, & Coleman, 2002; Tolman, 2006; Tolman et al., 2003; Tolman, 1999). Tolman and colleagues (2003) have developed a preliminary model of positive sexual health and gender for adolescent girls. The model is based on feminist scholarship that recognizes that young women's choices to engage in sexually healthy heterosexual relationships that are consensual, pleasurable, safe and non-exploitative are limited by social forces that do not acknowledge female sexuality and desire and by expectations that women should conform to

traditional notions of femininity (Tolman et al., 2003). Aggleton and Campbell (2000) have called on researchers and practitioners to approach sexual health as an affirming concept. Horne and Zimmer-Gembeck (2005) also claim that experiences in sexual relationships can lead to positive outcomes. However, their research focuses on young women only, examining the positive concepts of agency and pleasure.

Based on this research, some of the factors that are important to attaining positive sexual health are: access to information on safety, anatomy and diverse forms of sexual expression (beyond heterosexual intercourse); access to health care services; exposure to, or knowledge of, alternate models of masculinity and femininity; ability to communicate and accept one's sexual feelings, needs and desires; and safe, protected, pleasurable, consensual relationships (Aggleton & Campbell, 2000; Horne and Zimmer-Gembeck, 2005; Robinson et al., 2002; Tolman et al., 2003; Tolman, 1999). The data collection and analysis for this dissertation is thus structured conceptually around these factors. Finally, this dissertation conceptualizes the gendered dynamics of power as interacting with the social determinants of health to influence both young men's and young women's ability to achieve positive sexual health outcomes.

Central to the concept of power are the terms equity, inequity, equality and inequality. Researchers from Population Health and Health Promotion have clearly articulated the links between power, equity and the social determinants of health. Equity articulated in terms of power and social position has featured strongly in research and intervention in Population Health. However, there is a general lack of clarity and delineation between the terms equity and equality across disciplines and fields and in some cases the terms are used interchangeably (Braveman, 2006). Population Health research is concerned fundamentally with inequity and issues of social justice. Accordingly, the term inequity advances the concept of inequality to suggest that the lack of equality is unfair or unjust, thereby requiring the implementation of various measures which address that unfairness or injustice (Evans, Whitehead, Diderichsen, & Wirth, 2001). From the theoretical position of Population Health, the use of the term inequity in place of inequality asserts a moral and ethical claim that the inequity demands resolution (Labonte et al., 2005). As a result, equity has an explicit social justice component. In this

formulation two determinations are necessary to establish the presence of an inequity: 1) a determination that the phenomenon in question is *unequal*; 2) a determination that the unequal nature is *unfair* or *unjust*. Some have argued that the determination of unfairness or injustice is difficult to operationalize and assess (Braveman, 2006). Others have noted that the judgement of fairness is in essence a consideration of context, for example, sometimes equity demands unequal treatment based on differing starting points that may appear unfair (L'Heureux-Dube, 1999). L'Heureux-Dube (1999) offers the example of the protection of female prisoners from searches by male guards; this same protection was not extended to male prisoners. However, this unequal treatment was not deemed unfair based on the larger context of gender and sexual violence against women. As an illustration of the intermingling of terms and definitions L'Heureux-Dube (1999) uses the term equality throughout her article yet her conceptualization is consistent with the Population Health definition of equity. The new World Health Organization (WHO) Commission on the social determinants of health adds the criterion that inequities are avoidable meaning that because they stem from an injustice, they can, and should, be addressed and remedied (CSDH, 2008).

The term inequity is purposefully used in this dissertation to describe gender-based power inequities to indicate that these inequalities in power are unfair and unjust as they are based on one's gender. Age, class, disability and ethnicity are all sites of power differences but in terms of sexual health among heterosexual adolescents the most important site of power difference is gender or between men and women (Holland et al., 1998). The focus on gender does not mean that I have discounted other sites of power differences because I recognize that gender based power inequities operate within and through each site. While differences in income, class, gender and ethnicity can serve as markers of power inequities they are also indicators of the social determinants of health within a Population Health model. Power inequities are fundamental to understanding the social determinants of health within Population Health. Population Health researchers recognize that power, at a societal and personal level, creates and maintains inequities in health. It is not simply gender that creates inequities in health but the inequitable distribution of power associated with one's gender and the implications of this lack of power within a

given situation. As a result, power and the social determinants of health are intricately tied together and have overlapping influences on health outcomes.

The social determinants of health include one's income, education, ethnicity and gender and describe characteristics, often outside of one's personal control, that contribute to health and/or disease. The Canadian government's official list of the social determinants of health includes income and social status; social support networks; education; employment and working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; culture; gender; health services and; biology and genetic endowment (Labonte et al., 2005). Aspects of this list have been criticized for lacking concrete relevance to individuals' lives (e.g., physical environments) and for being devoid of policy relevance (Raphael, 2009). Raphael and colleagues (2009) have revised this list to apply more directly to individual life experience. This revised list includes Aboriginal status; early life; education; employment and working conditions; food security; gender; health care services; housing; income and its distribution; social safety net; social exclusion; unemployment and employment security. Others have acknowledged that the social determinants of health do not represent distinct variables but rather a dynamic and collective process of marginalization and exclusion that heightens an individual's vulnerability to disease (Shaw, Dorling, & Davey Smith, 1999). The WHO Commission on the social determinants of health also adapts this politicized view which asserts that mitigating the impact of social determinants of health on health outcomes is an issue of social justice (Marmot, 2005). The WHO Commission conceptualizes the social determinants of health in layers, one layer deals with the socioeconomic and political context, a second with social position which encompasses the determinants of education, occupation, income, gender and ethnicity/race and a third layer made up of material circumstances, social cohesion, behaviours, psychosocial and biological factors (CSDH, 2008). There is increasing evidence that the social determinants of health are linked in complex ways such that determinants such as poverty get "under the skin" and cause physiological and other effects that impact on health and well-being (Wilkinson, 1999). In essence, the social determinants of health are the collective label given to social conditions that are thought to influence health. The social determinants of

health interact, overlap and influence each other in complex ways and some of the social determinants of health may be more important than others when considering a specific health issue or risk.

Recognizing that this dissertation cannot attend to a comprehensive analysis of all of the social determinants of health, a primary focus was placed on gender. Gender, as illustrated by its integration as a cross-cutting issue by the WHO Commission on the Social Determinants of Health, intersects all of the remaining determinants. It has been argued that gender is the most significant marker of social position and inequity (CSDH 2007; Hearn, 2004). This finding does not discount other social determinants of health and their influence but suggests that gender intersects with many of these determinants. Further, because the dissertation examines power within heterosexual relationships, gender as a determinant of health is most intricately embedded throughout the focus and analysis.

As noted earlier, the theoretical basis of the social determinants of health is based on the adult experience. The one exception to this pattern is the determinant of early child development. Adolescence and its unique attributes are missing and as a result methods to measure the determinants that are grounded in the adolescent experience are limited. As a result, to determine the effects of the social determinants on adolescent health in Canada, we should also consider parental or household level information. Therefore, gender is considered in relation to the following social determinants of health: ethnicity (including country of birth); education (both personal and parental) and; income (perception of wealth, family affluence). I selected these social determinants of health for three main reasons. First, the social determinants of health that I selected are most often linked with power in the sexual health literature. Researchers have examined the influence of level of education, ethnicity and income or class on power within sexual relationships (Pulerwitz et al., 2000; Wingood & DiClemente, 2002). Second, the majority of research in adolescent health focuses on income and ethnicity and in some cases gender and their influence on sexual health. So as to contribute to this developing knowledge base and to draw from existing research I focus on the social determinants of health of income, educational performance and ethnicity. I also have attempted to use measures that may resonate with adolescent experience, including perception of wealth and family affluence and educational performance. Education is commonly measured as the level of education completed. This dissertation measures educational performance or

grade point average in order to capture the concept of education in a manner that makes sense within the adolescent experience. Third, in order to work within the logistical confines of the study location, the length and scope of the data collection tools has to be considered. Consequently, several of the determinants were deemed to be outside of the scope of this project such as healthy child development, biology and genetic endowment, physical and social environments and social support networks. Research has suggested the importance of these variables to sexual health outcomes, for example, young women are at increased risk of HIV infection because of biological or physiological vulnerabilities in their reproductive tracts and social capital has been shown to influence sexual risk taking (Smylie et al., 2006; UNAIDS, 1997). However, the focus of this dissertation was intentionally limited to make the project manageable and relevant to existing literature on gendered power dynamics.

The social determinants of health are closely linked to power in that we know that people in certain social positions lack power and thus are at a greater risk of poor health. Further, lack of social, economic and political power is believed to play a significant role in disease causation (Wallerstein, 1992). Powerlessness has both subjective and objective dimensions (Wallerstein, 1992). Individuals can lack power in the social, economic or political systems within which they live. This objective lack of power often becomes internalized (Wallerstein, 1992). Gender-based power inequities can mean that women lack power at both a structural and an interpersonal level as compared to their male counterparts. At the interpersonal level these gendered power inequities often become subjective forms of powerlessness wherein young women internalize norms that place power in the hands of young men (Holland et al., 1998). Power inequities could also be based on ethnicity, income or an overlapping contribution of any of the social determinants of health.

Gender is the primary determinant of health and source of power inequity explored here. Feminist scholars have endeavoured for decades to link the concepts of gender, femininity, masculinity and heterosexuality. Feminist approaches are used here because they acknowledge the socially constructed nature of these concepts. Gender is structured by expectations of what it means to be male or female in society. Feminists have also highlighted the ways in which these expectations are grounded in heterosexuality (Jackson, 2009; Rich, 1980). Gender explicitly acknowledges the power differentials

between males and females. Tolman and colleagues (2003) argue that gender is a key aspect of sexuality but that the link between gender and sexual health is understudied. Gender is inextricably tied to sexual health because it helps shape the expectations that are considered appropriate for males and females (including sexual roles). Gendered social expectations may place pressures on males to appear knowing and experienced when it comes to sex (Gahagan, Rehman, Barbour, & McWilliam, 2007). Females are expected to be the gatekeepers of male sexuality and appear unknowledgeable and sexually inexperienced.

This dissertation approaches gender as a relational concept which excludes neither males nor females in highlighting the social construction of masculinity and femininity. Connell and Messerschmidt (2005) state that gender is always relational and that expectations of masculinity and femininity are constructed in response to each other. Approaching gender as relational reminds us that gender is a fluid concept that changes often in response to evolving notions of masculinity and femininity. Some authors have noted that traditional expectations of gender are changing and that young men's and women's heterosexual relationships no longer operate according to stereotypical notions of dominant masculinity and passive femininity (Carpenter, 2002; Hill, 2006; Mundy, 2006). However, Hill (2006) contends that despite these changes the underlying differences between young men and women in heterosexual relationships remain intact because gender is relational. He argues that if men adopt more passive or feminine characteristics and women become more dominant or masculine then the underlying notion of gender as difference remains stable. Hill's (2006) work highlights the importance of considering gender as relational as it allows us to consider the influence of changing gender expectations on both men and women.

To fully understand gender the concepts of masculinity and femininity must be considered. Masculinity and femininity are often seen to be two distinct categories that form the basis of gender. Gender exists because of the categories of masculinity and femininity and the imbalance of power that is vested in each of these categories within the context of heterosexual relationships (Butler, 1990). The interplay of gender, masculinity and femininity has implications for sexual health. Feminist researchers have consistently shown that young women who adhere to traditional notions of femininity, notions that

require young women to be passive rather than active within their relationships, place themselves at increased risk within heterosexual relationships and experience more negative sexual health outcomes (Carpenter, 2002; Holland et al., 1998; Tolman, 1999). The effects of adherence to stereotypical expectations of masculinity on both young women and young men's health have also been highlighted. Young men who state that they are dominant or powerful in heterosexual relationships report more negative sexual health outcomes and are more likely to contribute to negative sexual health outcomes for their female partners (Blanc, 2001; O'Sullivan et al., 2006; Pulerwitz et al., 2006; Santana et al., 2001; Shearer et al., 2005).

To explain how power is linked to the concepts of gender, masculinity, femininity and heterosexuality Connell's (1987) Theory of Gender and Power is used as a critical theoretical tool for this dissertation. This theory is used for this dissertation because it emphasizes the relational and socially constructed nature of gender, masculinity, femininity and power and proposes the concepts of "hegemonic masculinity" and "emphasized femininity". The concepts of hegemonic masculinity and emphasized femininity are an important conceptual tool for this dissertation because they highlight the symbiotic nature of dominant social forms of masculinity and femininity. By illustrating the responsive and dichotomous nature of emphasized femininity to hegemonic masculinity and vice versa, the Theory of Gender and Power contextualizes popular messages of girl power and its relationship to heterosexual relationships. Messages of girl power essentially mirror Connell's concept of emphasized femininity by offering young women ways of being feminine that are strictly heterosexual and responsive to the needs of heterosexual men.

Not all young men and women adhere to the concepts of emphasized femininity and hegemonic masculinity. To recognize this, Connell (1987) articulates several forms of masculinity and femininity which exist in a hierarchy with hegemonic masculinity and emphasized femininity at the top. Hegemonic masculinity is dominant because multiple social forces have created an environment in which the characteristics of hegemonic masculinity are most valued in a particular social setting (Connell, 1987). Connell (1995) articulates that the characteristics of masculinity that are most valued (hegemonic) at a given time are reflected in the institutional houses of power within that particular society. Connell (1995)

states “the top levels of business, the military and government provide a fairly convincing corporate display of masculinity, still very little shaken by feminist women or dissenting men” (p.77). It is only through the corresponding power of these social institutions that hegemonic masculinity remains stable and powerful itself. Hegemonic masculinity articulates that some men in society may experience subordination in relation to other men who meet the definition of hegemonic masculinity which often requires that one is white, heterosexual, physically strong and capable and middle class (Hearn & Morgan, 1990). While certain forms of masculinity are seen as inferior to hegemonic masculinity, the central organizing principle of Connell’s theory is the subordination of women by men (Connell, 1987).

Similarly, Connell (1987) sees the existence of multiple femininities with emphasized femininity as the predominant version. Emphasized femininity is understood as the complement to hegemonic masculinity and thus is structured around the needs and desires of heterosexual men. Women who embody emphasized femininity are characterized as white, heterosexual, attractive to heterosexual males and middle class. Women that do not adhere to emphasized femininity are marginalized by those women who do (Connell, 1987). Multiple social institutions work to encourage, prescribe and maintain the characteristics of emphasized femininity, such as magazines, media and popular culture. As highlighted above, often these institutions are reflective of hegemonic masculinity thus creating a powerful force that dictates how young women should behave.

In a recent critique of the Theory of Gender and Power, Connell and Messerschmidt (2005) stated that the original theory left open the possibility that new definitions and ways of being a man would emerge and perhaps these ideas would not be based on the subordination of others. Connell and Messerschmidt (2005) recognize that expectations of masculinity and femininity are constantly evolving and acknowledge that the universal notion of women’s subordination by men as articulated in the original theory of Gender and Power may no longer explain the diverse relations between genders. This recognition is aligned with the idea that gender is fluid and evolves with social change, yet remains relational. This recognition is important conceptually to this dissertation because I approach power within heterosexual relationships positively, which allows for the possibility that young men and women may not

be strictly embodying notions of emphasized femininity and hegemonic masculinity within their relationships.

As articulated above, the concepts of masculinity and femininity manifest within the context of heterosexual relationships. Judith Butler (1990) sees gender expressed in and through heterosexuality. This is because heterosexuality is based on the idea of difference and gender expressed as masculinity and femininity emphasizes these differences (Jackson, 2009). Theorists from the field of masculinity studies in particular have argued that these differences are artificial and harmful to both men and women (Hill, 2006).

An essential aspect of Connell's (1987) concept of hegemonic masculinity is that a hegemonically masculine man is always heterosexual. Heterosexuality and hegemonic masculinity are linked by the notion of dominance. According to Rich (1980), heterosexuality is seen as compulsory and as a social institution that accrues benefits on its members. The claim that all heterosexual relationships are based on a dominant/submissive model has been critiqued (Mundy, 2006). In fact, Mundy (2006) questions at a very basic level why men's sexual agency is always equated with patriarchy. Similarly, Hill (2006) raises the issue of the changing sexual landscape and examines men's sexual agency within the context of increasingly powerful and sexually liberated women. I approach the study of adolescent heterosexual relationships with these critiques in mind by working with gender as relational and by approaching power positively. This understanding of gender and power creates a space in which patterns within adolescent heterosexual relationships that may not conform to a dominant/submissive model can be detected.

Despite these critiques and societal shifts in behaviour, heterosexuality is still based on traditional notions of dominant masculinity and passive femininity which have at their centre, the unavoidable issue of power. A key aspect of power within heterosexual relationships is that it is often characterized by inequity. This power inequity extends from the gendered expectations of men and women in society and thus the term gendered power dynamics is used to describe power within heterosexual relationships. Traditionally, this inequity in power has favoured men inside and outside heterosexual relationships. Some scholars have argued that power is shifting in women's favour in heterosexual relationships but it continues to mirror the unhealthy dominant/submissive pattern that has characterized social and personal

relations between men and women for decades (Hill, 2006). Increasing women's power so that women have dominance over men is not necessarily seen as positive or healthy for either men or women. Hill's (2006) observation underscores that power cannot simply be evaluated within a have/have not model; a more nuanced understanding is necessary. This observation is central to this dissertation in that it approaches power positively, in terms of equity, and acknowledges that young women and men can both have power within heterosexual relationships yet possibly express their power in different ways.

The concept of agency is often used to describe this more intricate understanding of power. Agency can be defined as the ability to act or make a choice. Agency is seen as distinct from power. Some researchers in sexual health have used the distinction between agency and power to explain women's ability to assert themselves (exercise agency) with heterosexual relationships that are governed at a larger level by male power (Allen, 2003b).

In this dissertation I adopt this important distinction between the concepts of agency and power based on the premise that within heterosexual relationships women possess agency in that they actively make choices and decisions regarding their behaviours. However, I recognize that those relationships exist within larger power structures that may work against women's agency and power. Understanding power as more of a structural force that often favours males clarifies that while women may exercise agency within heterosexual relationships, their choices or opportunities to exercise agency are, at a broader level, delimited by this larger power structure (Sherwin, 1998).

The distinction between agency and power reflects the work of Michel Foucault (1978). Foucault claimed that power is exercised, not possessed, is relational and cannot exist without resistance (Barker, 1998). Resistance allows individuals to be both subjects and agents of power relations (Sawicki, 1991). This notion of power holds that while young women and men may be subject to a broader system of power relations they are also agents in this system, making choices and resisting traditional ways of being and behaving. Foucault also challenged the idea that loosening restrictions on sexual behaviour is, in itself, liberating or has the potential to change power relations (Sawicki, 1991). Having the freedom to be sexually active does not mean that the underlying power relations that govern this behaviour are equitable where both sexes are concerned.

Consequently, one's power to negotiate safer sex is not solely an individual capacity but is mediated by the social structures which advantage or disadvantage some individuals over others (Hammarstrom & Ripper, 1999). These social advantages can be structured around several of the social determinants of health simultaneously. In this dissertation this theoretical perspective is reflected in the measurement and examination of the social determinants of health and their links to the gendered dynamics of power. In addition, this dissertation will approach power as a positive concept operationalized in heterosexual relationships as shared power. Measures to examine power have been adjusted to reflect this approach and determine whether shared power is evident in adolescent heterosexual relationships.

Organization of the dissertation

The dissertation is presented as four chapters with an introduction and conclusion. Due to the requirements of the Population Health program, each chapter is written in stand-alone article format to be tailored for subsequent publication in a peer reviewed academic journal. The introduction summarizes the rationale, methodology, purpose and objectives of the study. A discussion of the current state of knowledge in the field of adolescent sexual health and gendered power dynamics follows. Finally, the conceptual framework for the dissertation is presented.

Chapter one incorporates results from the first qualitative phase of the study. The results concentrate on how adolescents understand, define and experience the gendered dynamics of power within their heterosexual relationships. In this chapter I discuss how the participants in the study defined power and how they experience power within their relationships. The experience of power is described by how adolescents embody power as males and females and how they express this power as males and females within their heterosexual relationships, thereby incorporating a gendered analysis of power.

Chapter two expands the discussion of gendered power dynamics by focusing on the concept of girl power. The concept of girl power captures the interrelated issues of gender, heterosexuality and power which are at the theoretical centre of this dissertation. This chapter critically examines young

women's ideas about power and about their own power within heterosexual relationships in an effort to challenge dominant notions of girl power. These results also extend from the qualitative phase of the study.

Chapter three shifts focus from power to positive sexual health and summarizes how adolescent's experience positive sexual health by measuring various positive sexual health outcomes. Negative sexual health outcomes are also examined in order to maintain a balanced or holistic view of sexual health. An analysis of the links between indicators of the social determinants of health and the sexual health outcomes is also presented. This chapter presents results from the second quantitative phase of the study.

Chapter four integrates the central concepts of power, positive and negative sexual health outcomes and the social determinants of health. This quantitative paper uses regression analysis to uncover any associations between positive and negative sexual health outcomes and power while adjusting for the social determinants of health.

Finally, the conclusion summarizes the primary findings of the dissertation. A discussion of how these findings contribute to the knowledge base on adolescent sexual health and to the field of Population Health is also included. In the conclusion I also outline the limitations and strengths of the dissertation and recommend possibilities for future research and practice.

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Chapter 1

Power defined, embodied and expressed: Adolescents talk about power, gender and sexual relationships

Abstract:

Power, how it is defined, embodied and expressed by individuals is central to how those individuals will behave in relationships. International research reveals that gendered power dynamics are central to many positive and negative sexual health outcomes. This study will outline how a sample of Canadian adolescents define power, conceptualize how power is embodied by young men and women and describe how they express power within their heterosexual relationships. Results show that power is overwhelmingly defined as negative, with some adolescents denying that they have or exercise power. The embodiment of power is perceived to be gendered. "Powerful girls" are critiqued in a way that "powerful guys" are not. In contrast to their definitions of power, young men and women described expressing power in their relationships in generally positive fashions. A minority of young men described expressing power in dominant or controlling ways and a minority of young women described using their sexuality or their sexual ability as a means of power expression. More research is needed to continue to explore the concept of power with young people and listen for points of departure from traditional stereotypes of gender.

Introduction

Power, or the lack thereof, is central to how relationships between individuals will operate. Lack of social, economic and political power is believed to play a significant role in disease causation (Wallerstein, 1992). Powerlessness has both subjective and objective dimensions. Individuals can lack power in the social, economic or political systems within which they live. This objective lack of power often becomes internalized (Wallerstein, 1992). Gender-based power inequities can mean that women lack power at both a structural and an interpersonal level as compared to their male counterparts. At the interpersonal level these gendered power inequities often become subjective forms of powerlessness wherein young women internalize norms that place power in the hands of young men (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1990). The term inequity advances the concept of inequality to suggest that the lack of equality is unfair or unjust (Evans, Whitehead, Diderichsen, & Wirth, 2001). From the theoretical position of Population Health, the use of the term inequity in place of inequality asserts a moral and ethical claim that the inequality demands resolution (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005). The term inequity is thus purposefully used here to describe gender-based power inequities to indicate that these inequalities in power are unfair and unjust as they are based on one's gender.

International research has revealed the importance of gendered power dynamics within heterosexual relationships to several positive sexual health outcomes such as sexual satisfaction and self-esteem and to negative sexual health outcomes including violence, the transmission of HIV and sexually transmitted infections (Blanc, 2001). For young women, power inequities in heterosexual relationships mean fewer options to negotiate the terms of those relationships thereby often leading to sexually transmitted infections, unplanned pregnancies, and violence. For young men, inequities in heterosexual relationships are exacerbated by a society in which hegemonic forms of masculinity that legitimize dominance of men over women are highly valued (Connell, 2005). Reports from practitioners working with young men detail that the pressures to conform to hegemonic forms of masculinity may lead to violence, risk taking behaviours, incarceration and suicide (Population Council, 2001). Researchers have also detailed the negative consequences for both women's and men's health of the interplay between

power, gender and masculinity (Courtenay, 2000; Jewkes, 2002; Robinson, 2005; Santana, Raj, Decker, La Marche, & Silverman, 2006).

The literature on gendered power dynamics and heterosexual relationships in adolescence is sparse as the majority of the research focuses on adult heterosexual relationships and, particularly, on women. Consensus on how power operates in heterosexual relationships, indeed, how it is defined and experienced by various populations, has yet to be reached (Blanc, 2001; Population Council, 2001). In particular, questions about what power means to adolescents and how adolescents understand and express power in their heterosexual relationships remain unexplored. Given the links between gendered power dynamics and sexual health, examining adolescents' ideas about power and how it operates in their heterosexual relationships is overdue. This chapter will outline how a sample of adolescents in one Canadian city define power, conceptualize how power is embodied by young men and women and describe how they express power in their own heterosexual relationships. This article is one of the few to focus directly on Canadian adolescents' concepts of power in relation to heterosexual relationships and gender.

Literature Review

Definitions of Power

Power is embedded in all aspects of our social, personal and political lives. At the most intimate level, power is present in our sexual relationships. Power has been conceptualized differently by scholars. Sociologists, feminists and philosophers have offered several interpretations of how power is defined and how it is exercised within heterosexual relationships. In order to contextualize how adolescents themselves understand power, the work of some of these scholars will be outlined and discussed.

Central to understanding the effects of power in heterosexual relationships is understanding power itself. Power is often defined as: 1) a quantitative phenomenon or a simple capacity to act; 2) a capacity to act and a right to act (Hindess, 1996). The first definition of power generally implies that those with more capacity will dominate over those with less, thus an imbalance exists between those who exercise power and those who are subjects of power (Hindess, 1996). The right to act in the second

definition implies that power is exercised with the implicit or explicit permission of the subjects of that power. A subject is someone who is seen to be under the control of another. The right to act is often a presumed aspect of many definitions of power and is also the aspect that makes power distinct from the concept of agency. While agency is the capacity to act, power is seen as both the capacity to act and that the act itself is sanctioned, respected or has impact on others (Hindess, 1996).

The work of French philosopher Michel Foucault (1978) is perhaps the most cited when discussions of power arise. Foucault claimed that power is exercised, not possessed, is relational and cannot exist without resistance (Barker, 1998). Resistance allows individuals to be both subjects and agents of power relations (Sawicki, 1991). This theorizing of power recognizes that individuals may exercise and embody power in different ways depending on their relative positions within society and within relationships. The implications of one's gender, ethnicity, class, and social position are central to this understanding. Although young women and men may be subjected to a broader system of power relations they are also agents in this system, making choices and resisting traditional ways of being and behaving. Also important to the analysis of power within sexual relationships in a contemporary perspective is Foucault's challenge to the idea that loosening restrictions on sexual behaviour is, in itself, liberating or has the ability to change power relations (Sawicki, 1991). This assertion is important when we consider that power is often conflated with sexual expression for young women and men in today's society. Given the immense societal pressures on young men and women to enact certain gendered subject positions in their heterosexual relationships, resistance is an important concept.

Susan Sherwin (1998), a Canadian feminist philosopher, distinguishes between the concepts of autonomy and agency when discussing power and health care ethics. Sherwin states that there is a need to acknowledge women's agency and decision making within a system that limits women's options and possibilities for autonomy. Autonomy in this sense can be interpreted as power and power is distinct from agency, or the ability to act. The distinction between agency and power is an important one particularly in the case of heterosexual relationships. Various writers such as New Zealand scholar Louisa Allen have claimed that within heterosexual relationships women possess agency because they actively make choices and decisions regarding their behaviours (Allen, 2003). However, it is questionable whether women

possess power in these relationships when the choices and decisions available to them are shaped by a broader system of inequitable gendered power relations. Allen (2003) states that there is a need for a model of power which acknowledges women's experiences of agency within heterosexual relationships and which recognizes that these relationships are governed at multiple levels by male power. Recognizing power as a structural force that often favours men indicates that while women may exercise agency within heterosexual relationships, their choices or opportunities are delimited (Sherwin, 1998). This conceptualization of power also acknowledges the potential limiting or negative aspects of these larger power structures on sexual health outcomes for men and women. Distinguishing between power and agency will allow for the recognition of the similar and dissimilar ways in which young men and women exercise power without resorting to a simplistic have/have not analysis of power.

Power and Sexual Relationships

International research affirms that power inequities in heterosexual relationships have negative effects on both men and women. Women who report more having power in their relationships are more likely to use, or say they intend to use, condoms and report higher sexual self-efficacy (Blanc, 2001; Bowleg, Belgrave, & Reisen, 2000; Gutierrez, Oh, & Gilmore, 2000; Kershaw et al., 2006; Pettifor, Measham, Rees, & Padian, 2004; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002; Pulerwitz, Gortmaker, & DeJong, 2000). Research from the United States and Puerto Rico has shown that women's education levels are directly related to power in sexual relationships, condom use and communication about HIV risks (Pulerwitz et al., 2000; Saul et al., 2000). In addition, women who report having less power than their male partners or who claim that their male partners are dominant are less successful in negotiating safer sex and tend to report lower self-esteem (Buysse & VanOost, 1997; Galliher, Rostosky, Welsh, & Kawaguichi, 1999; Soet, Dudley, & Dilorio, 1999). In contrast, one South African study reported that women with higher power scores reported less consistent condom use (Harrison, O'Sullivan, Hoffman, Dolezal, & Monell, 2006). Findings from American and British research with girls show that those who adhere to conventional or traditional views of femininity tend to have romantic ideas about heterosexual relationships that rob them of agency (Holland, Ramazanoglu, Sharpe, & Thomson, 1998;

Holland & Ramazanoglu, 1992; Tolman, 1999). Without agency in their sexual relationships women are positioned as objects of men's desires and this makes safer sex negotiation near impossible (Kippax, Crawford, Waldby, & Benton, 1990).

Qualitative research from New Zealand reveals that young women do not perceive themselves to be in control of heterosexual relationships and feel they are "acted on" (Allen, 2003b). Young American women also report having less power than their male partners (Gutierrez et al., 2000). However, researchers have found evidence of young women who resist standard notions of passive femininity, speak of their sexual desires, and exert control in their heterosexual relationships (Allen, 2003; Allen, 2003b; Rosenthal, Lewis, & Cohen, 1996). Young women report determining how often to have sex, with whom and when, contraceptive use and discussions of sexual history (Allen, 2003; Levy, Otis, Samson, Pilote, & Fugere, 1997). Women have also reported that in spite of their feminist beliefs about power and agency these beliefs often don't translate well into practice (Allen, 2003; Miles, 1993).

In her study of young American women's first experiences of sexual intercourse, Thomson (1995) reported that many found the experience unpleasant, painful and disappointing. Yet some described the experience as positive and pleasurable. The young women who reported a positive experience described relationships that were equitable and affectionate and partners who recognized their needs and desires. These young women are described as responsible and powerful, meaning not passive or subordinate yet they made up only 3% of the study sample of 400 young women (Thompson, 1995). However, American research reported that for Black females, belief in equitable gender roles decreased participation in unwanted sexual activity but for Black males, belief in these roles decreased intimacy in their sexual encounters (Kalof, 1995).

Adoption of hegemonic masculinity leads men to believe that they must always be in control and exercise power (Blanc, 2001; Jensen, 2007). Research from multiple settings has shown that men who hold traditional views of masculinity are more likely to perpetrate violence against their partners, have unprotected sex, have sexually transmitted infections and have multiple sexual partners (Blanc, 2001; O'Sullivan, Hoffman, Harrison, & Dolezal, 2006; Pulerwitz, Barker, Segundo, Nascimento, 2006; Santana et al., 2006; Shearer, Hosterman, Gillen, Lefkowitz, 2005). Male power is reported to be the critical factor

in whether condoms are used or not (Bruhin, 2003). In fact, research from South Africa found that heterosexual relationships that are characterized as having high levels of male power are associated with HIV infection (Dunkle et al., 2004). In one study of South African men, those who held more traditional views of masculinity reported agreeing to unwanted sex with their partners (Harrison et al., 2006). By contrast, other studies from the United States and Switzerland report more condom use with men who perceived themselves to be dominant or powerful (Bruhin, 2003; O'Sullivan et al., 2006). Men who have not graduated from high school were significantly more likely to endorse traditional ideas about masculinity such as "it is essential for a man to get respect from others" and "men are always ready for sex" (Santana et al., 2006). It is important to note that these research studies come from diverse cultural settings and as a result may be reporting on different underlying issues while researching similar concepts.

Researchers have also demonstrated the links between equity within heterosexual relationships and positive outcomes. In another study featuring young South African men, it was reported that young men with low power scores reported fewer sexual partners (Harrison et al., 2006). Intervention research from Brazil and India has shown that when men move towards more equitable gender role beliefs, their risk for HIV and sexually transmitted infections is lowered and they report less violence, fewer partners and more condom use (Pulerwitz et al., 2006; Verma et al., 2006). In addition, American men who believe that there is a balance of power in their relationships report higher levels of relationship satisfaction (Sprecher & Felmee, 1997). Researchers have called for more involvement of males in research on sexual health and specifically investigation into the effects of male power and masculinity on sexual health (Amaro & Raj, 2000; Bowleg, 2004; Gahagan & Rehman, 2004). Notably, the majority of the research on young men's sexual health comes from outside of Canada. Thus, the findings may not apply to Canadian young men when the unique influences of ethnicity, nationality and culture are considered.

This chapter will extend this literature by studying Canadian male and female heterosexual adolescent relationships. In questioning how these adolescents define and express power within the context of their heterosexual relationships, this research endeavours to increase our understanding of power from a male and female adolescent perspective. By questioning young men and women, we can

determine whether traditional constructions of masculinity as dominant and femininity as submissive accurately depict adolescents' own experiences of power within heterosexual relationships.

Methods

This chapter reports on the first phase of this dissertation. Interviews with heterosexual youth (n=35) were conducted between June and July 2007 at an urban sexual health clinic in Ottawa, Canada. The clinic is centrally located and offers confidential sexual health information, testing, treatment and affordable contraception. The provision of affordable contraception such as the birth control pill, makes the clinic a popular choice for young women. Therefore, more young women frequent the clinic than young men. The building that houses the clinic is also home to a needle exchange site for injection drug users and is located close to many of the city's services for homeless, drug addicted and street involved persons. Due to its central location the clinic serves a diverse clientele that includes men and women of all ages, ethnicities, sexual orientations and classes. Clients are seen in the clinic on a first come, first serve basis. Wait times at the clinic can exceed one hour. Youth were recruited for this study through the use of information flyers posted in the clinic's waiting room. I conducted all of the interviews in a private conference room at the clinic.

Study Sample

A convenience sample of adolescents was recruited for participation. Adolescents were eligible to participate in this study if they were between the ages of 14 and 20, self-identified as heterosexual and could read and write in English. Recruitment continued until saturation (redundancy) was reached and no new information emerged from the participants (Robson, 2002). A determination of saturation was made for males and females separately. Due to the recruitment method, data collection extended beyond information saturation for females.

The study protocol was approved by the ethical review boards of both the University of Ottawa and the City of Ottawa's Public Health department. Adolescents who wished to participate told a

receptionist who, in turn, notified me. In all cases participants completed the interview while they waited to be seen. Each participant was given a \$5 gift certificate to a local coffee shop as compensation.

Data collection

A semi-structured interview guide was used. It included questions exploring how adolescents defined and expressed power in their heterosexual relationships and how they defined the concept of sexual health. Before the interview the participant signed an informed consent form and completed a brief demographic questionnaire. The questionnaire gathered information on age, self-identified ethnicity, country of birth, socioeconomic status and current sexually active status. Socioeconomic status information was gathered using the Family Affluence Scale (FAS) (Boyce, Torsheim, Currie, & Zambon, 2006) which consists of four items intended to determine the material wealth of one's family. A total score on the FAS of zero to two indicates low affluence, a score of three to five, medium affluence and a score of six to nine, high affluence. The lowest possible score on the scale is a zero and the highest a nine (Boyce et al., 2006). The demographic questionnaire was used to situate the participants in terms of indicators of the social determinants of health and to assess the usefulness of the FAS with this age group for consideration on the survey in a second quantitative phase. Each face-to-face interview was approximately 30 minutes in length and was tape-recorded and transcribed.

Data analysis

Interview transcripts were read and re-read to allow major themes to emerge. After this period of immersion transcripts were coded and categorized into themes (Creswell, 2003). The interview guide served as a descriptive analytical framework to structure the analysis (Patton, 1990). Nvivo qualitative analysis software was used to assist with this process (version 7.0).

Data from the demographic information form is summarized using descriptive statistics. Socioeconomic status information as measured using the Family Affluence Scale was analysed by adding up the responses to each question to arrive at a total score. The demographic information for each

participant was used during the qualitative analysis to attend to trends or differences in responses across these indicators.

Results

Participant Characteristics

A total of 35 adolescents were interviewed, 13 males and 22 females. The larger number of young women is reflective of the population frequenting the sexual health clinic. On average the youth were 18.5 years old with an age range of 15-22. The majority self-identified as heterosexual, three young women identified as bisexual but were currently in heterosexual relationships. The young women who identified as bisexual were included in the analysis for three main reasons. First, during their interviews these women made no reference to their bisexuality but spoke only of their participation in current and past heterosexual relationships. As a result, it was felt that their contribution to the research was valid and should be included because of the dissertation's focus on gender and power within heterosexual relationships. Second, the demographic forms that indicated their self-identification were reviewed post-interview. Thus, a decision to exclude these women would have been made after the young women had participated willingly and fully. This decision was deemed to be unacceptable. Finally, my analysis did not reveal any differences in the responses of these women when compared to the responses of the young women who self-identified as heterosexual. For the purposes of transparency, the women who self-identified as bisexual are identified as such whenever they are quoted.

The majority of the sample were currently sexually active (85.7 percent) and 100 percent had been sexually active in the past 12 months. Table one describes the demographic characteristics of the sample in more detail. Due to the small sample and the even smaller numbers of participants in each self-identified ethnic group the results are not generalized according to specific self-identified ethnic groups. Further, the participants reported a wide range of incomes as determined by the Family Affluence Scale. Consequently, trends by income group were not made. The scores on the Family Affluence Scale should also be interpreted with caution as the questions regarding family level outcomes may not be as reliable for those participants no longer living at home. Each participant's gender, age, ethnicity and Family

Affluence Scale score is used when he or she is quoted in order to situate the participant as fully as possible. All quotations are presented verbatim and with the participant's chosen pseudonym.

Table 1
Demographic Characteristics

	<u>Males (n=13)</u>	<u>Females (n=22)</u>
	<u>Mean (range)</u>	<u>Mean (range)</u>
Age	19 (17-22)	18 (15-21)
	n	n
<u>Ethnicity*</u>		
Caucasian	13	13
Black	1	1
African Canadian	0	1
Jamaican Canadian	0	1
French	2	1
Polish	1	1
Half Native	1	0
Ukrainian	1	0
Métis	0	1
Spanish	0	1
Canadian/Mexican	0	1
Arabic	0	1
Country of Birth		
Canada	11	21
Cameroon	1	0
Germany	1	0
Somalia	0	1
Currently in school		
No	4	6
Yes	9	16
Employment status		
Full-time	5	6
Part-time	3	11
Don't work	5	5
Current sexual activity		
Yes	10	20
No	3	2
FAS scale score	<u>n (mean score)</u>	<u>n (mean score)</u>
Low	1	3 (1.3)
Middle	5 (4.2)	12 (4.1)
High	7 (6.6)	7 (7.3)

*Ethnicity was self-defined and categories were not combined.

Power Defined

Adolescents were asked what the word power meant to them. Overwhelmingly, power was defined as having control either over oneself or over others. With few exceptions, this definition was consistent for both males and females. There were some subtle differences in the language that young men and women used to describe power. Some young women described power as a purely personal construct, or as power within; this was not the case for young men. For example, Tamica (Black, female, 19, FAS=5) stated: "um, basically just being in control of your own life, your own situations and yeh your own decisions" and Stacey (Caucasian, female, 16, FAS=2) declared: "uh power means being independent to me and not depending on anyone else".

Some young women described power as having control over something or control over a situation. For example, "Power? Um, obviously like being in control of something or a situation so whatever you say someone agrees to or will listen to you I guess" (Deborah, Caucasian, female, 18, FAS=2); "Power means ah dominance I guess like you have power over somebody else whether it is sexually or just physically or any way really having power is having a higher status I guess" (Gwyneth, Métis, female, 18, FAS=0). These ideas about the meaning of power were more closely aligned with what some of the young men thought. Generally, young men also described power as a power over construct, for example, "it's like to have control over them you know feel like you have control over the situation and like that um something specific, um I don't know how to describe it, you feel above them" (Jon, Caucasian, male, 18, FAS=9); "it's kind of if you have power you have control over something or like that's the best definition I can give" (Cornelius, Ukrainian/white, male, 19, FAS=6).

Unique to the young men's descriptions was the idea that power is ever-present, and, therefore, is indescribable. This definition of power seems to suggest that because male power is so ubiquitous it is invisible to those who hold it. This meaning of power was used by a minority of the young men in this sample:

Power, um, I don't know, it's one of those words that can only be defined by itself power, I don't know, you have power (Dave, French Canadian, male, 19, FAS=4);

Power, pretty much you have I'll just compare it to force and power, force like um something that needs like a fuel tank you need like to always re-supply like force whereas power is like infinite there's no, once you have power you just, it will be continuous right (Pheno, white, male, 19, FAS=6).

Power Embodied

Power is embodied by individuals in ways that are complex. Societal values associated with one's gender, class, and ethnicity affect the manner in which one embodies power. How "powerful girls" and "powerful guys" are conceptualized gives us an indication of how adolescents see power embodied and how gendered power dynamics operate at an individual level. Gendered power dynamics are tied up with constructions of masculinity and femininity. Adolescents' descriptions of "powerful girls" and "powerful guys" show that the embodiment of power is gendered and that a double standard exists in the way that this embodied power is expressed by males and females.

A powerful guy

When asked to describe a "powerful guy", young women and men again offered definitions that were more similar than distinct. Young men generally described a powerful male as someone who is respected and a leader. They often used physical descriptors like "bigger", "strong", "large". Most young men made no distinction between a powerful guy and a powerful girl, explaining that they saw both similarly, except for male physical power. Both males and females saw that power was embodied by men both in their behaviours (confidence, leadership) and in their physical appearance (big, strong):

A powerful guy, um basically almost the same as a girl, maybe it's a little more visual for guys like they care about like if they're bigger they feel more powerful and whatnot (Jon, Caucasian, male, 18, FAS=9).

For some young women there were instances where a powerful guy was associated with aggression, abuse and control. Herein, power was embodied in men's negative behaviour:

Um just maybe lying and yeh just that and telling I don't know, swearing at a person or telling them like abusing like verbally abusing them I guess (Candy, white, female, 18, FAS=8);

A powerful guy is somebody who you know demands you to do this or even asks you to get him a drink or do this or is demanding and is dominating and is very powerful and also you know making you have sex when you don't want to that's powerful, that's being very dominant and just wanting to control ever situation (Gwyneth, Métis, female, 18, FAS=0).

However, these examples were the minority. Most young women saw a powerful guy as physically strong, independent and confident:

Someone who is strong and like has a good head on their shoulders like they're good with their decisions and um respectful (Amyah, Arabic, female, 19, FAS=4);

A powerful guy, not powerful like I don't how to explain it, not powerful as in like abusive kind of like there's a certain limit to power before it becomes abuse like um powerful just strong but he knows how to use it like he doesn't go around like using it when he doesn't need to like hurting people for no reason that's like physical power, mental power like being able to like, just being smart like educated and going to school (Julia, Canadian/Mexican, female, 18, FAS=4).

A powerful girl

Young men described a "powerful girl" far more positively than did the young women interviewed. All of the young men offered very similar descriptions that generally included ideas about confidence, decision making and independence. Only one young man stated that he believed a powerful girl would be the equal of a powerful guy, raising the concept of gender equality. Others described a powerful girl as someone who doesn't "get pushed around", "makes her own choices" and "knows what she wants". Almost half of the young men stated that they felt there was no distinction between a powerful girl and a powerful guy, with the exception of physical appearance (i.e., "bigger"). Generally young men did not describe any physical characteristics of a powerful girl except for a confident appearance. In this sense, young men saw that power was embodied by young women in their behaviours. This was not the case for young women. Young men were more likely to assume that a powerful girl was self-confident in her beliefs and in her actions:

Uh someone who like knows like what they want and they're not going to compromise kind of they have their own beliefs (Cornelius, Ukrainian/white, male, 19, FAS=6);

Well I guess just being like sexually, not sexually, but ah gender like equal to other men like not being pushed around by other people whether it's someone in their sex or the other sex like taking control over their own life, the same as I would consider a powerful man really (Jake, white, male, 20, FAS=6).

Some young women offered descriptions of a powerful girl that were very similar to the young men's and they included concepts such as, making choices and goal setting:

Um someone who knows what they want and who is not afraid to say anything even if they feel uncomfortable (Deborah, Caucasian, female, 18, FAS=2);

Somebody who is strong minded and feels that they can accomplish tasks on their own, strong and independent (Jenny, Caucasian, female, 20, FAS=4).

Generally, the young women were much more critical in their descriptions of a powerful girl and were more likely to denigrate her looks and her clothes. Some of the young women's comments about a powerful girl's physical appearance raised the issue of sexuality as power. The idea that powerful girls are sexually attractive to men but are not "slutty" in appearance or behaviour suggests the existence of a stereotypical good girl/bad girl dichotomy that indicates that power can be a precarious possession for women. However, this same idea was questioned by some of the young women:

Someone who doesn't feel I guess defined by their sexuality, someone who has high self esteem, confidence, know what they want in life....like their self esteem isn't based on how attractive they are or how thin they are or how much attention they get from guys (Allison, Black/Jamaican, female, 20, FAS=5);

Well I mean, obviously, well maybe not obviously but confidence, you can't, if you see someone that is powerful you can't sit there and be wearing say, I don't know, like I couldn't sit here in ridiculously tight booty shorts and a tube top and say I have power (Amber, Polish/white, female, 17, FAS=4);

Well more attractive girls I'm going to say have more power with guys but still they're like slutty girls then like they've got nothing so....I just think because then you're easy right so like guys don't respect you anymore if you're like throwing everything you've got out there (Kelly, European/white, female, 18, FAS=8).

Other young women offered negative assessments of powerful girls by touching upon stereotypes of lesbianism and feminism that highlighted pervasive sexual double standards. The young women quoted here questioned the idea of a powerful girl in a manner that was not seen in their descriptions of a powerful guy:

Probably a butch and um really loud and obnoxious having people do what they say or whatever they want to do, being in control all the time (Candy, white, female, 18, FAS=8);

See that sucks how it is completely opposite [as compared to a powerful guy] Like I think that a powerful female is a very, that kind of a negative things too sometimes they're both negative and positive I think there are more negative connotations on them now though cause like a powerful woman is not bitchy but it's hard to like get to know them not get to know them it's hard to have a conversation with them you find them that they push their opinions on you more, I find it very feminist, like feminists are like that right, feminists are kind of like they bother you in a way just because of the way they think that they are a lot more powerful than men so they kind of like in that sense like ok maybe they are but it brings other people down right (Charlie, white, bisexual, female, 17, FAS=5).

Power Expressed

After exploring how young men and women defined power, the interview moved on to how they expressed power in the context of their heterosexual relationships. Responses were categorized into five main themes. Four of these themes were common to both males and females: 1) The exercise of control; 2) Questioning power, practicing equity; 3) The power of communication and; 4) The use of sex as power. One theme was unique to the young women's descriptions of how they expressed power: 5) The power of "no".

The Exercise of Control

The largest number of men and the fewest women were clustered in this category. For one young woman, this theme meant feeling powerless and having no control within her relationship: "To be honest, I probably didn't have much power in it....not being heard and the other person not really giving a shit about me" (Candy, white, female, 18, FAS=8). A second young woman described the exercise and permission of control. She expressed power by "taking control" but also by allowing her partner to also have control: "just kind of like taking control at times but like letting him have his power too" (Rebecca, Caucasian, female, 16, FAS=6).

For young men, the use of control as an expression of power raised traditional notions of masculinity such as "taking the lead" and asserting dominance. In some cases, the young men recognized that these expressions of masculinity were limited and only partially tolerated by their female partners. While for others, control was exercised by asserting their choices. For example, one young man

expressed power by controlling where sexual encounters took place explaining that he and his girlfriend always had sex at his house "on his turf":

How I express power, taking the lead (Mike, Black, male, 22, FAS=6);

Um just by you know you want to be in control sometimes it's fun like but yeh um I don't know just being in control, but not always, you don't want to do it too much otherwise they get annoyed and it's not fun (Jon, Caucasian, male, 18, FAS=9);

I'd say just being like dominating when you're actually doing sexual activities like just not being too dominating but still like if they want you to be like showing that you are powerful kind of (Cornelius, Ukrainian/white, male, 19, FAS=6).

Questioning power, practicing equity

Equal numbers of male and female participants explained that their expressions of power were characterized by equity. Although the participants used the specific terms "equal", or "equality" indicating equality, they associated these terms with the practice of fairness within a relationship that was characterized as right or just. Thus, the term equity is used to describe this theme. These participants stated that they did not express power in their relationships and reiterated the idea that power is negative and expressed over someone. This use of power within their relationships would indicate a lack of equity which was not acceptable to these participants. In fact, many of the participants in this group were confused by the question about how they expressed power. This confusion seemed to be primarily because power, having it or using it, was seen as negative in and of itself:

I don't express power in a sexual relationship, I have no desire to overpower anyone at all, I just like for things to be equal and balanced like everything in my life I like to have a balance (Jake, white, male, 20, FAS=6);

It has always pretty much been equal and if it isn't then that guys gone (Laura, Caucasian, bisexual, female, 20, FAS=4);

Um, I just see it being as something of equality, I think it's, once you start trying to take power over someone else it's silly like I think it should be all about equality within the relationship (Lynne, Caucasian, female 18, FAS=5).

Those participants that spoke of experiencing equitable relationships described them as reciprocal, positive, and respectful. The expression of power was seen as unnecessary because the relationships

were based on fairness and equity. Again there was the common thread that expressing power was negative and should be avoided:

Cause it's never one person calling the shots its always mutual like no one's really got anyone whipped in this one (Dave, French Canadian, male, 19, FAS=4);

I mean it's powerful the fact that like we are both fair with each other....like we don't argue much about that kind of stuff we just kind of do what we want" (Sara, Caucasian, female, 20, FAS=7).

The power of communication

Open communication was seen as an expression of power by both young men and women. These participants stated that they express power in their relationships by being open in communicating to their partners about their comfort levels, boundaries, and choices. This theme highlighted positive ideas about honesty and respect. Setting boundaries for acceptable behaviours and asserting their own needs were more common to the young women's descriptions:

I think the way that I express power is I mean like I know what I won't do so I just I discuss that with my boyfriend and we talk.....that was important to me just to be able to let him know what I wanted and that I wasn't going to be influenced or manipulated (Amyah, Arabic, female, 19, FAS=4);

I only do things that I want to do, I don't do anything that I'm forced to do, I don't, I try my best not be conned into anything that I feel uncomfortable doing, that's my way of expressing power and I let it be know before I even get myself into that situation what I do or don't do (Tamica, Black, female, 19, FAS=5);

I would just let her know what I'm comfortable with and not comfortable with and stick with that (Dan, white, male, 18, FAS=2).

Communicating one's likes, dislikes and personal boundaries can be seen as a positive expression of power. This theme resonates with the concept of power within. The participants here used power as a means of asserting themselves in a manner that was not dominant or controlling.

The use of sex as power

When asked to describe how they express power in their heterosexual relationships, some of the adolescents spoke of participating in specific sexual acts that made them feel powerful. The adolescents who discussed expressing their power through sexual acts were generally more candid in the interviews.

Both young men and women spoke of expressing power by performing specific sex acts that enabled their partners to experience sexual pleasure. Young women's responses are in line with current popular press accounts that describe young heterosexual women as sexually empowered because they apparently willingly participate in a range of sexual acts with a large number of partners (Harris, 2007; Timson, 2005). A troubling aspect of this theme is that it seemed to be the only way in which some of the young women expressed power in their heterosexual relationships. Only one young man understood power as enabling his female partner to experience pleasure:

To actually show that you have power in a relationship you have to do it [sexual intercourse] it's like I don't know if's just I find it easier sometimes to just do it and like go to work and just hope nothing happens (Charlie, white, bisexual, female, 17, FAS=5);

Um, being on top just like how that my ex-man didn't want me to be on top because I had more power and I was in control I think. I enjoy being on top so I would that'd be, it makes me feel more powerful, or giving head [oral sex] to a man....because I am in control cause I am holding you or I am going to hold you and I am making you feel how I want to make you feel because I can do it and I'm better so I think giving head to a guy makes me powerful (Gwyneth, Métis, female, 18, FAS=0);

I guess like, ah if you go down on a girl you know, it makes them really crazy (Pheno, white, male, 19, FAS=6).

It is important to highlight that both Charlie and Gwyneth resisted the notion that using sex to feel powerful was, in fact, an expression of powerlessness. Charlie described her power as following through on things she said she would do; sex was the means by which she expressed this power. It is possible that Charlie uses power in this manner outside of her heterosexual relationships and thus sex in itself is not her sole expression of power. Gwyneth challenged the perception that the provision of oral sex was a sign of powerlessness. She actively questioned this idea by asserting that it was her partner who was powerless as she was in control of the situation.

One young man described refusing or withholding sex as a way in which he expressed power. He explained it was a way to tease his girlfriend who often "withholds" sex and to prove that he can do the same. For one young woman initiating sex was the way in which she used sex as a means of expressing power in her relationship:

How do I express power, sometimes I do it by, I can withhold sometimes and if she doesn't like that and it's funny cause I can get her back and not even to prove anything just cause I don't feel like it right now (James, Caucasian, male, 20, FAS=7);

Um, my boyfriend is kind of lazy so if we're going to have sex I have to initiate it so that's how I get to have power in the relationship is I get to decide when we're having sex cause he just doesn't ever take the initiative (Jenny, Caucasian, female, 20, FAS=4).

The power of "no"

The one theme that was unique to the young women's descriptions was the power of saying no. The young women stated that refusing the sexual advances of their male partners was an expression of power. Yet in some cases, saying no was framed in terms of "self respect" and "sticking up for yourself" and not as power. Questioning whether their actions did in fact constitute power was unique to young women. Young women's reluctance to associate their actions with power may be due to the belief that power is negative and controlling:

I didn't really have power in my relationship actually but uh, no just by me being able to say no, that's my power (Nat, Canadian/white, female, 19, FAS=7);

Um I don't think of power as like a sexual thing like I don't think anybody really has to have power just like make sure that I say no if I don't want to (Julia, Canadian/Mexican, female, 18, FAS=4);

I guess by like making decisions like when I want to have sex and like where by like kind of like respecting myself like if I don't want to have sex then I'm not going to have sex...I really wouldn't classify it as like power it's more just like having an opinion (Kelly, European, female, 18, FAS=8).

Conclusions

This chapter explores young Canadian adolescents' ideas about power and how it is expressed within the gendered landscape of heterosexual relationships. In general, power was seen as a negative concept, or as power over, with many adolescents rejecting the idea that they expressed or had power. Challenging ideas that adolescent heterosexual relationships operate according to traditional notions of male dominance and female submissiveness, the adolescents spoke of equity in their relationships. The practice of equity was described as a resistance to power and not as power itself, because power was generally seen as negative.

The participants showed conclusively that power is gendered. Adolescents believe that power is embodied physically by men and in non-physical ways by women. In fact, the embodiment of power by women was considered suspect by the participants. A powerful guy is considered by both young men and women to fit the traditional notion of hegemonic masculinity (Connell, 2005). A powerful woman or girl is considered by both young men and women to be a woman who projects confidence and self esteem. Yet, her power is questioned and appears to be contingent upon an appraising male gaze. Hegemonic masculinity is said to be neither productive nor healthy for young men and women. However, the young men and women studied here view aspects of this notion of manliness as powerful and, in many ways, desirable.

The young men in this study described the ways in which they expressed power in their relationships in very similar ways to the young women. Dominance in attitudes and behaviours were described in ways that acknowledged the limits of these practices in their relationships. A good portion of the young men spoke of equity, with some rejecting ideas of dominance all together. In research from New Zealand (Allen, 2003) interviewed young men who spoke about equal power within their relationships when in the presence of their partners but admitted to coercive practices when interviewed alone. This finding highlights that the experience and practice of equity are complex and it is possible that the young men in my study, if probed, would admit to similar practices. The influence of the sex of the interviewer on results is somewhat inconclusive but the young men may have moderated their responses in the presence of a female interviewer. Nonetheless, this research may provide important insights into how young men understand and experience power. The finding that young men perceive or experience equity within their heterosexual relationships is promising. Of course, larger studies are needed to further investigate this possible trend.

While the young women in this study also spoke of equity and generally described themselves as powerful, the source of their power in a minority of cases needs to be critically discussed. As detailed in the popular press, a few young women in this study seemed to draw a large portion of their power from their sexuality (Levy, 2005). In a culture obsessed with the objectification of youth and celebrity this is not surprising. The majority of young women in the study did not equate their power with sex or their

abilities to please their partners sexually. Most young women spoke of their power in active, positive ways, using terms such as confidence, assertiveness and having the ability to make sexual decisions that suited them. This finding confirms the limited research on young women's sexuality that describes young women who reject standard ideas of feminine passivity that limit their power to assert themselves in their sexual relationships (Allen, 2003b; Levy et al., 1997; Rosenthal et al., 1996).

The young women were more sceptical and critical of the concept of power as evidenced by their descriptions of powerful young women and men. Young women more often described a powerful girl using negative terms and questioned the idea of power generally. The negative perception of powerful women may indicate that young women may not be as willing to engage with this identity. This lack of engagement with power may be due in part to young women's experiences in a social world where their access to concrete power beyond power tied to their sexuality, is limited. Young women will continue to remain sceptical of women's power until power resonates positively in their lives. Third wave feminist writers remind us that while power gains in terms of sexual and reproductive health are important, gendered power inequities exist and must be challenged (Ahn, 2001; Rumack, 2001; Siegel, 2007). As Ahn (2001) writes, popular culture has made feminism a "dirty word" and has created the substandard girl power in its place. The popular view of feminism as negative may explain some of the discomfort that the young women here expressed about powerful women. Working with young women to establish a more positive relationship with power is required. While acknowledging and validating women's expressions of power and agency is essential, so is remembering that concrete power comes from institutions and politics and women's lack of power in these realms needs to be continually questioned (Forbes, 1996). Also critical to understand is that while patriarchy is a system that places power in the hands of males in society, it does not mean that each individual man embodies or expresses power in this dominant manner. Listening to young men to understand their diverse experiences of power and its expression is essential to moving our knowledge of this complex phenomenon forward.

Indeed, the participants in this study articulated ideas about agency and power that cannot be understood under the traditional dichotomous stereotypes of dominant male/submissive female (Allen, 2003; McNay, 2000). Nevertheless, I do not suggest that power inequities between women and men no

longer exist. There is certainly evidence here that they do. I recommend continued exploration of the concept of power with young people to listen for points of departure from traditional stereotypes of gender. Feminists and social theorists may need to develop more nuanced models of gender that resonate with this generation's experience of heterosexual relationships or risk missing their evolving ideas about men, women and power.

The primary limitation of this study was the inability to analyse the influence of ethnicity and socioeconomic status on the participants' understandings of power. The convenience sampling method and analysis process did not allow for an in-depth exploration of these issues. If the research setting had allowed for purposeful sampling issues of ethnicity and class (income) and their intersections with power could have been explored through direct sampling of participants with specific demographic criteria. This would have been an important addition to the literature as it is recognized that the embodiment and expression of power is intricately linked with class and ethnicity. The inclusion of the ethnicity and Family Affluence score results after each quote contextualized each participant but broad conclusions about specific ethnic or income groups cannot be made from this amount of data. The use of a convenience sampling technique may also limit the applicability of the findings to other settings or groups because participants were not selected along common purposeful or theoretical directions.

Also, issues of sexual orientation and power demand further attention. Three of the young female participants self-identified as bisexual but were in heterosexual relationships. The sample of bisexual women was too small to make conclusions about possible differences in results based on sexual orientation. It is possible that these young women have a unique perspective on power within heterosexual relationships because of their bisexual identities, however, no inconsistencies with the responses of the heterosexually identified women were found. If the interviews had probed or questioned directly the influence of sexual identity on power and gender, it is possible that these young women may have articulated the influence of their bisexual identities on their opinions and experiences of power. More research is needed to investigate power within bisexual, gay and lesbian relationships as well as on bisexual individuals within heterosexual relationships.

Finally, the study took place in a sexual health clinic and this location may have influenced the results. If the study had taken place in a different setting it is possible that the participants would have spoke of issues of power more broadly and further insights may have been gained. The participants who presented at the sexual health clinic may also represent a distinct population.

This study is one of the first to explore young heterosexual Canadians ideas about the gendered dynamics of power and heterosexual relationships. Results indicate that power is a multifaceted concept that is perceived and experienced in diverse ways by the adolescents in this sample. This study creates the groundwork for future inquires into issues of power, gender and adolescent heterosexual relationships.

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Chapter 2

"I think girls they hand over some of their power": Girl Power *R*efined.

Abstract

Purpose: The concept of girl power has been used to describe young women's increasingly liberalized sexual behaviour, often in negative ways. The primary purpose of this chapter is to describe the concept of girl power and how it is understood by young women themselves.

Methods: Over a period of one month 22 interviews were conducted with young women on the subject of power, sexual health and heterosexual relationships. The interviews were conducted at an urban sexual health clinic in Ottawa, Canada. Analysis was conducted using open coding and constant comparison around the concept of girl power and then categorization of patterns into themes.

Results: The young women described various ways in which they expressed power in their heterosexual relationships. Girl power in the context of these relationships was described by five broad positive and negative themes: 1) Setting boundaries; 2) Getting what one wants; 3) Performing; 4) Contingent on male power; 5) Limited. The young women descriptions of power were limited but, young women recognized these restrictions openly.

Conclusions: Young women do appear to be resisting traditional notions of femininity in the ways that they express power; still, a great source of their power does seem to stem from sex and sexuality. The false nature of sex as a source of power has important implications for young women's sexual health. It is important to keep an analysis of power in all our discussions with young women and men about sex and heterosexual relationships because power inequities continue to shape both positive and negative outcomes for adolescents.

Introduction

Hillary Clinton's foray into the United States presidential race and the nomination of Sarah Palin as the vice-Presidential nominee for the Republican party in 2008 have pushed the subject of women and power into the limelight. Commentators have highlighted a palpable discomfort with the idea of women in such influential roles and both Clinton's and Palin's femininity has been called into question (Baird, 2008; Timson, 2008; Traister, 2008).

This American presidential campaign has reminded us that even at the dawn of the twenty-first century, the idea of a powerful woman is still suspect. Powerful women are ridiculed in ways that powerful men are not. At the same time, young women are inundated with messages that teach them that their power comes from sex, namely heterosexual sex, and that the expression of this power represents liberation. Such discussions often include references to the success of "girl power" (Traister, 2008). A term most often credited to the British pop group the *Spice Girls*, girl power loosely encapsulates the idea that girls can do and be anything. Defined as: "power exercised by girls; a self-reliant attitude among girls and young women manifested in ambition, assertiveness, and individualism" (Oxford Online Dictionary, 2008), girl power is believed to be embraced and embodied by young women. However, recent popular press articles have derided these purportedly powerful young women as heterosexually promiscuous and, in some cases, dangerous when they exercise their power, often in the only sanctioned manner, which is through sex with boys and men (Timson, 2005; Wente, 2004; Wilson, 2004). These articles revive the sexual double standard, thereby reinforcing the long held divide between "good" girls and "bad" girls. Good girls are good because they use their power to safeguard their virginity until marriage (Agrell, 2007; Siegel, 2007). In contrast, bad girls use their power to push past the boundaries of acceptable premarital heterosexual behaviour for young women (Harris, 2007). Journalists claim that girl power originated as a call for young women to stand up for themselves socially and politically. However, girl power is infused with the traditional sense of using sex to get ahead (Harris, 2007). Needless to say, using sex as a means of power is operationalized only within a heterosexual model that is dependent on men (Jackson, 2009; Levy, 2005; Morris-Roberts, 2004; Phillips, 2000; Rich, 1980).

Rich (1980) articulated the link between power and heterosexuality in her analysis of the "institution of compulsory heterosexuality". The institution of compulsory heterosexuality refers to claims that heterosexuality is naturalized within society and, as such, defines and reinforces wider gender relations within and beyond the confines of a particular heterosexual relationship (Rich, 1980; Phillips, 2000; Morris-Roberts, 2004; Levy, 2005; Jackson, 2009). The notion of compulsory heterosexuality is vital to messages of girl power because power within these messages is only achieved through heterosexual practices and rules.

With the notion of girl power in mind I set out to explore how young men and women defined power in their heterosexual relationships and listened closely for evidence of girl power in their explanations. I approached the messages on girl power within the popular press with a critical eye and questioned whether young women themselves would define their power as solely sourced from their heterosexual relationships. I approached this aspect of this dissertation with the optimistic belief that young women are mistakenly characterized in sexual health research as powerless because that research uses a pre-defined framework of female oppression and male domination. Therefore, I began by asking young women how they expressed power in their heterosexual relationships, rather than by assuming that they were powerless. I make an explicit commitment to honour the young women's words and not to reframe their claims of power within the same pre-defined oppressive\dominant framework. This pre-defined framework often characterizes young women's expressions of power, particularly sexual power, as evidence that they have been "duped" by patriarchy. I believe that this characterization robs young women of agency and represents a simplistic explanation of their power within heterosexual relationships. I do nonetheless acknowledge the existence of larger patriarchal power structures that affect and delimit women's sexual choices. These structures function both to define women's sexuality in the world and to construct how a young woman herself understands her own sexuality (Braun & Gavey, 1999). I am working from the belief that there is a need to move beyond essentialist notions of male domination and female oppression within heterosexual relationships in order to understand their multifaceted nature and to work toward gender equity.

The broad goal of this dissertation was to explore how a sample of self-identified heterosexual Canadian adolescents define, describe and experience the gendered dynamics of power in their heterosexual relationships. The results presented in this chapter focus on my conversations with the female participants and centre on the concept of girl power as articulated above.

Methods

This chapter reports on the first phase of my two phase dissertation investigating the gendered dynamics of power and positive sexual health outcomes among a sample of heterosexual Canadian youth. This phase involved semi-structured interviews with a convenience sample of heterosexual youth at a public sexual health clinic. The sexual health clinic is located in a central Ottawa location and serves a diverse clientele. The clinic operates as a walk-in and clients are seen on a first come first serve basis. After registering with the receptionist clients wait in a large waiting room to be seen. Wait times at the clinic can exceed one hour. Participants were recruited using information flyers posted in the waiting room.

Adolescents were eligible to participate if they were between the ages of 14 and 20, self-identified as heterosexual and could read and write in English. If clients were interested in completing an interview they informed the receptionist and then I was informed. In all cases the interviews were completed while the clients waited for their appointment. Interviews were conducted between June and July 2007 in a private conference room at the clinic; I conducted all interviews personally. Each participant was given a \$5 gift certificate to a local coffee shop as compensation. The dissertation protocol was approved by the ethical review boards of the University of Ottawa and the City of Ottawa's Public Health Department.

A semi-structured interview guide was used that included questions on how young women expressed power in their relationships, how they perceived their partners expressing power and the ways in which they believed powerful guys and girls behave in relationships. Data collection continued until saturation was reached and no new information emerged (Robson, 2002). Prior to the commencement of the interview each participant completed a consent form and a short demographic questionnaire. The

demographic questionnaire collected information on age, self-identified ethnicity, country of birth, socioeconomic status and sexual activity status. Socioeconomic status was collected using the Family Affluence Scale (FAS) which consists of four questions intended to determine the material wealth of one's family (Boyce, Torsheim, Currie, & Zambon, 2006). A total score on the FAS between zero and two indicates low affluence, a score of three to five, medium affluence and a score of six to nine, high affluence (Boyce et al., 2006). The face-to-face interviews were approximately 30 minutes and were tape recorded and transcribed.

Data Analysis

Transcripts were read and re-read to allow major themes to emerge. A final reading using girl power as the sensitizing concept (the concept which gives the direction along which to focus the analysis) was completed to look for specific references to the ways in which the young women described their power (Patton, 1990). Transcripts were then coded using open coding and constant comparison across cases around the concept of girl power and then categorized into themes (Flick, 2007; Patton, 1990). Nvivo qualitative analysis software was used to organize this process (version 7.0).

All demographic information is summarized using descriptive statistics. A score for the Family Affluence Scale was calculated by summing up the responses to each question. The results of this scale are presented for all participants but the results for those in the older age category (18-20 years) should be interpreted cautiously. Some of the questions such as "do you have a bedroom for yourself at home", which were intended to give an indication of crowding or poor housing, may not apply to those who are living alone outside of the family home. Given the small sample and the limited diversity within the sample, conclusions regarding socioeconomic status or ethnicity cannot be made. However, in order to situate the participants each quote is given with their sex, age, ethnicity and Family Affluence Scale score. All quotes are presented with the participant's chosen pseudonym.

Results

Participant Characteristics

A total of 22 females were interviewed, 19 self-identified as heterosexual and three self-identified as bisexual. The young women who self-identified as bisexual were included because they were currently

in heterosexual relationships and spoke only of their experiences of power within these relationships. Further, the analysis did not reveal any differences in their responses when interviewed about power as compared to those women who self-identified as heterosexual. The self-identified bisexual women are identified when they are quoted to increase transparency. In terms of ethnicity, the majority self-identified as Caucasian and were between the ages of 15-21 (mean 18.22) (Table 1).

Table 1
Demographic Characteristics

	n
Ethnicity*	
Caucasian	13
Black	1
African Canadian	1
Jamaican Canadian	1
French	1
Polish	1
Métis	1
Spanish	1
Canadian/Mexican	1
Arabic	1
Country of Birth	
Canada	21
Somalia	1
Currently in school	
No	6
Yes	16
Employment status	
Full-time	6
Part-time	11
Don't work	5
Current sexual activity	
Yes	20
No	2
FAS scale score	<u>n (mean score)</u>
Low	3 (1.3)
Middle	12 (4.1)
High	7 (7.3)

*Ethnicity was self-defined and categories were not combined.

Girl Power

Young women alluded to the concept of girl power throughout the interviews in the way they claimed to express power within their heterosexual relationships. These expressions of power were classified into five broad themes: 1) Setting boundaries; 2) Getting what one wants; 3) Performing; 4) Contingent on male power; 5) Limited. These themes do not represent a complete understanding of girl power nor do they encapsulate all that girl power means to young women. They are simply the themes that arose from my conversations with the select sample of young women represented here.

Setting Boundaries

Setting boundaries centers on the idea that young women determine when sex happens, how it happens and within the parameters of their own choosing. The strongest aspect of this theme was "saying no". The majority of young women stated in some way that refusing their boyfriends' sexual advances indicated their power. Some young women stated that their ability to say no was their only power in their heterosexual relationship:

I didn't really have power in my relationship actually but uh, no just by being able to say no, that's my power (Nat, Canadian/white, female, 19, FAS=7);

I think that's basically the one word that describes like all the woman's power you know if she has the initiative or the determination to say no then she has all the power in the world (Ashley, Spaniard, female, 17, FAS=6).

Related to saying no was the concept of "withholding" sex. Withholding sex was distinguished from saying no as it was a purposeful decision by women to withhold sex from their partners to punish them or to achieve a desired outcome. Central to this aspect was the stereotypical idea that young men are focused only on sex. Thus, withholding sex was a central source of power for young women in their heterosexual relationships:

Like girls will withhold sex and that's how they express power cause guys are like such dogs like they're like bow down to like no we're not having sex as long as you don't like buy me this or like apologize you know what I mean it's the total opposite cause like you can't punish a guy with sex you have to take it away (Kelly, European, female, 18, FAS=8);

...girls can go you know sometimes without having sex and guys want it all the time and so we can use it as a weapon [laughs] so yeh I think girls have a little more power, yeh cause we can use it to our advantage you know what I mean (Amyah, Arabic, female, 19, FAS=4);

Um, girls express power [pause] um, I find that girls who are controlling they'll withhold sex or ah use it to get what they want or um something like that (Laura, Caucasian, bisexual, female, 20, FAS=4).

Saying no or withholding sex as a form of power was questioned by one young woman. For Stacey, saying no was not a power issue if the male partner in the relationship was a "good person" and was respectful of the woman's wishes. Stacey saw the use of saying no as a negative and manipulative form of power:

If she was trying to express power by saying no then yeh that's wrong.....because she's manipulating him and using power in a negative way (Stacey, Caucasian, female, 16, FAS=2).

Boundary setting was not represented as easy and often involved enforcing protective activities like condom use and establishing the parameters of certain sex acts. Some young women described certain sexual acts that they made clear they would not perform, such as anal or oral sex, while others spoke of waiting before having intercourse with their partners:

I only do things that I want to do, I don't do anything that I'm forced to do, I don't, I try my best not be conned into anything that I feel uncomfortable doing, that's my way of expressing power and I let it be know before I even get myself into that situation what I don or don't do, so that's my way (Tamica, Black, female, 19, FAS=5);

By defining like the outlines of the relationship just being like for example, saying they have to use condoms and if they, the guy says no then just not having sex with them because it's not worth the risk to yourself (Lynne, Caucasian, female 18, FAS=5);

You know wanting sex when she wants it not having sex when she doesn't want to have sex because of her own issues that's having control that's having power over the relationship (Gwyneth, Métis, female, 18, FAS=0).

Central to this theme was the concept of permission; the young women *allowed* sex to happen. The idea that permitting sex to happen represents a source of power for women has been questioned by some feminist researchers who claim that young women have conflated their needs with those of their male partners (Allen, 2003b; Holland, Ramazanoglu, Sharpe, & Thomson, 1998). While it is important to

recognize that women's choices are structured by the context of their heterosexual relationship and at a broader social level, it is not productive to suggest that women are completely powerless in negotiating heterosexual encounters. The young women here felt powerful, described ways in which they expressed power and, thus their power is acknowledged and not negated even when considering the impact of larger power structures.

Getting what one wants

Many young women equated power with getting what they wanted. The young women's methods of achieving their desired outcomes varied but all articulated that if their outcome were achieved it was an indication of their power. Some of these young women were self-defined "powerful women" and some described having "powerless" male partners. When asked how they knew if they had power, getting what they wanted was the key response:

How do I know if I have power in a relationship? I find myself doing a lot of things that I also enjoy to do or if I find myself, you know, actually enjoying the time we share together in bed um, how else would I have power, basically if I you know do what I want, how I want and when I want that would basically be it (Gwyenth, Métis, female, 18, FAS=0);

I always get what I want basically (Tamica, Black, female, 19, FAS=5).

It is interesting that while describing themselves as more dominant and powerful than their partners the young women simultaneously criticized dominant behaviour in men. Too much power or dominance and control were seen as negative expressions of power in young men and often signalled to the young women that these men were actually powerless. Some young women acknowledged that there was a different set of standards that governed appropriate expressions of power for men and women. One participant described these rules as unfair but justified because of men's tendency to abuse power:

It's like yeh you've got the power like good for you and if the guys got the power everyone is telling the girl to break up with him like you know what I mean like it just it sucks like I feel bad for guys in that sense but like I mean it's also their fault like they abuse their power most of the time (Kelly, European, female, 18, FAS=8);

I find any relationship I've seen where the man has all power it really like you feel bad for the woman but when the woman has the power you never feel bad for the man unless it is a bitch but that's not the type of power you're looking, we're talking about sexual power like yeh (Charlie, white, bisexual, female, 17, FAS=5).

While both of these participants spoke of the benefits to men of being with powerful women, Charlie specifically referenced sexual power. Her words emphasize the limits of women's power within heterosexual relationships and the fine line between being powerful and being a "bitch". Charlie alludes to the fact that a man would benefit from a woman who expressed power using sex but presumably would not benefit if she were powerful in other ways. Both young women's responses are evidence of the complexity of gendered power dynamics within heterosexual relationships and the need to extend the analysis of power beyond the pre-defined framework of male domination and female oppression.

Performing

The theme of performing encompasses those young women who stated that their power came from the exercise of their sexual abilities or from their adoption of powerful modes of self-representation. Performance is thus about projecting an image of control or about the ability to please one's male partner.

Some of the young women interviewed self-identified as powerful. Yet, they described being powerful as a role they performed. Portraying an image of a powerful woman, they explained, gave their male partners the impression that they were powerful and ensured that they could not be manipulated or taken advantage of:

I mean I have my insecurities but you can't let a guy see that cause he'll take advantage of you yeh.....um I kind of fake it, act like I'm confident, act like I know what I'm talking about even if I don't and um yeh, I just, yeh you just, it's the way you portray yourself (Amyah, white, female, 17, FAS=5).

Performing sexually in order to please one's partner was seen in two distinct ways. The first was expressing a desire for sex or initiating sexual activity as a form of power. Some young women explained that because guys "always wanted it" initiating sexual activity was a substantial source of power:

Um, by proving to the male that they're good....yeh good in bed yeh and it's weird because like I don't know like not just being on top like actually showing an interest gives a lot of power to the woman (Charlie, white, bisexual, female, 17, FAS=5);

I would say, trying [pause] because more girls would, you know, that you know, the guys like sex I would say more than girls in that way I would think the girl would try to you know bring on the sex instead of the guy so that the guy would think she is more powerful in the sexual relationship aspect (Amber, Polish/white, female, 17, FAS=4).

The second way that performing sexually was described included participating in explicit sexual acts or adopting sexual positions that signalled power. A small sample of the women interviewed here were open and vocal about this theme. They did not represent the majority:

Um, being on top just like how that my ex-man he didn't want me to be on top because I had more power and I was in control I think I enjoy being on top so I would that'd be it, it makes me feel more powerful, or giving head to a man even though it usually makes it seem like you're my bitch....but it's not really that because I am in control cause I am holding you or am I going to hold you and I am making you feel how I want to make you feel because I can do it and I'm better so I think giving head to a guy makes me powerful (Gwyneth, Métis, female, 18, FAS=0);

I feel powerful lately because.....him and I had sex the other day.....and like after I've never seen a male so exhausted right and like and that makes me feel so, so powerful in your relationship so like ever since then I kind of get his look from him sometimes where you like you feel like you've done it, like you've finally won you know....and that makes me feel very powerful like it makes me feel like I can do something you know like there's something out there for me as well (Charlie, white, bisexual, female, 17, FAS=5).

The idea that young women have falsely conflated power with sexual ability is widely cited in popular and academic literature (Levy, 2005; Baker, 2008). While in some cases the young women interviewed spoke of feeling powerful or expressing power by having confidence, by goal setting and by pursuing an education in addition to sexual related power, a few cited sexual ability as their only source of power. However, I note that the interviews did take place in a sexual health clinic and were focused on heterosexual relationships. Thus the young women's limited responses may have been influenced by this setting.

Contingent on male power

Girl power in many cases was contingent on the level of male power operating within the particular heterosexual relationship. Many young women commented that a girl could be powerful but not

if her partner was powerful. Young women often implicitly raised the idea of equity when they described their own power in a relationship. Equity was implicit in the young women's descriptions although the term equity was never used explicitly. Rather the young women interviewed used words like "equal" and "mutual" to describe an underlying sense of fairness in their heterosexual relationships. Young women who described their relationship as equal often stated that they did not have or did not exercise power because they perceived that an equitable relationship eliminated the need to have or to use power. In these instances, girl power operated when male partners allowed it to or when relationships were characterized as equitable and both partners defined as equals:

She could absolutely [decide when and how sex happened] but I mean like I said it's got to be a mutual understanding, you can't have the guy be powerful and have the girl make decisions like that (Jenny, Caucasian, female, 20, FAS=4);

Guys, I guess they're so used to being at like the position of power that some girls it's harder for them to portray the power they want so they usually just leave it to the guy and depending on the type of guy like some guys are easier to be powerful with and some guys it's out of the question (Tamica, Black, female, 19, FAS=5);

It's based on how the other person treats you, cause you can tell, yeh I guess how the other person treats you and how they, willing they are to, just like if you ask them a simple favour like how willing they are do that for you would yeh I guess would show that they see you as an equal I guess and would say that you have, that you have some power in what happens in your relationship and that they listen to your choices and your opinions on certain things that are going on between you (Allison Black/Jamaican, female, 20, FAS=5).

Some young women questioned the idea that men had more power or that male power governed the relationship. These young women acknowledged that perhaps they gave some of their power away or allowed male power to dominate. These statements can be seen as an attempt by young women to rationalize or justify inequity in their relationships by stating that they allow for or approve of the inequity (Baker, 2008). Alternatively, these expressions may be a form of resistance in that the young women are recognizing inequity while asserting that *they* allow this inequity to exist:

I think usually men do have more control but then maybe that's cause I let them have more control, I don't know (Gwyneth, Métis, female, 18, FAS=0);

I think girls they hand over some of their power yeh, well most of the time they probably hand over more power (Allison, Black/Jamaican, female, 20, FAS=5);

I don't know, I like, I never really, I think overall a lot of girls don't really try to have the power in the relationship I think, I think it's mostly the guys that take that so I don't know (Amber, Polish/white, female, 17, FAS=4).

Limited

Some young women described themselves as powerful and their relationships as equal but then acknowledged that at a broader societal level women's ability to exercise power was limited. Some stated that perhaps this situation existed because men and women were raised differently and were taught to use power in different ways. Others recognized that concrete positions of power occupied by Prime Ministers, Presidents and world leaders were most often held by males and that women still had important advances to make in this realm. These responses indicate that young women realize that the concept of girl power extends beyond the popular cultural image of a sexy and attractive heterosexual woman. These young women are aware that there are power sources and positions that they have yet to access:

I think guys like even now are totally like they have so much more power than women like I don't know what it is I just think it's like even like all our Prime Ministers and the Presidents have been women, I mean have been men, you know what I mean like even on that note like they've all been men like when you get high up it's really really rare to see like, like I'm an engineer and like I'm very much outnumbered by guys....yeh like men are definitely more powerful (Kelly, European/white, female, 18, FAS=8);

I don't know what it is, like just the way they're brought up or something I just think, it's like something all guys have it's just like a different type of, the way they think, it's just everything is just different, I don't know. There's some girls that are close but they're still different, yeh they're still not the same, at the same level as certain guys are (Tamica, Black, female, 19, FAS=5);

It's always been focused more on guys anyway you know now that women are coming up more to me personally it's going to change the women are going to be more...yeh, the women are still more powerful than the men it's just not as recognized cause it's the women (Leila, African/Canadian, female, 21, FAS=3).

These important passages acknowledge that young women have not been duped into thinking that their only source of power comes from their sexuality. Their words indicate that some young women realize that there is a broader system of inequitable gendered power dynamics operating in their lives. Recognizing the existence of these systems and the limitations they place on women's ability to exercise power may be the first step in challenging or resisting the status quo.

Discussion

Young women's efforts to gain power in their heterosexual relationships in some cases are limited by and contingent upon their male partners. They are also dependent upon the broader parameters of heterosexuality and gendered power dynamics. While the boundaries of girl power prescribed by the institution of compulsory heterosexuality are limited, young women were aware of these boundaries; they questioned and critiqued them. Some young women recognized that women had yet to achieve social and political positions of power. This recognition of the broader system of gendered power dynamics that are enforced within and through heterosexuality creates a critical awareness among these women that may encourage change.

In the language of feminism young women do appear to be *resisting* traditional notions of female oppression and certainly recognize that there are sources of power from which they are excluded. Evidence of their expressions of power are demonstrated by their ability to set boundaries within their relationships including determining when sex happens and the ability to ensure that their desired outcomes are achieved. Illustrations of young women exercising agency within the larger institution of compulsory heterosexuality have also been found in previous research (Allen, 2003; Allen, 2003b; Jackson & Cram, 2003; Kitzinger, 1995). In some cases when the young women studied here acknowledged their lack of power they justified it as something they allow to exist. For example, convention holds that in heterosexual relationships male sexual pleasure takes priority over female sexual pleasure. The young women affirmed this model but presented the prioritization of male pleasure as an active choice that they made. This also corroborates work by Holland and colleagues (1998) that young women have the "male in the head" meaning that young women take on male needs as their own.

The young women in Allen's (2003) study felt that they were exercising power by *choosing* to continue having sexual intercourse with their male partner even if they were not enjoying it as well as by choosing to make their male partner's pleasure a priority to the exclusion of their own. Philosopher Michel Foucault would classify this choice as "effective patriarchy" or disciplinary power in action, wherein women play a key role in their own subjugation without even realizing it (Allen, 2003). However, Allen (2003), argues that "...dismissing the exercise of power that young women describe as experiencing

around sexual negotiation in relationships runs the risk of ignoring the complexity with which heterosexual power operates (p.242)". Similar to Allen (2003), I claim that the experiences of power reported by young women in this dissertation need to be acknowledged and cannot be dismissed as a kind of false consciousness. Examples of the young women's expressions of power are found throughout their descriptions. Highlighting these expressions is an important contribution to the literature on young women's sexual health. Evidently, when the analysis of power within young women's relationships does not automatically begin with the assumption that young women are powerless, new insights can be gained.

The young women interviewed seemed to be aware of the imbalance in power between men and women in heterosexual relationships and some young women did articulate that women give away power or consented to the status quo. In some cases this consent did appear to serve their own happiness and, in some cases, the happiness of their partners. Swartz (2007) explains that power may not be as invisible as some may think; people tend to be very aware of their oppression yet consent to it to maintain a level of happiness or security. The level of young women's awareness of the power imbalances in their relationships is further evidence that they have not been "duped" but rather are conscious and even critical of these imbalances.

The finding that a central way in which young women expressed power was to set boundaries for acceptable behaviour in their heterosexual relationships confirms the work of Tolman and colleagues (2003). These researchers state that a consequence of girls being charged with managing male sexuality is that their own needs are seen as secondary. Public health prevention and sexual health education curricula often place young women in this gatekeeping role reinforcing the sexual double standard and notions of "good" and "bad" girls (Braun & Gavey, 1999). This finding has implications for sexual health promotion. Rather than reinforcing the gatekeeping role of young women, public health campaigns should encourage young men to take responsibility for their own health decisions and encourage young women to place primacy on their own needs within relationships. Given the strong societal pressures to be sexually active, the finding that young women are setting boundaries and saying no within their relationships is important. Further research should endeavour to understand the underlying reasons

behind these expressions of power and whether young women do perceive these expressions as undermining their own needs.

In spite of the assertion that they were powerful, some of the young women interviewed described being powerful as a performance. The notion of young women performing sexually for men has been raised by journalists reporting on issues of teen oral sex. It has been reported that young women see oral sex as a powerful act, performed for males (Wilson, 2004). Writers have also cited the recent rise in the mainstreaming of pornography as integral to the creation of an atmosphere of performance (Cooke, 2008; Levy, 2005). By teaching women that their power comes from sex, the idea of performance is inescapable. When performing young women may not be in tune to their own needs and desires in relationships and thus may be more likely to make choices that are not consistent with their needs. Further, the performance of power is troubling in that once the sexual performance is over, the power dissipates. This loss of power is evidenced by the “bad” girl, “good” girl double standard. Also troubling are the heterosexual boundaries within which these performances are deemed powerful and acceptable. The interplay between gender, heterosexuality and performance has also been described by Judith Butler (1990). Butler (1990) argues that the privileged position of heterosexuality within society is maintained by the performance of gender. In essence, the parameters of heterosexuality can only be reinforced by performing traditional expectations of gender. Thus, by performing sexually in their heterosexual relationships, young women reinforce traditional expectations of femininity within the heterosexual model. Further research should explore the links between young women’s sexual power and expressions of femininity in heterosexual relationships. It is possible that the traditional association of femininity with powerlessness does not resonate with young women and perhaps they see their sexual performance as feminine and, therefore, as powerful. Finally, issues of sexual orientation were not explored in the interviews despite the presence of bisexually identified women; this is a limitation. More research is needed to understand how bisexuality and power are related and whether patterns of gender, masculinity and femininity are similar as found within a heterosexual model.

Finally, some researchers have linked this idea of performance to poor sexual health outcomes for young women (Impett & Tolman, 2006). By performing sexually, young women may be more likely to

ignore, or be detached from, their own feelings and thus may be unable to protect themselves from sexual abuse, sexually transmitted infections or unplanned pregnancies. Young women must be encouraged to express their needs within their relationships and think critically about popularly packaged societal messaging that narrowly limits their possibilities for power and healthy sexual expression.

Some feminist writers have argued that the freedom to be sexually active is something that women have taken from men, and can thus be seen as a legitimate source of power (Machin & Thornborrow, 2006). Conversely, others assert that young women and men have conflated sexual liberation with liberation in the political and social sense (Frostrup, 2007; Levy, 2005; Sethna, 2008). However, I believe that while the young women interviewed do feel that sex is powerful, they do not always confuse this power with political and social liberation and recognize that there are other sources of power they have yet to access. Despite increasingly sexually liberalized behaviours for both young women and men, power is still embedded inequitably inside and outside heterosexual relationships, and it is this inequity that shapes outcomes, both positive and negative.

Limitations

There are three primary limitations of this work. First, as mentioned above the inclusion of bisexual women without probing the influence of their sexual identification on their opinions is a significant limitation. Due to the manner in which the interviews were completed the young women's self-identified sexual status was not known until after completion of the interview therefore, the issue of bisexuality could not be addressed in the interview. Since the notion of girl power is so intricately tied to heterosexuality is it possible that the young women who self-identified as bisexual may have differing views. How much their opinions are mediated by their participation and by their efforts to garner power in non-heterosexual activities is unknown. Future research should endeavour to explore these issues further.

Second, the term *girl power* was not used directly in the interviews and issues of girl power were not specifically questioned. The interviews focused broadly on expression of power within heterosexual relationships and the analysis focused on instances of girl power. I used this popular catch phrase as a

way to begin exploring some of the more complex issues at play in regard to the expression of young women's power in heterosexual relationships. In order to conduct a thorough investigation of girl power a more in-depth interview approach is needed.

Finally, the influence the participant's ethnicity and income on their ideas about power were not probed explicitly in the interviews. Participant quotes are given with demographic information to situate the individual. This issue is linked to the small, convenience based, sample which did not recruit participants purposefully according to specific demographics and to the data analysis methodology which was not concurrent with data collection. As a result, conclusions about the influence of ethnicity, for example, on girl power are not made although it is possible that young women from different ethnic and culture backgrounds have varying ideas on power with heterosexual relationships. Future research should purposefully sample young women from various ethnic backgrounds and adopt a grounded theory approach to data analysis in order to fully explore this issue.

Conclusion

In conclusion, girl power as represented by the *Spice Girls* requires that a young woman remain attractive, feminine and sexy to men (Lemish, 2003). The young women here acknowledge that these characteristics garner power but not unconditionally. It is important to acknowledge that sex is a source of power for women but it is the social and political value that is placed on this power in comparison to other sources of power that needs to be questioned. Thus the *redefinition* of girl power may also be a *revaluing* of girl power as young women do feel that sex is power but recognize the unfairness in their inability to access or exercise other forms of power with the same effect. Despite the seemingly popular embrace of girl power, significant advances for women in heterosexual relationships are needed. Moreover, it is possible that as young women, power in the form of sexual ability is perceived as positive because of the intense social messaging that reinforces this idea and the social rewards that accompany this type of power for those who have it. Further consciousness raising among young women is required to help young women recognize power sources that extend beyond sex while being careful to critique but not negate the ways in which they currently feel powerful (Siegel, 2007b). Awareness of the limits of

performing sexually as a sole source of power will increase young women's ability to resist and redefine their power in positive ways.

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Chapter 3

An examination of the social determinants of health, positive and negative sexual health outcomes
among heterosexual Canadian adolescents

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Abstract

Introduction

While health is generally seen as a positive and desirable state, sexual health is often associated with undesirable and negative outcomes. This paper takes a holistic view of sexual health which considers both positive and negative outcomes while placing emphasis on positive outcomes. The analysis will focus on whether adolescents experience positive sexual health outcomes within their heterosexual relationships and explore the associations between indicators of the social determinants of health and these outcomes.

Methods

A convenience sample of male and female adolescents who self-identified as heterosexual and were between the ages of 14 and 20 years were recruited to participate in this study. All participants completed a self-administered written survey. The survey included demographic information, questions on sexual behaviours, power, positive and negative sexual health outcomes.

Results

Score for males and females differed for many of the positive sexual health outcomes. Males scored higher on the measure of sexual self-efficacy ($p=0.011$). Young women reported a statistically significantly higher score for sexual communication and health protective communication as compared to males (0.048 , $p=0.009$; respectively). Median scores on the sexual satisfaction scale were equal for males and females ($p=0.370$). Few statistically significant results were seen when outcomes were compared across indicators of the social determinants of health.

Conclusions

This study highlights the presence of positive sexual health outcomes within adolescent relationships and the possible influence of some key social determinants of health indicators on adolescent sexual health. These findings add to the developing literature based on positive aspects of adolescent sexuality and to the literature on Canadian adolescent's sexual health.

Introduction

While health is generally seen as a positive and desirable state, sexual health is often associated with undesirable and negative outcomes such as, sexually transmitted infections (STIs), HIV infection, and unplanned pregnancy. Sexual health is equated with negative outcomes or with outcomes that one endeavours to avoid. Despite broad definitions of sexual health such as that offered by the World Health Organization (see box 1), research on positive sexual health outcomes is limited. We know little about whether young people's heterosexual relationships include positive aspects and about young peoples' experiences of positive outcomes.

Box 1: World Health Organization - Definition of Sexual Health

"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (World Health Organization, 2004, p.3)".

There has been an international call from the World Health Organization to sexual health programmers and practitioners to shift focus toward the broader concept of positive sexual health (World Health Organization, 2002). This shift is intended to increase our awareness of the complexity of adolescent sexuality while encompassing concerns over negative outcomes (Glasier, Gulmezoglu, Schmid, Moreno, & VanLook, 2006).

In the Canadian context, the majority of data on adolescent sexual health outcomes are focused on negative outcomes and risk reduction behaviours. National data from both the 1996 National Public Health Survey (NPHS), the 2003 Canadian Community Health Survey (CCHS), and the Canadian Association for Adolescent Health exists on rates of condom use, sexually transmitted infections, unplanned pregnancies, age of first intercourse and number of sexual partners (CAAH, 2006; Maticka-Tyndale, 2001; Statistics Canada, 2005). These data report both positive and negative trends. Generally, more adolescents report the use of condoms during intercourse, however, adolescents who report an earlier age of first intercourse are more likely to have multiple partners and more likely to report experiencing a sexually transmitted infection (Maticka-Tyndale, 2001; Statistics Canada, 2005). Overall, data from the 2003 CCHS reveals that approximately 4% of 15-24 year olds reported having been diagnosed with a sexually transmitted infection; this is most likely an underestimate due to the lack of symptoms for many sexually transmitted infections (Statistics Canada, 2005). Pregnancies among young women have declined steadily in Canada over the past 20 years however, the ratio of abortions to live

births among young women has remained stable giving an indication that the number of unplanned pregnancies is unchanged (Canadian Federation for Sexual Health, 2007).

In Canada, adolescents' health and sexual health outcomes often differ by their social position. One's social position can be described by the social determinants of health. The social determinants of health include one's income, education, ethnicity and gender and describe characteristics, often outside of one's personal control, that contribute to health and/or disease. The interplay between the social determinants of health and sexual health outcomes is an important yet understudied aspect of adolescent health in Canada. Data from the 2000/2001 CCHS indicates that adolescents' self-rated health varies by income group, 78% of adolescents in the highest income households (\$60,000-\$80,000 or more) reported very good or excellent health compared to 64% in the poorest households (\$30,000 or less). Further, adolescents from households where at least one parent had postsecondary education also reported their health to be very good or excellent significantly more often than adolescents from households in which parents are less educated (Tremblay, Dahinten, & Kohen, 2003). Research on sexual health specifically has shown that earlier initiation into sexual activity, riskier sexual practices, sexually transmitted infections, and adolescent pregnancies tend to be higher among youth in lower socioeconomic groups (Hardwick & Patychuk, 1999; Health Canada, 1999; Singh, Darroch, & Frost, 2001). In contrast, lower rates of early intercourse and teen pregnancy are found among adolescents not born in Canada versus those who are Canadian born (Singh et al., 2001). In Canada, lower education at the individual level is also associated with early sexual intercourse and lower rates of contraception use (Health Canada, 1999).

Canadian literature on any possible links between positive sexual health outcomes and the social determinants of health is limited. Researchers from British Columbia have begun to explore protective factors that may influence the practice of risk behaviours among adolescents (Saewyc et al., 2009). However, this research did not focus on sexual behaviours specifically, looked at protective factors rather than positive outcomes, and did not examine any of the social determinants of health. Research from the United States and the Caribbean reveals that education and scholastic achievement are linked to sexual abstinence, which is a positive outcome for many young people (Blum & Ireland, 2004; Chewing et al., 2001). Research from other settings has shown the importance of positive outcomes such as sexual satisfaction to overall well-being and to safer sex negotiation (Holland & Ramazanoglu, 1992; Rosen & Bachman, 2008). However, the links between these outcomes and indicators of the social determinants of health is lacking.

This chapter has two primary purposes: 1) to assess whether adolescents experience positive sexual health outcomes within their heterosexual relationships and; 2) to explore the associations between indicators of the social determinants of health, positive and negative sexual health outcomes among heterosexual adolescents.

Methods

A convenience sample of adolescents who self-identified as heterosexual and were between the ages of 14 and 20 years were recruited from an Ottawa urban sexual health clinic and from undergraduate classrooms at the University of Ottawa to participate in this study. At the sexual health clinic recruitment was done via information flyers posted in the clinic waiting room. At the university, I introduced the study to the class and referred them to the study information sheet and survey if they wished to participate. A convenience sample was employed to work within the parameters of the recruitment sites. The study protocol was approved by the ethical review boards of both the University of Ottawa and the City of Ottawa's Public Health Department.

Data collection

All participants completed a self-administered written survey. The survey included demographic information, questions on sexual behaviours, power, positive and negative sexual health outcomes.

Measures

As described, the sexual health literature is generally focused on negative sexual health outcomes and adverse events such as unplanned pregnancies and sexually transmitted infections. Researchers have begun to address this imbalance by focusing on positive sexual health outcomes and on factors that contribute to the achievement of positive sexual health among young people (Aggleton & Campbell, 2000; Horne & Zimmer-Gembeck, 2005; Robinson, Bockting, Rosser, Miner, & Coleman, 2002; Tolman, 1999; Tolman, Streipe, & Harmon, 2003). Despite this shift in focus, the literature on positive sexual health is sparse and measures designed to evaluate positive sexual health outcomes are lacking. Some factors linked to the achievement of positive sexual health among young people are: the ability to communicate needs and desires within a sexual relationship; the experience of physical and emotional satisfaction; the freedom from coercion and violence and; the ability to protect themselves from unwanted outcomes such as sexually transmitted infections. These general factors were used to guide a search of the literature to locate measures that could be used for this study. Three main criteria were used to screen measures: 1) whether the measure had a positive orientation

and measured a concept that has been shown to have positive implications for sexual health; 2) used gender neutral language; and 3) was contemporary in terms of language and concepts. The selected measures employed here are: sexual satisfaction, sexual self-efficacy, sexual assertiveness, condom use, health communication, and health protective communication. The primary rationale for the selection of these measures was that they met the three screening criteria above and had been previously used with an adolescent or young adult population. These measures are intended to give an overview of some of the factors that may contribute to positive sexual health. It is acknowledged that these measures do not represent an exhaustive inventory. Brief details on each of the measures are included below, for complete scale information see Appendix C.

Sexual satisfaction was measured using a four question score developed by Impett and Tolman (2006) for use with adolescent girls. Sexual satisfaction or sexual pleasure has been linked to positive outcomes such as emotional well-being and relationship satisfaction (Rosen & Bachmann, 2008). The questions were previously untested with young men. Questions asked whether participants felt that their most recent sexual experience was physically and emotionally satisfying and whether it made them feel closer to the person they were with. Possible responses were strongly agree, agree, disagree, strongly disagree and were dichotomized into agree (1 point) and disagree (0 points) for analysis. Possible scores ranged from 0 to 4 and items were summed for a total score with higher scores indicating more satisfaction.

Sexual self-efficacy: Sexual self-efficacy was measured using a subscale from Snell's Sexual Self-Concept Questionnaire (Snell, 2001). In previous research, scores on the sexual self-efficacy scale have been linked to condom and contraceptive use among young adults (Snell, 1998, 2001). The Snell's Sexual Self-Concept Questionnaire contains 20 five item subscales that can be used individually or together. Sexual self-efficacy is defined as "the belief that one has the ability to deal effectively with the sexual aspects of oneself" (Snell, 2001). Questions on this scale asked participants whether they felt they were able to cope with and deal with their own sexual needs and desires and ensure rewarding sexual experiences. Possible responses fell on a 5-point Likert scale which ranged from "this does not describe me" to "this totally describes me". Possible scores ranged from 0 to 4 and items were summed for a total score with higher scores indicating more self-efficacy.

Sexual assertiveness was also measured using a subscale from Snell's Sexual Self-Concept Questionnaire (Snell, 2001). Sexual assertiveness is defined as "the tendency to be assertive about the sexual aspects of one's life" (Snell, 2001). The ability to assert one's needs within a sexual relationship has important

implications for positive sexual health. Previous research has shown that young men are more able to assert their needs within sexual relationships, making this an important outcome particularly for women who are often characterized as passive (Rosenthal, Moore, & Flynn, 1991). Questions on this scale asked participants whether they were assertive or passive when it came to voicing their needs, desires and preferences within a sexual relationship. Possible responses fell on a 5-point Likert scale which ranged from "this does not describe me" to "this totally describes me". Possible scores ranged from 0 to 4 and items were summed for a total score with higher scores indicating more sexual assertiveness.

Sexual communication within one's sexual relationships, specifically about one's desires and preferences is seen as a key indicator of positive sexual health. This was measured using the Sexual Communication Scale from the Centre for AIDS Prevention Studies at the University of San Francisco (Dolcini, Coates, Catania, Kegeles, & Hauck, 1995). This scale includes 6 questions that ask participants whether they can comfortably discuss sexual matters, including likes and dislikes with their sexual partners. Possible responses ranged from strongly agree to strongly disagree on a 4-point Likert scale. Possible scores ranged from 6 to 24 and items were summed for total score with higher scores representing better communication.

Willingness to communicate with a sexual partner about protection from pregnancy and STIs has been linked to the use of contraceptives among adolescents (Ryan, Franzetta, Manlove, & Holcombe, 2007; Stone & Ingham, 2002). The Health Protective Communication Scale from the Centre for AIDS Prevention Studies at the University of San Francisco was used to measure communication related to protective behaviours (Van der Straten, Catania, & Pollack, 1998). Originally designed as a 10 item scale, six items were selected to narrow the focus for this population and to look specifically at communication related to sexual health including communication about previous partners, STIs and condoms. Possible responses ranged from strongly agree to strongly disagree on a 4-point Likert scale. Possible scores ranged from 6 to 24 and items were summed for a total score with higher scores representing better communication.

Sexual Behaviours & Negative Sexual Health Outcomes: Participants were asked which sexual behaviours they were currently engaged in which ranged from touching to oral sex to intercourse (Impett & Tolman, 2006). This range of behaviours was used to extend the literature which often focuses solely on heterosexual intercourse experience only. Questions on previous sexually transmitted infections, condom use, pregnancies and HIV tests were also included as measures of negative sexual health outcomes. For pregnancy,

hiv tests, and previous STIs each question had a yes, no, or I don't know response category. I don't know responses were categorized as missing variables for the analysis. For condom use participants could respond that they never used condoms, rarely used condoms, sometimes or always used condoms. Responses were categorized into consistent condom users (those who responded always) versus non-consistent users (those who responded never, rarely or sometimes) for analysis. Finally, participants were asked whether they had experienced physical violence or verbal abuse from their partner in the past year. Response options for these two questions were yes or no only. Experience of physical and verbal abuse is an important negative outcome which has broad implications for adolescent sexual health and is often overlooked in the study of adolescent relationships.

Social Determinants of Health: Participants were asked to provide basic sociodemographic information to give an indication of their social position. Participants were asked to self-define their ethnicity. These responses were then grouped into nine broad categories (Table 1). Ethnicity has been shown to be a key mediator of sexual health outcomes in research primarily from the United States (Singh et al., 2001). The participants in this study were predominately white and a minority were from non-white ethnic groups. Due to the limited diversity within the sample participants were grouped into "white" and "non-white" for analysis. It is recognized that this analysis is limited in that it masks individual difference between distinct ethnic groups.

Research on adolescent sexual health has also shown the importance of Canadian birth (immigration status) on outcomes in the Canadian context (Singh et al., 2001). To address this issue, participants also indicated whether they were born in Canada. For analysis those born in Canada were used as the reference group and compared to those not born in Canada.

Participants were then asked to describe who they currently lived with. For analysis participants who currently lived with both parents were used as the reference category and compared to those living in other parenting arrangements or outside of the parental home. This grouping recognizes the importance of joint parental support on adolescent health outcomes (Boyce, King, & Roche, 2008).

Income or socioeconomic status has been shown to be related to sexual health outcomes among adolescents. Since adolescent's socioeconomic status is often directly related to parental or familial socioeconomic status a series of questions were used to assess this indicator: perception of wealth and maternal education. Participants were asked to provide the highest level of education that their mothers had completed.

Maternal education is known to be a good approximation of socioeconomic status (Bradley & Corwyn, 2002; Desai & Alva, 1998; Pueyo, Serra-Sutton, Alonso, Starfield, & Rajmil, 2007). Mothers with postsecondary education (university or college) were used as the reference category and compared to those without postsecondary education (elementary, junior high, high school).

Participants were asked if they considered their families wealthy, middle class or poor. This indicator is important because it is assessing adolescent's own perception of their family's wealth (Boyce et al., 2008). Income is related to various positive and negative health outcomes among adolescents (Hanson & Chen, 2007; Phipps & Lethbridge, 2006). Those who rated their families as wealthy were used as the reference category and were compared to those who considered themselves middle class or poor for analysis; "I don't know" responses were categorized as missing variables.

School attendance and performance have been shown to be important indicators of adolescent social position and health outcomes (Koivusilta, Rimpela, & Kautiainen, 2006). These indicators are also important because they involve the provision of personal information rather than information about a parental figure. Participants were asked to provide their current grade average using the following possible responses A (80-100%), B (70-79%), C (60-69%), D (50-59%), F (0-49%). For grade average, participants in the highest category (A) were used as the reference category for analysis. Finally, all results are presented separately for males and females and outcomes for males and females are compared to recognize gender as a determinant of health.

Data Analysis

Analysis was completed using SPSS (version 16.0). Descriptive statistics (means, medians, standard deviations, percentages) are reported for all variables where appropriate. Cronbach alpha statistics are calculated to give an indication of the internal consistency/reliability of all scales with this particular sample. Demographic characteristics were compared for those participants from the university and those participants from the clinic setting to ensure pooled data analysis was justified. Continuous variables normally distributed are compared by the various indicators of the social determinants of health with a Student's t-test; a non-parametric approach (Mann-Whitney) is used otherwise. Dichotomous variables are compared using a chi-square or Fisher's exact test.

Results

A total of 353 females and 101 males participated in the survey phase of the study. For those participants who were not sexually active, many of the survey questions were not applicable to their experience and as a result there was a high percentage of missing values among these participants. Due to this issue, only those participants who stated that they had been sexually active in the past 12 months were included in the analysis (females $n=254$ (71.9%); males $n=75$ (74.2%)). The mean age of both males and females was 19 years (Table 1). With the exception of age and ethnicity for females, there were no statistically significant demographic differences between the participants from the two recruitment sites. In terms of age, the clinic captured younger women and seemed to capture more young women who fell into the "non-white" ethnic category. Due to the similarities across all other demographic variables, groups were combined for analysis. The internal consistency reliability of all scaled variables was tested using the Cronbach alpha statistic. All scales showed acceptable internal consistency reliability for both sexes (Table 2). Convention states that the alpha statistic should be above 0.70 but values higher than 0.90 may indicate that some items on the scale are redundant (Streiner & Norman, 2003).

Table 1
Demographic characteristics

	Males (N=75)	Females (N=254)
Variables	n (%)	n (%)
ETHNICITY		
White	61 (81.3)	188 (74.0)
European	4 (5.3)	7 (2.8)
Asian	0	13 (5.1)
South Asian	3 (4.0)	5 (2.0)
Black	1 (1.3)	18 (7.1)
Middle Eastern	4 (5.3)	4 (1.6)
First Nations/Métis	0	6 (2.4)
Latina	0	7 (2.8)
Mixed ethnicity	1 (1.3)	4 (1.6)
BORN IN CANADA		
Yes	62 (82.7)	220 (87.0)
CURRENTLY IN SCHOOL		
Yes	64 (86.5)	221 (88.8)
LIVING SITUATION		
Both parents	24 (33.8)	78 (36.0)
University residence	8 (10.8)	53 (21.5)
Roommates	22 (29.7)	47 (19.0)
Parent & step-parent	6 (8.1)	9 (3.6)
Mother only	4 (5.4)	25 (10.1)
Father only	0	5 (2.0)
Girlfriend/boyfriend	4 (5.4)	12 (4.9)
Alone	1 (1.4)	11 (4.5)
SEXUAL BEHAVIOURS		
Kissing	72 (97.3)	245 (97.6)
Touching/Being touched clothes on	72 (96.0)	241 (96.0)
Touching/Being touched no clothes	71 (94.7)	233 (92.8)
Give oral sex to a male	3 (4.0)	216 (86.1)
Give oral sex to a female	66 (88.0)	29 (11.6)
Receive oral sex from a male	3 (4.0)	206 (82.1)
Receive oral sex from a female	69 (92.0)	29 (11.6)
Vaginal intercourse	69 (92.0)	232 (92.4)
Anal intercourse	8 (10.7)	40 (15.9)
CURRENTLY USE BIRTH CONTROL		
Yes	41 (58.6)	166 (66.7)
TYPE OF BIRTH CONTROL		
Pill	14 (33.3)	136 (80.0)
Condom	27 (64.3)	23 (13.5)
Injection	0	5 (2.9)
Other	1 (2.4)	6 (3.5)

Table 2
Cronbach Alphas for Scaled Variables

	Males (N=75)	Females (N=254)
Scale	Alpha (n)	Alpha (n)
Sexual satisfaction, last experience	0.771 (70)	0.886 (238)
Sexual self-efficacy, overall	0.910 (67)	0.931 (236)
Sexual assertiveness, overall	0.735 (66)	0.798 (235)
Sexual communication, current/recent relationship	0.713 (68)	0.745 (244)
Health protective communication, past year	0.789 (67)	0.845 (238)

Scores for males and females differed for many of the positive sexual health outcomes (Table 3). For the sexual self-efficacy scale, the median score was significantly higher for males than females ($p=0.011$). This result was in the expected direction in that males are seen to be more able to assert themselves within sexual relationships. Young women reported a statistically higher score for sexual communication and health protective communication as compared to males ($p=0.048$, $p=0.009$; respectively). Overall, young men were less likely to communicate within relationships either about protection and risk or about their own sexual likes and dislikes.

Median scores on the sexual satisfaction scale were equal for males and females ($p=0.370$). This scale was composed of four questions which asked whether or not one's most recent sexual experience made them happy, was a good experience, made his/her body feel good and, made them feel closer to his/her partner. The median score for both males and females was the highest possible score on the scale and thus both groups are reporting high levels of sexual satisfaction which is a positive finding, particularly for young women.

When scores on the various sexual health measures were compared across indicators of the social determinants of health again results were different for males and females (Table 4a, 4b, 5a, 5b). No statistically different scores were found for males when the negative sexual health outcomes were examined by indicators of the social determinants of health. Only one statistically significant difference was found when the positive outcomes were examined. Scores on the sexual assertiveness scale were statistically higher for males in the wealthy reference category (Table 4b). When scores for females were compared by high and low grade point average statistically significant differences were seen across three negative sexual health outcomes, namely, previous STI, previous pregnancy and previous HIV test (Table 5a). For females, no statistically different scores were seen for the positive sexual health outcomes when compared by indicators of the social determinants of health.

Table 3
Positive and Negative Sexual Health Outcomes by Gender

	Males (N=75)	Females (N=254)	
Sexual Health Outcome	Median (range*)	Median (range*)	p value
Health protective communication, last year	12.0 (8, 15)	14.0 (10, 18)	0.009^
Sexual communication, current/recent relationship	19.0 (17, 20)	20.0 (17.25, 22)	0.048^^
Sexual satisfaction, last experience	4.0 (4, 4)	4.0 (4, 4)	0.370
Sexual self-efficacy, overall	3.4 (2.4, 4)	3.0 (2, 3.8)	0.011^
Sexual assertiveness, overall	2.4 (1.8, 3.1)	2.6 (2, 3.4)	0.168
Condom use, last intercourse	n (%)	n (%)	p value
Never	9 (13.4)	45 (19.9)	0.314
Some of the time	16 (23.9)	65 (28.8)	
Most of the time	24 (35.8)	58 (25.7)	
All of the time	18 (26.9)	58 (25.7)	
STI diagnosis, past year			
Yes	4 (6.0)	25 (10.1)	0.352
No	63 (94.0)	222 (89.9)	
HIV test, past year			
Yes	14 (19.7)	90 (35.9)	0.010†
No	57 (80.3)	161 (64.1)	
You/partner ever been pregnant			
Yes	4 (5.7)	31 (12.6)	0.131
No	66 (94.3)	215 (87.4)	
Experience of physical violence, past year			
Yes	14 (19.7)	20 (8.0)	0.008†
No	57 (80.3)	231 (92.0)	
Experience of verbal abuse, past year			
Yes	18 (25.4)	60 (23.9)	0.875
No	53 (74.6)	191 (76.1)	

* Range is reported as interquartile range
[^] Statistically different score, Mann-Whitney U test
^{^^} Statistically different score, Student's t-test
⁺ Statistically different score, Fisher's exact test

Table 4a
Positive Sexual Health Outcomes by Indicators of the Social Determinants of Health – **Females**

	Health Protective Communication, past year	Sexual Communication, recent relationship	Satisfaction, most recent relationship	Self-efficacy, overall	Assertiveness, overall					
	Median (range*)	p	Median (range)	p	Median (range)	p				
ETHNICITY										
White	14 (10, 18)	0.743	12 (17, 22)	0.224	4 (4, 4)	0.324	3 (2, 3.8)	0.970	2.6 (2, 3.4)	0.776
Non-white	15 (10, 18)		9 (18, 22)		4 (3, 4)		3 (2, 3.8)		2.8 (2, 3.4)	
COUNTRY OF BIRTH										
Canada	14 (10, 18)	0.275	12 (17, 22)	0.893	4 (4, 4)	0.315	3 (2, 3.8)	0.374	2.6 (2, 3.4)	0.260
Outside Canada	12.5 (8.25, 16)		9 (17.25, 22)		4 (2, 4)		3 (1.45, 3.75)		2.3 (1.65, 3.4)	
LIVING SITUATION										
Both parents	13 (10, 19)	0.724	9 (18, 21.5)	0.410	4 (4, 4)	0.348	3 (2.15, 3.8)	0.495	2.8 (2, 3.5)	0.061
Others	14 (9.75, 18)		12 (17, 22)		4 (3, 4)		3 (2, 3.8)		2.5 (2, 3.27)	
GRADE POINT AVERAGE										
High	13.5 (8.75, 18)	0.575	20 (18, 22)	0.462	4 (4, 4)	0.349	3 (2, 3.6)	0.814	2.4 (1.8, 3.4)	0.690
Low	14 (10, 18)		19 (18, 22)		4 (4, 4)		3 (2, 3.8)		2.6 (2, 3.4)	
PERCEIVED WEALTH										
Wealthy	13 (9, 21)	1.0	19.5 (17, 21)	0.575	4 (4, 4)	0.094	2.8 (2, 3.15)	0.136	2.3 (1.8, 3.3)	0.277
Middle/poor	14 (10, 18)		20 (17, 22)		4 (3, 4)		3 (2, 3.8)		2.6 (2, 3.4)	
MATERNAL EDUCATION										
Post-secondary	14 (10, 18)	0.634	19 (17, 21)	0.110	4 (4, 4)	0.849	3 (2.2, 3.6)	0.919	2.6 (2, 3.4)	0.350
Low	14 (9.75, 18)		20 (18, 23)		4 (3.25, 4)		3 (2, 4)		2.8 (1.8, 3.6)	

* Range reported as interquartile range. All differences were tested using a Mann-Whitney U test except for Sexual Communication which was tested using a students t-test.

Table 4b
Positive Sexual Health Outcomes by Indicators of the Social Determinants of Health – **Males**

	Health Protective Communication, past year		Sexual Communication, recent relationship		Satisfaction, most recent relationship		Self-efficacy, overall		Assertiveness, overall	
	Median (range*)	p	Median (range)	p	Median (range)	p	Median (range)	p	Median (range)	p
ETHNICITY										
White	12 (8, 14.5)	0.384	11 (17, 20)	0.531	4 (4, 4)	0.959	3.2 (2.4, 4)	0.139	2.6 (1.8, 3.2)	0.992
Non-white	14 (9.75, 19)		9 (16, 22)		4 (3.25, 4)		3.8 (3.4, 4)		2.4 (2, 2.6)	
COUNTRY OF BIRTH										
Canada	12 (8, 15)	0.681	11 (17, 20)	0.500	4 (4, 4)	0.134	3.3 (2.4, 4)	0.226	2.6 (1.7, 3)	0.361
Outside Canada	11.5 (8.75, 17)		10 (16, 22)		4 (2, 4)		3.7 (3, 4)		2.4 (2, 3.4)	
LIVING SITUATION										
Both parents	13 (10, 16)	0.148	10 (17, 21.5)	0.400	4 (3, 4)	0.389	3.4 (2.85, 4)	0.497	2.6 (1.75, 3)	0.974
Others	14 (9.75, 18)		12 (17, 22)		4 (3, 4)		3 (2, 3.8)		2.5 (2, 3.27)	
GRADE POINT AVERAGE										
High	11 (8, 17)	0.885	19 (17.5, 22)	0.275	4 (4, 4)	0.757	3.5 (3, 4)	0.357	2.6 (2, 3.4)	0.396
Low	12 (9, 15)		19 (17, 20)		4 (3.75, 4)		3.2 (2.4, 4)		2.2 (1.7, 3)	
PERCEIVED WEALTH										
Wealthy	11.5 (9.5, 16)	0.598	20 (18, 20)	0.366	4 (4, 4)	0.543	3.4 (2.4, 4)	0.535	2.8 (2, 3.6)	0.032 [^]
Middle/poor	12 (8, 15.5)		18.5 (16, 21)		4 (4, 4)		3.3 (2.4, 4)		2.2 (1.8, 3)	
MATERNAL EDUCATION										
Post-secondary	12 (9, 16)	0.478	19 (17, 21)	0.468	4 (4, 4)	0.407	3.4 (3, 4)	0.309	2.3 (1.8, 3.2)	0.891
Low	11 (8, 15)		18 (17, 20)		4 (4, 4)		3.2 (2, 4)		2.3 (1.9, 3)	

* Range reported as interquartile range. All differences were tested using a Mann-Whitney U test except for Sexual Communication which was tested using a students t-test.

[^] Statistically different score, Mann-Whitney U test

Table 5a
Negative Sexual Health Outcomes by Indicators of the Social Determinants of Health – **Females***

	STI, Past year		Pregnancy, previous experience		HIV test, past year		Condom use, past year		Physical abuse, past year		Verbal abuse, past year	
	n (%)	p	n (%)	p	n (%)	p	n (%)	p	n (%)	p	n (%)	p
ETHNICITY												
White	19 (10)	0.803	20 (10.5)	0.069	70 (36.1)	1.0	48 (27)	0.459	16 (8.2)	1.0	44 (22.7)	0.378
Non-white	6 (11)		11 (20)		20 (35.7)		10 (20.8)		4 (7.1)		16 (28.6)	
COUNTRY OF BIRTH												
Canada	24 (11)	0.217	26 (12.2)	0.572	80 (36.9)	0.561	50 (25.4)	1.0	18 (8.3)	1.0	51 (23.2)	0.663
Outside Canada	1 (3.1)		5 (15.6)		10 (30.3)		7 (25)		2 (6.1)		9 (27.3)	
LIVING SITUATION												
Both parents	10 (13.2)	0.354	4 (5.4)	0.075	33 (43.4)	0.112	21 (30.8)	0.318	5 (6.6)	1.0	18 (23.7)	1.0
Others	14 (8.5)		23 (13.9)		54 (32.1)		36 (23.6)		13 (7.7)		40 (23.8)	
GRADE POINT AVERAGE												
High	4 (6)	<0.001 ⁺	4 (6)	<0.001 ⁺	27 (40.3)	0.022 ⁺	18 (29)	0.723 [^]	5 (7.5)	0.195	16 (23.9)	0.490 [^]
Low	11 (7.3)		11 (7.4)		46 (30.1)		33 (24)		10 (6.5)		34 (22.2)	
PERCEIVED WEALTH												
Wealthy	1 (3)	0.334	5 (15.2)	0.563	13 (39)	0.701	8 (26)	1.0	2 (6.1)	1.0	7 (21.2)	0.829
Middle/poor	23 (11)		24 (11.4)		77 (35.8)		50 (25.7)		16 (7.4)		51 (23.7)	
MATERNAL EDUCATION												
Post-secondary	19 (11.6)	0.498	16 (9.7)	0.132	61 (36.7)	0.561	43 (28.6)	0.236	10 (6)	0.122	36 (21.7)	0.738
Low	6 (8.1)		12 (16.7)		24 (32.4)		13 (20)		9 (12.2)		18 (24.3)	

* Reports only percent (%) and number (n) who responded "yes". All p values are Fisher exact test results except where noted with a ^ which are non-significant Chi-square values.

⁺ Statistically different score, Chi-square test

Table 5b
Negative Sexual Health Outcomes by Indicators of the Social Determinants of Health – Males*

	STI, Past year		Pregnancy, previous experience		HIV test, past year		Condom use, past year		Physical abuse, past year		Verbal abuse, past year	
	n (%)	p	n (%)	p	n (%)	p	n (%)	p	n (%)	p	n (%)	p
ETHNICITY												
White	4 (6.6)	1.0	3 (4.7)	0.350	12 (18.8)	0.618	17 (28)	0.665	13 (20.3)	1.0	16 (25)	1.0
Non-white	0		1 (14.3)		2 (28.6)		1 (14.3)		1 (14.3)		2 (28.6)	
COUNTRY OF BIRTH												
Canada	4 (7.4)	0.579	3 (5.3)	0.569	11 (19)	0.711	16 (29.6)	0.488	12 (20.7)	1.0	15 (25.9)	1.0
Outside Canada	0		1 (7.7)		3 (23.1)		2 (15.4)		2 (15.4)		3 (23.1)	
LIVING SITUATION												
Both parents	1 (4.3)	1.0	1 (4.5)	1.0	4 (17.4)	1.0	34 (77)	0.257	6 (26.1)	0.525	7 (30.4)	0.554
Others	14 (8.5)		23 (13.9)		54 (32.1)		36 (23.6)		13 (7.7)		40 (23.8)	
GRADE POINT AVERAGE												
High	1 (5.2)	0.708 [^]	1 (5)	0.068 [^]	5 (25)	0.335 [^]	7 (35)	0.616 [^]	5 (25)	0.335	6 (30)	0.241 [^]
Low	11 (7.3)		11 (7.4)		46 (30.1)		33 (24)		10 (6.5)		34 (22.2)	
PERCEIVED WEALTH												
Wealthy	1 (6.7)	1.0	1 (6.7)	1.0	2 (13.3)	0.718	3 (20)	0.742	4 (26.7)	0.480	4 (26.7)	1.0
Middle/poor	3 (5.8)		3 (5.5)		12 (21.8)		15 (29.4)		10 (18.2)		14 (25.5)	
MATERNAL EDUCATION												
Post-secondary	2 (4.4)	0.581	2 (4.2)	0.575	11 (22.9)	0.561	14 (30.4)	0.233	9 (18.8)	0.747	13 (27.1)	1.0
Low	2 (10)		2 (10)		3 (14.3)		3 (15)		5 (23.8)		5 (23.8)	

* Reports only percent (%) and number (n) who responded "yes". All p values are Fisher exact test results except where noted with a ^ which are non-significant Chi-square values.

Discussion

This study describes both positive and negative sexual health outcomes among a sample of heterosexual adolescents. Overall, I found a high degree of positive outcomes among this sample. This study highlighted the presence of positive sexual health outcomes within adolescent relationships and the possible influence of some key social determinants of health indicators on adolescent sexual health. These findings add to the developing literature base on positive aspects of adolescent sexuality (Blum & Ireland, 2004; Russell, 2005; Smiler, 2008; Tolman, 2006; Tolman et al., 2003) and to the literature on Canadian adolescent's sexual health.

Young men were less likely than young women to report communicating within their relationships. Young men communicated less about risks and protection and less about their likes and dislikes within their relationships. Positively, young women reported high levels of communication including the ability to communicate their likes and dislikes within their sexual relationships. The finding supports research that reveals that young men are less comfortable discussing contraception before intercourse and are less likely than young women to do so (Gahagan & Rehman, 2004; Ryan et al., 2007; Troth & Peterson, 2000). Young women seem to bear most of the responsibility for communicating about risk and protection. Communication regarding condom and contraceptive use is a key factor in the adoption of these methods for safer sex among heterosexual youth (Stone & Ingram, 2007; Wight, 1992). Moreover, the males in this study scored lower on the selected communication measures as compared to previous American samples (Catania, 1998; Dolicini et al., 1995). This may in part be due to the fact that the males in this study were slightly younger than those in previous research studies.

Persistent gender norms indicate that young men have a sense of entitlement to sexual experiences (Dixon-Mueller, 1993). These norms may explain why young men's scores on the sexual self-efficacy scale were statistically higher than young women's. However, statistically significant differences were also seen between young men and women on reports of an experience of physical violence in the past year. Gender norms position young men as the perpetrators of dating violence and women as the victims of this violence. However, in this sample a significantly higher percentage of young men reported an experience of physical violence in the past year as compared to young women. Previous research has generally documented equal reports of violence by young men and women (Halpern, Osiak, Young, Martin, & Kupper, 2001). Others have noted that young women

are more likely to report perpetrating violence than being victims of violence (O'Leary, Slep, Avery-Leaf, & Cascardi, 2008). It is possible that an experience of violence from a female partner is particularly salient for young men because this behaviour falls outside traditional norms of femininity. While this may explain the higher rates of violence reported by young men it does not undermine the importance of attending to issues of violence among both young men and women. Sexual health practitioners need to be aware of, and question, persistent gender norms when treating young male and female clients to ensure that outcomes that are traditionally associated with one group are not missed in another.

Reports of a HIV test in the past year also revealed statistically different results between males and females. In this sample, higher proportions of young women reported a previous HIV test. This may be indicative of the fact that young women access sexual health services more often than their male peers (Flicker, Flynn, Larkin, Travers, Guta, et al., 2009) and thus have more opportunity to be tested. However, young women are also often placed in a 'gatekeeping' role for their own and for male sexual health and thus they may be being offered more HIV tests as a result of this persistent gender norm.

In part because of persistent gender norms and norms about adolescent sexuality there is very little data on outcomes such as pleasure and satisfaction among adolescents. For young women particularly, gender norms about their sexuality have created an environment in which discussions of desire and pleasure are consistently absent (Dixon-Mueller, 1993; Fine & McClelland, 2006; Tolman & Szalacha, 1999). The inclusion of a measure of sexual satisfaction for both young women and men represents an important contribution of this study. As is the finding that both young men and women reported high levels of sexual satisfaction at their last sexual experience. Whether levels of sexual satisfaction and other positive outcomes mediate or limit the experience of negative sexual health outcomes is a question that demands further investigation.

The analysis of an adolescent's social position as determined by various indicators of the social determinants of health did not result in many statistically significant results. However, for young women we did see a confirmation of the research that highlights the importance of educational performance for sexual health outcomes (Blum & Ireland, 2004; Churning et al., 2001). More young women in the low grade point average group reported a previous experience of a pregnancy or a STI. In contrast, more young women in the high grade point average group reported an HIV test in the past year. This finding may indicate that women with higher educational performance (as measured by grade point average) seek out sexual health services at a

greater rate. For both young men and young women a pattern was evident that suggest that perceived wealth has an impact on positive outcomes. For young men, those in the wealthy reference group had statistically higher scores on the sexual assertiveness scale. For young women results for sexual satisfaction and sexual self-efficacy, while not statistically significant point to a possible influence of perceived wealth on outcomes. For young women we also see a trend towards higher reports of pregnancy and physical violence among young women whose mothers have less than post-secondary education. Again these results were not statistically significant but point to important areas for future inquiry.

This study had three main limitations. First, the rates of negative outcomes in this sample were low. For example, only 16% of the sample reported a previous diagnosis of a sexually transmitted infection and less than 20% reported having ever been pregnant. These rates were even lower when participants were grouped by indicators of the social determinants of health. One possible reason for these low rates is the way in which sexually active was defined in the study. Participants self-defined whether they were sexually active based on a range of activities. While the majority of the participants had engaged in activities that could have placed them at risk for negative outcomes such as STIs and pregnancy, some had not. Thus, the rates of negative outcomes may be low as a result of this broad self-defined inclusion criterion. As a result, the sample size for those with negative outcomes may be too small to find a meaningful association. However, allowing adolescents to self-define whether they were sexually active by a range of activities reveals the complexity of their understandings of sexual activity.

Related to the sample size issues is the convenience nature of the sample. Because participants self-selected and the sample strategy was non-random results may not be generalizable beyond this sample. Finally, the sites of recruitment may also limit the generalizability of the results as the participants at the sites may not be representative of Canadian adolescents. Although the demographics of the participants from the two separate recruitment sites were similar those who were recruited from the sexual health clinic and the university may be distinct in ways not examined.

Second, although research on positive sexual health is limited, where possible I employed existing measures to add to the literature base and to permit direct comparisons. Some of the scales used were previously untested with a male sample although all showed good internal consistency reliability as measured by

the Cronbach's alpha statistic. Future research should endeavour to refine and validate these scales with a larger male sample.

Third, the survey instrument relied on self-report and thus may be susceptible to bias especially recall or social desirability bias. In particular, the results on the sexual satisfaction scale, which were all very high, may represent a ceiling effect due to a social desirability bias or the positive orientation of the questions. There is also a lack of data on sexual satisfaction so it is unclear whether this ceiling effect for this score represents a true picture of the outcome. Previous research on the satisfaction scale with young women revealed results that were less positive with only 34% of young women affirming all four items on the scale (Impett & Tolman, 2006). However, the participants in Impett & Tolman's (2006) study were younger than those in this study and were less sexually experienced. Further research is needed to examine the issue of sexual satisfaction with a mixed sex sample.

Conclusion

Discussing positive sexual health factors may be an important way in which to engage youth positively around issues of sexual health and safer sexual behaviours. Researchers have consistently outlined gaps in sexual health education created by the focus on negative outcomes (Connell, 2005; Ingram, 2005). Connell (2005) notes that the inclusion of positive aspects of sexuality in education may help to bridge the knowledge-practice gap between what young people learn and what they experience. Protective factors, like risk, have been shown to have cumulative effects for young people (Blum & Ireland, 2004). The presence of multiple positive sexual health outcomes is thus a positive finding for this group. Further investigation is needed to determine if these positive factors have a real effect on reducing risk and negative outcomes. Finally, practitioners working with young people need to attend to issues of social position and gender. These findings illustrate that sexual health information and promotion for adolescents may need to be tailored to specific groups including adolescents from different socioeconomic groups and genders. Traditional sexual health promotion campaigns often rely on outdated ideas about masculinity and femininity which may decrease the effectiveness of these campaigns because they do not resonate with adolescents' real-life experiences (Larkin, Andrews, & Mitchell, 2006). Sexual health promotion campaigns that also fail to acknowledge the differing social positions of youth and the possibility that these positions create different information needs may also similarly

fail. More research is needed to improve our understanding of the overlapping influence of gender and other social determinants of health on both positive and negative sexual health outcomes for Canadian adolescents.

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Chapter 4

Power and sexual health: Exploring positive sexual health outcomes and power among heterosexual adolescents.

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Abstract

Purpose: To investigate the interrelated issues of relationship power, the social determinants of health and sexual health outcomes among a sample of sexually active heterosexual adolescents. Sexual health is approached from a holistic perspective that considers both positive and negative outcomes while emphasising the positive.

Methods: A cross-sectional self-administered survey was employed to explore the variables of relationship power, sexual health and the social determinants of health. Descriptive statistics and regression analyses were conducted to explore associations between the variables of interest.

Results: 254 sexually active females and 75 sexually active males participated in this study. Regression analyses revealed that for both males and females an experience of physical or verbal abuse in the past year was negatively associated with scores on the relationship power scale and communication was positively associated with scores on the relationship power scale. For males sexual assertiveness was negatively associated with scores on the relationship power scale. For females, sexual satisfaction, sexual self-efficacy and sexual assertiveness were positively associated with scores on the relationship power scale.

Conclusions: The results reveal the complex associations between relationship power, sexual health and gender among a sample of heterosexual adolescents. The findings challenge existing stereotypes about males and females within sexual relationships that demand further investigation. In particular, the negative association between sexual assertiveness and scores on the relationship power scale among young men challenges common societal conceptions of male power as primarily dominant within sexual relationships. Shifting the focus away from negative sexual health outcomes to a more holistic view of sexual health and incorporating a gender analysis may improve our understanding of adolescent sexual health substantially.

Introduction

The study of power within sexual relationships is often focused on an individual's lack of power within her/his relationship and the resultant negative outcomes. In the study of HIV infection, important advances have been made regarding the influence of power as a social and structural phenomenon on sexual health outcomes, on violence within relationships and on unwanted pregnancies (Blanc, 2001). Missing is the link between power and positive outcomes such as sexual communication, sexual satisfaction and self-efficacy within a sexual relationship. This chapter will explore the associations between positive and negative sexual health outcomes and power while taking into consideration the social determinants of health within a sample of heterosexual Canadian adolescents.

As Tolman (1999) states, positive sexual health includes the experience of intimacy, meaningful relationships, love and safety and is more than just avoidance of sexual intercourse and negative sexual health outcomes. One of the goals of this dissertation is to increase our understanding of the positive aspects of sexual health by adopting a more holistic perspective on sexual health. This perspective may provide further insight into improving sexual health for adolescents. Therefore, this dissertation includes an explicit focus on positive sexual health outcomes while also considering negative sexual health outcomes.

Power is conceptualized as a key aspect of positive and negative sexual health outcomes. Within heterosexual relationships, power interacts with gender to create, in most cases, inequities. An inequity in power can be defined as a case in which one individual has more power than the other in the relationship and this is seen as unjust or unfair (Evans, Whitehead, Diderichsen, & Wirth, 2001). In heterosexual relationships, power differences based solely on one's gender certainly adhere to this definition.

However, in this chapter power is conceptualized as a shared, equitable component of a heterosexual relationship, such that power becomes a positive concept. The majority of the research in sexual health has focused on lack of power among specific groups, namely women, or on power inequities. Inequities in power have been consistently shown to interact with the social determinants of health, such as gender, ethnicity, income, and education to increase or decrease risk of negative outcomes (Sionean et al., 2002; Wingood & DiClemente, 1998, 2000). For example, in Canada there is evidence that higher family income is associated with better self-rated health amongst adolescents (Tremblay, Dahiten, & Kohen, 2003). Studies on sexual health have shown that earlier initiation into sexual activity, riskier sexual practices, sexually transmitted infections, and

unplanned pregnancies tend to be higher among youth in lower socioeconomic groups (Cubbin, Santelli, Brindis, & Braveman, 2005; Health Canada, 1999; Langille, Flowerdew, & Anderou, 2004; Singh, Darroch, & Frost, 2001). Moreover, many of these social determinants of health are associated with less power within heterosexual relationships (Pulerwitz, Gortmaker, & DeJong, 2000; Wingood & DiClemente, 2000) revealing the complex relationship between power, positive and negative sexual health outcomes and social determinants.

The principal goal of this chapter is to improve our understanding of the association between power, gender, and sexual health within a sample of self-identified heterosexual males and females. To do this, the present analysis explores how power is associated with various positive and negative sexual health outcomes while considering the influence of selected indicators of the social determinants of health including gender.

Methods

A convenience sample of adolescents who self-identified as heterosexual and were between the ages of 14 and 20 years was recruited from an Ottawa urban sexual health clinic and from undergraduate classrooms in four faculties at the University of Ottawa to participate in this study. At the sexual health clinic recruitment was done via information flyers posted in the clinic waiting room. At the university, I introduced the study to the class and referred them to the study information sheet and survey if they wished to participate. Adolescents were eligible to participate if they were between the ages of 14 and 20, self-identified as heterosexual and could read and write in English. A convenience sample was used to work within the limitations set by the recruitment sites. The study protocol was approved by the ethical review boards of both the University of Ottawa and the City of Ottawa's Public Health Department.

Data collection

All participants completed a self-administered written survey. The survey included demographic information, questions on sexual behaviours, power, positive and negative sexual health outcomes.

Measures

Dependent Variables:

Positive Sexual Health Outcomes:

The sexual health literature is generally focused on negative sexual health outcomes and adverse events such as unintended pregnancies and sexually transmitted infections. Researchers have begun to address this imbalance by focusing on positive sexual health outcomes and on factors that contribute to the achievement of positive sexual health among young people (Aggleton & Campbell, 2000; Horne & Zimmer-Gembeck, 2005; Robinson, Bocking, Rosser, Miner, & Coleman, 2002; Tolman, 1999; Tolman, Streipe, & Harmon, 2003). Despite this shift in focus, the literature on positive sexual health is sparse and measures designed to evaluate positive sexual health outcomes are lacking. Some factors linked to the achievement of positive sexual health among young people are: the ability to communicate needs and desires within a sexual relationship; the experience of physical and emotional satisfaction; the freedom from coercion and violence and; the ability to protect themselves from unwanted outcomes such as sexually transmitted infections. These general factors were used to guide a search of the literature to locate measures that could be used for this study. Three main criteria were used to screen measures. The measures had to: 1) have a positive orientation and measure a concept that has been shown to have positive implications for sexual health; 2) employ gender neutral language; 3) be contemporary in terms of language and concepts. The selected measures employed here are: sexual satisfaction, sexual self-efficacy, sexual assertiveness, condom use, health communication, health protective communication, and access to protection (condoms). These measures are intended to give an overview of some of the factors that may contribute to positive sexual health. It is acknowledged that these measures do not represent an exhaustive inventory. Brief details on each of the measures are included below, for complete scale information see Appendix C.

Sexual satisfaction or sexual pleasure has been linked to positive outcomes such as emotional well-being and relationship satisfaction (Rosen & Bachmann, 2008) and has been emphasized as a key, but missing, aspect of prevention campaigns (Higgins & Hirsch, 2004; Philpott, Knerr, & Boydell, 2006). Sexual satisfaction was measured using a four question score developed by Impett and Tolman (2006) for use with adolescent girls. The questions were previously untested with young men. Questions addressed whether participants felt that their most recent sexual experience was physically and emotionally satisfying and whether it made them feel

closer to the person they were with. Possible responses were strongly agree, agree, disagree, strongly disagree and were dichotomized into agree/disagree for analysis. Items were summed for a total score with higher scores indicating more satisfaction.

Sexual self-efficacy has been shown to be positively related to effective use of contraception and protection and feminist researchers propose that it is a key factor to women's sexual subjectivity and satisfaction (Schick, Zucker, & Cheng, 2008; Snell, 1998, 2001). Sexual self-efficacy was measured using a subscale from Snell's Sexual Self-Concept Questionnaire (Snell, 2001). The Snell's Sexual Self-Concept Questionnaire contains 20 five item subscales that can be used individually or together. Sexual self-efficacy is defined as "the belief that one has the ability to deal effectively with the sexual aspects of oneself" (Snell, 2001). Questions on this scale asked participants whether they felt they were able to cope with and deal with their own sexual needs and desires and ensure rewarding sexual experiences. Possible responses fell on a 5-point Likert scale which ranged from "this does not describe me" to "this totally describes me". Items were summed for a total score with higher scores indicating more self-efficacy.

Sexual assertiveness was also measured using a subscale from Snell's Sexual Self-Concept Questionnaire (Snell, 2001). Sexual assertiveness is defined as "the tendency to be assertive about the sexual aspects of one's life" (Snell, 2001). The ability to assert one's needs or desires is seen as a positive outcome particularly for young women who are often characterized as passive in the context of sexual relationships (Holland & Ramazanoglu, 1992). Questions on this scale asked participants whether they were assertive or passive when it came to voicing their needs, desires and preferences within a sexual relationship. Possible responses fell on a 5-point Likert scale which ranged from "this does not describe me" to "this totally describes me". Items were summed for a total score with higher scores indicating more sexual assertiveness.

An important measure of protection, male condom use, is a key aspect of positive sexual health. Those participants who reported an experience of sexual intercourse in the past 12 months were asked how often they used condoms during these encounters. Response categories were: all of the time, most of the time, some of the time and never. To facilitate the analysis, responses were dichotomized into consistent condom use and non-consistent condom use. Participants who reported that they used condoms "all the time" were classified as consistent condom users and those who reported condom use most/some of the time or never were classified as inconsistent users.

Sexual communication within one's sexual relationships, specifically about one's desires and preferences is seen as a key indicator of positive sexual health. It was measured using the Sexual Communication Scale from the Centre for AIDS Prevention Studies at the University of San Francisco (Dolcini, Coates, Catania, Kegles, & Hauck, 1995). This scale includes 6 questions that ask participants whether they can comfortably discuss sexual matters, including likes and dislikes with their sexual partners. Possible responses ranged from strongly agree to strongly disagree on a 4-point Likert scale. Items were summed for total score with higher scores representing better communication.

Willingness to communicate with her or his partner about specific protective behaviours has been linked to the use of contraceptives among adolescents (Ryan, Franzetta, Manlove, & Holcombe, 2007; Stone & Ingham, 2002). This concept was measured using the Health Protective Communication Scale from the Centre for AIDS Prevention Studies at the University of San Francisco (Van der Straten, Catania & Pollack, 1998). Originally designed as a 10 item scale, six items were selected to narrow the focus for this population and to look specifically at communication related to sexual health including communication about previous partners, sexually transmitted infections (STIs) and condoms. Possible responses ranged from strongly agree to strongly disagree on a 4-point Likert scale. Items were summed for a total score with higher scores representing better communication.

The participants were asked whether they felt that they had access to condoms when needed. Access to protection and, more broadly, sexual health services, is seen as a key factor in positive sexual health. Responses to this question were dichotomized into agree and disagree from four responses (strongly agree to strongly disagree).

Negative Sexual Health Outcomes:

Negative sexual health outcomes were measured to contrast with the positive sexual health outcomes to determine whether power had a stronger association with positive or negative outcomes. The most commonly assessed negative sexual health outcomes were measured: 1) diagnosis of a sexually transmitted infection in the past year; 2) previous experience with pregnancy (self or partner); 3) experience of physical or verbal abuse from a partner in the past year. For previous sexually transmitted infection diagnosis and pregnancy, response options were yes, no and I don't know. "I don't know" responses were categorized as missing for analysis. For

experience of violence, two questions separately evaluated whether participants had experienced physical or verbal abuse from a partner in the past year. The only response options for these two questions were yes or no.

Independent Variables:

Sexual Relationship Power Scale

Power was measured using the Sexual Relationship Power Scale (SRPS) which is based on theories of gendered power dynamics and interpersonal power (Pulerwitz et al., 2000). The SRPS measures relationship power or one's power in relation to their relationship partner. The scale interprets relationship power as imbalanced or inequitable. When this interpretation is viewed positively, it becomes power equity or shared power. This positive interpretation was used in this study and the scoring of the scale was modified as described below. The SRPS includes two subscales, relationship control and decision making dominance. The relationship control subscale consists of 15 statements which ask participants about commitment and control within the relationship. Possible responses ranged from strongly agree to strongly disagree on a 4-point Likert scale. Items were summed for a total score. The decision making dominance subscale consists of eight statements which ask about who makes decisions about various issues within the relationship. Possible responses were me, both of us equally, and my partner. Originally scored on a 3-point scale, this scale was changed to a 2-point scale to give shared decision making a higher value than dominant decision-making, in order to keep in line with the focus of this study on power as a positive, equitable concept. The scales are reported on separately as well as the results summed for a total score.

Social Determinants of Health Indicators:

Selected indicators of the social determinants of health were measured on the survey. A focus was placed on variables that have been consistently shown to be related to health or sexual health outcomes specifically for adolescents and on to power with sexual relationships. The selected factors were socioeconomic status, ethnicity, personal educational attainment and gender.

Income or socioeconomic status has been shown to be related to health and sexual health outcomes among adolescents (Hardwick & Patychuk, 1999; Phipps & Lethbridge, 2006) and to power within sexual relationships (Saul et al., 2000; Wingood & DiClemente, 2000). Since adolescents' socioeconomic status is often

directly related to parental or familial socioeconomic status, a series of questions was used to assess this indicator: perception of wealth, maternal education. Maternal education is known to be a good approximation of socioeconomic status (Bradley & Corwyn, 2002; Desai & Alva, 1998; Pueyo, Serra-Sutton, Alonso, Starfield, & Rajmil, 2007). Participants were asked to provide the highest level of education that their mothers had completed. Mothers with post-secondary education (university or college) were compared to those with elementary, junior high, or high school educations. Participants were asked if they considered their families wealthy, middle class or poor. Those who rated their families as wealthy were used as the reference category and were compared to those who considered themselves middle class or poor for the regression analysis. For both of these questions "I don't know" responses were categorized as missing variables.

School attendance and performance have been shown to be important indicators of adolescent social position and health outcomes (Koivusilta, Rimpela & Kautiainen, 2006). Educational performance has also been shown to have an important protective effect, particularly in the context of sexual health, and has been linked to sexual relationship power (Blum & Ireland, 2004; Chewing et al., 2001; Pulerwitz et al., 2000). Participants reported their current grade average in school. Participants in the highest category (A) were used as the reference category for analysis.

Ethnicity is an important marker of disadvantage and has been shown to be related to both power sexual health outcomes both positively and negatively depending on the setting (Singh, Darroch, & Frost, 2001; Wingood & DiClemente, 2000). Participants were asked to self-identify their ethnicity; these responses were then grouped into nine broad categories (see table 1). In order to use ethnicity as a variable in the regression analysis the broad groups of "white" and "non-white" were created. It is acknowledged that this masks individual differences between diverse ethnicities. However, there were too few individuals in each unique category to use each category separately within the regression models, so this crude analysis was undertaken.

Data Analysis

Separate regression analyses were conducted for males and females to recognize gender as a determinant of health. Gender has been shown to be a critical determinant of health, particularly in the case of sexual health. Issues of gender, masculinity, femininity and relationship power are also integrated throughout the analysis to contextualize this determinant.

Many of the survey questions were not applicable to participants who were not sexually active. As a result there was a high percentage of missing values among these participants. Due to this issue only those participants who stated that they had been "sexually active" in the past 12 months were included in the analysis. Sexually active was self-defined by a list of sexual behaviours and was not limited to sexual intercourse (Impett & Tolman, 2006) (Table 1). Demographic characteristics of the sample were summarized using descriptive statistics (means and frequencies). The internal consistency reliability of the scaled measures was tested using the Cronbach's alpha statistic. In order to validate the construct validity of the Sexual Relationship Power Scale (SRPS) for use with this sample, the association between the SRPS score and predetermined theoretically related variables was tested using Spearman correlations. Finally, mean scores on the SRPS were compared by gender using a Student's t-test.

Several regression analysis models were used to examine the associations between various sexual health outcomes (dependent variables) and sexual relationship power while adjusting for selected social determinants of health indicators (independent variables). For continuous dependent variables, a multiple linear regression model was used. For dichotomous dependent variables, a logistic regression model was used. Statistical software (SPSS version 16.0) was used to complete this analysis. Absolute mean differences were calculated using Confidence Interval Analysis (CIA, version 2.0). For each linear regression model, the four assumptions for linear regression were tested, namely, the linear relationship between the independent and dependent variables, the independence of the errors, constant variance of the errors (homoscedasticity) and normality of the error distribution.

Results

A total of 254 sexually active females and 75 sexually active males participated in this study. The majority of participants were white/Caucasian and were born in Canada. The mean age of both the females and males was 19 years and all participants self-identified as heterosexual as per the inclusion criteria (Table 1). It is important to note that some of the male and female participants who self-identified as heterosexual also reported engaging in same-sex sexual activities.

Table 1
Demographic characteristics

	Males (N=75)	Females (N=254)
Variables	n (%)	n (%)
ETHNICITY		
White	61 (81.3)	188 (74.0)
European	4 (5.3)	7 (2.8)
Asian	0	13 (5.1)
South Asian	3 (4.0)	5 (2.0)
Black	1 (1.3)	18 (7.1)
Middle Eastern	4 (5.3)	4 (1.6)
First Nations/Métis	0	6 (2.4)
Latina	0	7 (2.8)
Mixed ethnicity	1 (1.3)	4 (1.6)
BORN IN CANADA		
Yes	62 (82.7)	220 (87.0)
CURRENTLY IN SCHOOL		
Yes	64 (86.5)	221 (88.8)
LIVING SITUATION		
Both parents	24 (33.8)	78 (36.0)
University residence	8 (10.8)	53 (21.5)
Roommates	22 (29.7)	47 (19.0)
Parent & step-parent	6 (8.1)	9 (3.6)
Mother only	4 (5.4)	25 (10.1)
Father only	0	5 (2.0)
Girlfriend/boyfriend	4 (5.4)	12 (4.9)
Alone	1 (1.4)	11 (4.5)
EXPERIENCED PHYSICAL VIOLENCE, PAST YEAR		
Yes	14 (19.7)	20 (8.0)
EXPERIENCED VERBAL ABUSE, PAST YEAR		
Yes	18 (25.4)	60 (23.9)
SEXUAL BEHAVIOURS*		
Kissing	72 (97.3)	245 (97.6)
Touching/Being touched clothes on	72 (96.0)	241 (96.0)
Touching/Being touched no clothes	71 (94.7)	233 (92.8)
Give oral sex to a male	3 (4.0)	216 (86.1)
Give oral sex to a female	66 (88.0)	29 (11.6)
Receive oral sex from a male	3 (4.0)	206 (82.1)
Receive oral sex from a female	69 (92.0)	29 (11.6)
Vaginal intercourse	69 (92.0)	232 (92.4)
Anal intercourse	8 (10.7)	40 (15.9)
CURRENTLY USE BIRTH CONTROL		
Yes	41 (58.6)	166 (66.7)

* Participants could choose all answers that applied

Table 1, continued
Demographic characteristics

	Males (N=75)	Females (N=254)
Variables	n (%)	n (%)
TYPE OF BIRTH CONTROL CURRENTLY USING		
Pill	14 (33.3)	136 (80.0)
Condom	27 (64.3)	23 (13.5)
Injection	0	5 (2.9)
Other	1 (2.4)	6 (3.5)
CONDOM USE DURING INTERCOURSE, PAST YEAR		
Never	9 (13.4)	45 (19.9)
Some of the time	16 (23.9)	65 (28.8)
Most of the time	24 (35.8)	58 (25.7)
All of the time	18 (26.9)	58 (25.7)
STI DIAGNOSIS, PAST YEAR		
Yes	4 (6.0)	25 (5.7)
HIV TEST, PAST YEAR		
Yes	14 (19.7)	90 (19.7)
YOU/PARTNER EVER PREGNANT		
Yes	4 (5.7)	31 (12.6)

Internal Consistency Reliability of Scaled Variables

Internal consistency for all scales among this population was tested using Cronbach alpha statistics. Convention states that the alpha statistic should be above 0.70 but values higher than 0.90 may indicate that some items on the scale are redundant (Streiner & Norman, 2003). For the Sexual Relationship Power Scale the results for the full scale for both males ($\alpha = .791$) and females ($\alpha = .839$) fell into this accepted range. Internal consistency reliability was also acceptable when both of the subscales were examined separately. The internal consistency reliability of all the other scaled variables were acceptable for both males and females (Table 2).

Table 2
Cronbach Alphas for Scaled Variables

	Males (N=75)	Females (N=254)
Scale	Alpha (n)	Alpha (n)
Sexual Relationship Power scale (SRPS)	0.791 (65)	0.839 (230)
Relationship Control subscale (SRPS)	0.803 (65)	0.870 (231)
Decision Making subscale (SRPS)	0.781 (75)	0.732 (253)
Sexual satisfaction	0.771 (70)	0.886 (238)
Sexual self-efficacy	0.910 (67)	0.931 (236)
Sexual assertiveness	0.735 (66)	0.798 (235)
Sexual communication	0.713 (68)	0.745 (244)
Health protective communication	0.789 (67)	0.845 (238)

Sexual Relationship Power

Mean scores on the Sexual Relationship Power Scale were lower for young men than for young women, this result was consistent for the full scale and the subscales (Table 3). However, only the difference on the relationship control subscale was statistically significant. The full SRPS was found to be moderately associated with the an experience of both physical and verbal violence in the past year for males (physical $r = -0.393$, $p = 0.001$; verbal $r = -0.540$, $p < 0.001$), weakly associated with physical abuse for females ($r = -0.210$, $p = 0.001$); and moderately associated with verbal abuse for females ($r = -0.406$, $p < 0.001$) (Table 4a, 4b).

Scores on the Sexual Relationship Power Scale were not associated with consistent condom use or with birth control use among this sample (Tables 4a, 4b). For females there was a weak statistically significant inverse relationship between scores on the SRPS and a diagnosis of a sexually transmitted infection in the past year ($r = -0.137$, $p = 0.039$). There were no statistically significant relationships between a diagnosis of a sexually transmitted infection in the past year and scores on the SRPS for the male sample.

For males there were no statistically significant relationships between scores on the SRPS and overall sexual self-efficacy, grade point average, or sexual satisfaction during their most recent sexual encounter. For females there was a weak inverse statistically significant relationship between grade point average and scores on the relationship control subscale only ($r = -0.213$; $p = 0.001$). There was also a weak statistically significant positive relationship between sexual satisfaction during their most recent sexual encounter and the full scale for females and a negative relationship between overall sexual self-efficacy and the full scale ($r = 0.360$, $p < 0.001$; $r = -0.232$, $p < 0.001$, respectively).

Regression models

Tables 5 and 6 show the results of the multivariate linear and logistic regression analysis examining the associations between various sexual health outcomes and relationship power as measured by the SRPS while adjusting for selected indicators of the social determinants of health. For males, two positive sexual health outcomes, communication in the most recent relationship and overall sexual assertiveness were statistically significantly associated with scores on the SRPS. This association between communication, sexual assertiveness and the SRPS scores was inverse or negative. This means that young men with higher scores on the SRPS would have lower scores on the measures of sexual assertiveness and communication. For females, the opposite relationship was found; overall sexual assertiveness, communication in the most recent relationship, overall sexual self-efficacy and satisfaction in the most recent sexual encounter were positively associated with scores on the SRPS. The four assumptions for linearity were well met for all of the linear regression models with the exception of the sexual satisfaction model for females. The sexual satisfaction model did not meet the assumption of normality and thus a more complex non linear model may be needed to fully explain the association between scores on the SRPS and satisfaction.

For both males and females a previous experience of physical or verbal abuse from a partner in the past year was negatively associated with scores on the SRPS; these relationships were statistically significant. The odds of experiencing physical abuse were ten times more likely for each point lower on the SRPS for males and four times more likely for each point lower on the SRPS for females. Similarly, the odds of experiencing verbal abuse were sixty times more likely for each point lower on the SRPS for males and eight times more likely for each point lower on the SRPS for females. The logistic regression analysis revealed a previous experience of pregnancy, a STI in the past year, consistent condom use and access to condoms were not associated with scores on the SRPS.

Table 3
Sexual Relationship Power Scale Scores

	Males (N=75)		Females (N=254)	
	Mean, sd (n)		Mean, sd (n)	
Full scale score	3.14, 0.46 (72)		3.24, 0.53 (253)	
Decision making subscale	2.87, 0.94 (75)		3.04, 0.83 (254)	
Relationship control subscale	3.30, 0.34 (72)		3.42, 0.44 (253)	
		p value		Absolute mean difference (95% CI)
				-0.1 (-0.24, 0.04)
				-0.17 (-0.39, 0.05)
				-0.12 (-0.23, -0.01)

* Statistically significant different means, Students t-test, 2-tailed

Table 4a
Correlations between sexual relationship power scale and selected sexual health outcomes – Males

Sexual Health Outcome	Full Scale		Relationship Control Subscale		Decision Making Subscale	
	r	p value	r	p value	r	p value
STI diagnosis, past year	0.057	0.651	0.030	0.811	0.041	0.740
Consistent condom use	0.166	0.164	0.056	0.640	0.090	0.440
Current birth control use	0.108	0.375	0.156	0.201	0.050	0.680
Physical violence, past year	-0.393*	0.001	-0.324*	0.006	-0.314*	0.007
Verbal abuse, past year	-0.540*	<0.001	-0.518*	<0.001	-0.428*	<0.001
Sexual self-efficacy, overall	-0.152	0.211	0.096	0.431	-0.218	0.07
Sexual satisfaction, last experience	0.039	0.751	0.151	0.216	0.059	0.625
Grade point average	-0.066	0.582	-0.130	0.275	-0.036	0.758

* Statistically significant correlation, Spearman correlation, 2-tailed

Table 4b

Correlations between sexual relationship power scale and selected sexual health outcomes – Females

	Full Scale		Relationship Control Subscale		Decision Making Subscale	
	r	p value	r	p value	r	p value
Sexual Health Outcome						
STI diagnosis, past year	-0.137*	0.039	-0.119	0.062	-0.134*	0.036
Consistent condom use	0.015	0.814	0.089	0.158	-0.032	0.612
Current birth control use	0.094	0.139	0.041	0.516	0.077	0.224
Physical violence, past year	-0.210*	0.001	-0.304*	<0.001	-0.121	0.056
Verbal abuse, past year	-0.406*	<0.001	-0.431*	<0.001	-0.309*	<0.001
Sexual self-efficacy, overall	-0.232*	<0.001	0.180*	0.005	-0.232*	0.001
Sexual satisfaction, last experience	0.360*	<0.001	0.332*	<0.001	0.298*	<0.001
Grade point average	-0.071	0.264	-0.213*	0.001	-0.024	0.698

* Statistically significant correlation, Spearman correlation, 2-tailed

Table 5

Results for OLS Linear Regressions of five sexual health outcomes on SRPS scores adjusting for selected indicators of the social determinants of health*

	Males		Females	
	Unstandardized β (95% CI)	p value	Unstandardized β (95% CI)	p value
Sexual health outcome				
Sexual self-efficacy, overall	-0.248 (-0.674, 0.178)	0.249	0.406 (0.143, 0.670)	0.003
Health protective communication, last year	-0.270 (-2.541, 2.001)	0.813	1.121 (-0.194, 2.436)	0.094
Communication, recent relationship	2.289 (1.022, 3.555)	0.001	1.927 (1.238, 2.615)	<0.001
Sexual satisfaction, last experience	0.101 (-0.287, 0.489)	0.605	0.729 (0.447, 1.011)	<0.001
Sexual assertiveness, overall	-0.558 (-0.981, -0.134)	0.011	0.309 (0.074, 0.545)	0.010

* Social determinants of health adjusted for: perception of wealth, maternal education, grade point average, ethnicity.

Table 6

Results for Logistic Regressions of five sexual health outcomes on SRPS scores adjusting for selected indicators of the social determinants of health*

Sexual health outcome	Males		Females	
	Odds ratio (95% CI)	p value	Odds ratio (95% CI)	p value
Consistent condom use	1.349 (0.406, 4.485)	0.625	1.134 (0.606, 2.120)	0.695
STI diagnosis, past year	1.524 (0.153, 15.21)	0.720	0.567 (0.259, 1.241)	0.156
Previous pregnancy	0.287 (0.014, 5.923)	0.419	0.980 (0.439, 2.192)	0.962
Physical violence, past year	0.092 (0.018, 0.472)	0.004	0.245 (0.087, 0.688)	0.008
Verbal abuse, past year	0.016 (0.002, 0.152)	<0.001	0.122 (0.060, 0.246)	<0.001
Condom access	0.497 (0.018, 13.874)	0.680	2.254 (0.887, 5.727)	0.088

* Social determinants of health adjusted for: perception of wealth, maternal education, grade point average, ethnicity.

Discussion

This chapter reports on the examination of the associations between power and several positive and negative sexual health outcomes while adjusting for indicators of the social determinants of health. The balance of power within heterosexual relationships has been shown to be a key predictor of sexual health outcomes for both men and women (Blanc, 2001). Additionally, the social determinants of health are known to mediate both power within relationships and sexual health outcomes among diverse populations. Power was evaluated using the Sexual Relationship Power Scale (Pulerwitz et al., 2000). The scale was statistically significantly associated with several variables previously shown to be related to power among young women, such as physical and verbal abuse, and STIs, indicating that the SRPS shows good validity with another female sample. It is important to note that the scoring of the SRPS was modified in this study and as a result the findings cannot be directly compared to previous research. However, we do see similar relationships between scores on the modified SRPS and previous research possibly because low scores continue to represent unbalanced relationship power whereas high scores are interpreted as indicative of shared relationship power.

There is little data on young men and power yet a statistically significant negative association between scores on the SRPS and an experience of physical and verbal abuse in the past year is seen here. The experience of abuse and violence is intricately tied to powerlessness (Jewkes, 2002) and this result may mean that the SRPS is working well with the young male sample. Again, because the scoring of the scale was modified in this study the results cannot be directly compared to previous research. However, as with the results for young women, lower scores on the SRPS continue to represent unbalanced relationship power. Thus the association between low scores and the negative outcomes of abuse is consistent with the literature. Further validation of the modified scale with larger samples is needed to confirm this interpretation.

For both young men and young women sexual communication in the most recent relationship was statistically significantly associated with scores on the SRPS. Sexual communication was measured by questions that asked whether one could voice his or her needs within a relationship and be heard by their partner. This finding is in the expected direction for young women as it shows that young women who report shared relationship power (high scores on the SRPS) are able to communicate their needs within their sexual relationships. This is an important finding for young women who are often described as unable to express their needs within sexual relationships and often favour young men's needs over their own (Holland, Ramazanoglu,

Sharpe, & Thomson, 1998). However, the directionality of these findings cannot be determined because of the differing time points for each measure. For example, it is unknown whether communication leads to more balanced relationship power or vice versa. When this finding is coupled with the positive associations between the positive sexual health outcomes of sexual satisfaction in the most recent sexual encounter, overall sexual self-efficacy and sexual assertiveness and scores on the SRPS, an expansion of the previous literature on young women and relationship power is seen (Pulerwitz et al., 2000; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002). Previous research on women and relationship power has been negatively orientated and has highlighted links between powerlessness or unbalanced power and negative outcomes, for example, HIV infection or experiences of abuse (Dunkle et al., 2004). This chapter extends and re-orientates this research to reveal associations between relationship power and sexual health outcomes that are positive and possibly health promoting.

For young men, the regression analysis also revealed a positive association between communication in the most recent relationship and scores on the SRPS. This finding indicates that those young men with higher communication scores, or a greater ability to voice their likes and dislikes within a relationship, also report higher SRPS scores. Young men are typically characterized as poor communicators within relationships (Gahagan, Rehman, Barbour, & McWilliam, 2007). Further, stereotypes of powerful men are generally negative and do not include positive qualities such as communication. Since the SRPS was modified to weight shared relationship power higher than dominant decision making this may explain this positive association. As a result, a new more positive picture of young men and relationship power emerges. However, there was no statistically significant association between scores on the SRPS and the health protective communication scale for young men which may suggest that relationship power is related to the ability to express one's likes and dislikes within a relationship but not to the expression of concerns about risk, STIs or protection from STIs. However, as with the young women, we cannot determine the directionality of these associations, or which outcome precedes the other. No associations were seen between consistent condom use or a STI diagnosis in the past year and scores on the SRPS among young men. Research from international settings has reported both less condom use and more condom use among men who report more power within a relationship (Dunkle et al., 2004; O'Sullivan, Hoffman, Harrison, & Dotezal, 2006), suggesting that continued research needs to be done in this area.

There is very little research on young men and power and confirmation of these findings is needed.

However, this study suggests that some young men who score higher on the SRPS or report more shared relationship power are able to communicate their sexual needs within a relationship but may not communicate about protection and risk factors. Young men's limited communication about risks and protection has been previously demonstrated (Ryan et al., 2007; Gilmore, DeLamater, & Wagstaff, 1996). Further, conventions of masculinity hold that young men should be knowledgeable about sex, should always be willing to engage in sexual intercourse and should prioritize their own sexual pleasure (Courtenay, 2000; Campbell, 1995). A number of studies have also shown that young men's sexual desires and needs are often implicit within relationships and young women often favour men's needs over their own (Holland et al., 1998). Therefore, while some of the young men in this study reported that they are able to communicate their sexual needs within sexual relationships, the conventions of masculinity and femininity may be facilitating this communication and may make it implicit rather than explicit.

Interestingly, sexual assertiveness was negatively associated with power among young men. Sexual assertiveness was measured by questions that asked whether individuals were assertive about their sexual desires, needs and wants within a sexual relationship. It is possible the SRPS was inconsistent with the more directive tone of the sexual assertiveness scale because the SRPS was rescored to weight shared relationship power higher than dominant relationship power thus offering a more positive equitable orientation to power. When compared with the finding that scores on the SRPS were positively associated with sexual assertiveness for young women we see the complexity of the concepts of gender and relationship power. The contrast between notions of assertiveness or dominance and equity or shared relationship power suggests that the expression of relationship power may be gendered. It is possible that for young women to garner power in their relationships they must be more assertive than their male counterparts. Further research is needed to fully explore the various dimensions of the experience and exercise of relationship power as perceived by young men and young women and the links between these dimensions and notions of dominance and equity.

For both young men and women the odds of reporting an experience of physical and verbal abuse in the past year were significantly higher among those who scored lower on the SRPS. In fact, the odds of reporting verbal abuse from a partner in the past year were sixty times higher for each point lower on the SRPS for males. This is an important finding particularly for young men. The literature on the links between relationship power,

intimate partner violence and young women's sexual health is extensive, and these results add to these findings (Campbell, 2002). However, these findings are also pertinent because they highlight that young men also report experiences of physical and verbal abuse and that this abuse is linked to relationship power. Recent research has shown that a greater percentage of young women are perpetrators of physical or verbal abuse than are recipients of physical or verbal abuse within relationships (O'Leary, Slep, Avery-Leaf, & Cascardi, 2008; Shook, Gerrity, Jurich, & Segrist, 2000). Some have linked this to a greater acceptance of female aggression as gender norms shift (O'Leary et al., 2008). Interestingly, lack of power and dissatisfaction with one's power within a relationship has been linked to the perpetration of violence in relationships (Kaura & Allen, 2004; Ronfeldt, Kimerling, & Arias, 1998). These findings and the results outlined here point to a need to further explore the issues of power, violence and gender in adolescent relationships. Specifically, further research is needed to explore these concepts with young men.

This study had six main limitations. First, as with many sexual health surveys, this study was limited by its reliance on self-report. The survey did not include a measure of social desirability response bias thus, there were no measures taken to confirm the truthfulness of the answers given by the young people. Still, this survey was anonymous and confidentiality was assured.

Second, the study is limited by the small sample of young men. A small sample size increases the chance of making a type-II error or failing to find a relationship between some factors and SRPS scores that may in fact exist. Future research should endeavour to recruit more young men in order to increase the statistical power to detect possible associations between the variables of interest. Linked to the issue of sample size is the handling of the variable of ethnicity. The sample size of participants from diverse ethnic groups was not large enough to conduct a meaningful analysis of ethnicity. Therefore, the broad crude grouping of ethnicities into "white" and "non-white" was used to facilitate the regression analysis. Within the Canadian context it is arguable that non-white ethnic minorities as a group are vulnerable to social and structural racism (Abada, Hou, & Ram, 2007; Statistics Canada, 2003) and thus in terms of the social determinants of health this broad grouping can be justified. The small sample size may also explain the low numbers of adolescents who reported negative outcomes, such as a STI diagnosis in the past year or a previous pregnancy. Since sexual activity was self-defined by a list of sexual behaviours it is possible that some adolescents who self-defined as sexually active may have only engaged in less risky behaviours such as kissing or oral sex. While these

behaviours were seen to constitute sexual activity by the participants these behaviours cannot lead to negative outcomes such as pregnancy and may explain the small numbers who reported negative outcomes. However, the majority of the sample had engaged in vaginal intercourse. Allowing adolescents to self-define whether they were sexually active reveals how broadly that term is understood. However, this broad understanding may have led to a sample in which negative outcomes are underrepresented and positive outcomes are overrepresented. Future research with young people should endeavour to include larger samples in order to facilitate a finer analysis these issues.

Third, an extensive review of the literature in addition to correspondence with the scale author revealed only two cases in which the Sexual Relationship Power Scale was used with a male sample. One study that included adult men in South Africa was found. Its authors reported that the Sexual Relationship Power Scale was not as reliable with men as it has been with women (Jewkes, Nduna, Jama, & Levin, 2002; Pulerwitz, 2005). However, in another study the scale was found to be reliable with adolescent men in New York (US). Nevertheless, it has not been published to date and further results or details on the sample are not available (J. Pulerwitz, personal communication, June 27, 2006). In this study, the concepts of the Sexual Relationship Power Scale were explored in interviews prior to the survey implementation and concepts were deemed relevant to both young men and women. Further, I found that the scale showed substantial reliability for both males and females. Therefore, it was judged to have sufficient potential and was used. This study also scored this scale differently than previous studies to reflect the positive focus of this dissertation overall. As a result of this modified scoring approach the findings here cannot be directly compared to previous literature which generally approaches power from an individual have/have not perspective. Further validation research is needed to support this new interpretation of the SRPS and the lack of this research within the current study is a limitation. However, this work creates the groundwork for future research on sexual relationship power and young men.

Fourth, a convenience sampling strategy was used for recruitment and the survey was administered only to youth who voluntarily agreed to participate in this study. It is possible that because a non-random sample was used, the participants represent a distinct population of individuals who were more open or have more experience with sexual health issues because they were willing to participate in this study. Reaching young people to participate in research is often challenging; the demographics show the cross-section of youth included but the findings from this study may not be widely generalizable beyond this particular sample.

Fifth, due to the use of a cross-sectional survey and the varying time references used by some of the outcome measures the directionality of the associations is unknown. More research is needed to determine the causal order of outcomes. For example, does shared relationship power lead to improved communication or vice versa? This research would be important from an intervention perspective to learn how best to improve adolescent sexual health.

Finally, as described in the results, the linear regression model which examined the association between power and sexual satisfaction for females did not meet the normality assumption. A more complex non-linear model may provide a fuller explanation of this variable. However, given the strength of the statistical association found between sexual satisfaction and power it is unlikely that the use of a non-linear model would reveal different results.

In conclusion, several positive sexual health outcomes were associated with relationship power as measured by the modified SRPS for both young men and women in this sample. Shifting the focus away from negative sexual health outcomes to a more positive view of sexual health may improve our understanding of adolescent sexual health and may offer opportunities for intervention to improve adolescent outcomes. From a health promotion perspective, a recent survey of Toronto adolescents reported that a lack of a positive orientation towards youth sexuality was a key barrier to accessing sexual health services. Young men and women surveyed for this report also indicated a gap between what they learned about sexual health and what they would like to know. Knowledge of healthy relationships and sexual pleasure were among the top three concerns for the adolescents studied (Flicker, Flynn, Larkin, Travers, Guta, et al., 2009). This report highlights the importance of positive outcomes from an adolescent perspective and the possible implications of adapting a positive perspective on youth sexual health broadly. The findings presented here regarding relationship power, communication and violence also challenge existing stereotypes about males and females involved in heterosexual relationships that demand further investigation. Practitioners may need to consider whether new approaches to sexual health promotion that challenge these stereotypes are needed and whether approaching sexual health positively may engage youth more effectively.

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Conclusion

This conclusion summarizes the primary findings of this dissertation. The findings are organized around the three primary objectives outlined in the introduction. A discussion of how the findings contribute to the literature on adolescent sexual health is also articulated. The strengths and limitations of the dissertation are then examined, followed by its contributions to Population Health. This chapter then concludes with recommendations for research and practice that extend from the findings.

Objective One - To investigate how young people understand, define and experience positive sexual health.

This dissertation joins the growing literature on positive sexual health by outlining the presence of multiple positive sexual health outcomes in a sample of Canadian male and female heterosexual youth. Despite their likely exposure to messaging that highlights the negative consequences of engaging in heterosexual relationships during adolescence, the young people studied here experienced a wide range of positive sexual health outcomes. These results emphasize the need for programs and interventions that extend beyond risk and engage young people positively around issues of safer sex and heterosexual relationships (Aggleton & Campbell, 2002).

Moreover, this dissertation used positively-focused scales and measures from diverse sources to describe how the participants experienced positive sexual health within their heterosexual relationships. The results reveal high levels of positive outcomes among this sample, for both young men and women. The participants reported high levels of sexual self-efficacy, sexual assertiveness, satisfaction and communication within their heterosexual relationships. By employing existing measures to address positive sexual health concepts this dissertation strengthens the evidence base for these measures in particular and allows for meaningful direct comparisons. This is an important contribution as the exploration of positive adolescent sexuality is a new and expanding area of inquiry.

The measurement of positive sexual health outcomes was balanced by the consideration of negative outcomes which continue to have important implications for adolescent sexual health. Findings from this sample are generally reflective of Canadian statistics. Approximately 16% (10% females; 6% males) of this sample reported a sexually transmitted infection in the past year, compared to the national rate of 10% (Canadian Federation for Sexual Health, 2007). The teen pregnancy rate in Ontario is 23/1,000 women under the age of 20 years (2.3%) (Canadian Federation for Sexual Health, 2007). Just over 12% of the young women here reported having ever been pregnant. This higher rate is probably due to the fact that the dissertation was conducted in part at a sexual health clinic. Finally, 35% of Ontario youth reported condom use at last intercourse compared to 26.9% of the participants here who reported they used condoms "all the time" during their experiences of intercourse over the past year (Canadian Federation for Sexual Health, 2007). The open response categories used in this dissertation allow us to see the subtleties in the participants' condom use behaviour.

Finally, this dissertation also aimed to improve our understanding of how adolescents defined the concept of positive sexual health. While this question was explored during the qualitative phase of this study the results are not reported here. Upon close consideration of the data it became clear that the question related to how positive sexual health is defined was not clearly understood by the participants. The participants generally spoke of positive aspects of their sexual relationships and of sexual intercourse as opposed to what a definition of positive sexual health was specifically. Further research on this issue is needed to ensure congruence between what is measured as positive health and what adolescents understand positive sexual health to be.

In addressing this primary objective this dissertation adds to the literature on adolescent sexuality by summarizing both positive and negative outcomes within a sample of participants who self-identified primarily as heterosexual. Through the consideration of both positive and negative outcomes this dissertation describes a more complete picture of sexual health among heterosexual adolescents by moving beyond negative and risk oriented outcomes.

Objective Two - To investigate how young people understand and experience the gendered dynamics of power.

Young men and young women interpreted power as a negative concept and associated it with control. There was some discrepancy in the language that the young men and women used to describe their opinions on power. It is within these discrepancies that the influence of gender on the participants' ideas is seen. Some young women spoke of power as a personal ability or as "power within" oneself. Whereas other young women described power as a "power over" concept which was more aligned with the young men's definitions. Unique to the young men was the idea that power is indescribable. The invisible or intangible nature of power for young men can be seen as indicative of the ubiquitous nature of male power within our social context.

Generally, the definitions of power offered by young women and young men were more similar than distinct. This similarity offers points of commonality from which to design intervention or research programs focused on the issue of power within heterosexual relationships. This aspect of the dissertation adds in particular to the literature on young men and their understandings of power. Work on young women's understandings of power has been done in many cases as the primary step in the development of some important scales to measure power within young women's lives and relationships (Pulerwitz, Gortmaker, & DeJong, 2000). However, research that has questioned how young men understand power is limited. Research exists on young men's understanding of gender equity. Its focus is often on issues of masculinity and gender roles specifically (Barker, 2000) and not on how young men understand their power, their female partner's power or how power is employed within heterosexual relationships. This dissertation thus contributes to the literature on gendered power dynamics within heterosexual relationships and their implications for sexual health through the inclusion of young men and women.

The quantitative measurement of relationship power gives a statistical indication of how the gendered dynamics of power are experienced by heterosexual adolescents. Relationship power was measured using the Sexual Relationship Power Scale (SRPS) (Pulerwitz et al., 2000).

The young men scored lower on the SRPS as compared to the young women. The predominant assumption regarding power and heterosexual relationships is that young women have less power than their male partners. However, this assumption is based on a have/have not analysis of power. This study approached power as a positive concept and examined shared power within the relationship. Thus, a possible explanation for the young men's lower scores may be that the Sexual Relationship Power scale, which was previously under tested with a male sample, did not accurately reflect the young men's experiences with power. However, the scale showed substantial internal consistency reliability with the male sample and the questions regarding decision making, violence and dominance in relationships are certainly equally applicable to young men.

Additionally, the scoring of the SRPS was modified slightly for this study to weight shared decision making higher than dominant decision making, reflecting the positive orientation of the project. The construct validity of this new interpretation was not tested which represents a limitation of this research. However, this new positive approach to power opens up avenues for future research and validation. Overall, the quantitative measurement of power reveals that this is a multifaceted and possibly fluid concept and should be interpreted as such (Harrison, O'Sullivan, Hoffman, Dolezal, & Morell, 2006).

Objective Three - To investigate associations between the social determinants of health, positive and negative sexual health outcomes and the gendered dynamics of power.

Due to the limited size and diversity of this sample, conclusions regarding the relationship between selected social determinants of health such as ethnicity, income and maternal education should be interpreted cautiously. Significant differences were found between males and females, or across gender as a determinant of health, for sexual self-efficacy, sexual communication, health protective communication, and scores on the SRPS. Ethnicity, grade point average, maternal education and perceived wealth were adjusted for in the models. For males,

sexual assertiveness, communication and an experience of physical and verbal abuse in the past year were negatively associated with scores on the SRPS. For females, sexual assertiveness, communication, sexual self-efficacy were positively associated with scores on the SRPS and an experience of physical and verbal abuse in the past year were negatively associated with scores on the SRPS. These findings add to the literature on gendered power dynamics within heterosexual relationships by considering positive sexual health outcomes and the influence of the social determinants of health simultaneously. Previous research has tested the association between the Sexual Relationship Power Scale and primarily negative variables (Pulerwitz et al., 2000; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002; Pettifor, Measham, Rees, & Padian, 2004). The finding that positive sexual health outcomes have a positive association with scores on the SRPS provides further opportunities for intervention beyond the traditional focus on risk reduction. Contrary to previous findings, condom use over the past year and a diagnosis of a sexually transmitted infection in the past year were not strongly associated with scores on the SRPS. There was a weak negative association between a STI diagnosis in the past year and scores on the SRPS for females only. If we consider gendered power dynamics to be fluid and continually evolving, this finding is of interest. It may indicate simply that within this sample gendered power dynamics have a different manifestation than in previous studies or it could indicate the presence of a methodological limitation. For example, as mentioned previously the scoring of the SRPS was modified slightly for this study. The scoring weighted shared decision making higher than dominant decision making, thus the results cannot be directly compared to previous research. Also, rates of negative outcomes were low in this sample. This may be due to the open response categories used for defining sexual activity. As a result of these open categories some individuals who were included in the sexually active sample may not have engaged in high risk behaviours that had the possibility to lead to outcomes such as pregnancy or sexually transmitted infections. Further research is needed to examine this new interpretation of the SRPS and its association with both positive and negative outcomes.

In addition to the consideration of the social determinants of health within the regression analysis both the positive and negative sexual health outcomes were individually examined according to indicators of the social determinants of health. Research has revealed the influence of various aspects of adolescent education, including total education completed, academic performance and satisfaction with school on sexual health outcomes (Corcoran, 2000; Singh, Darroch, & Frost, 2001). The results of this study reveal an association between grade point average and sexual health outcomes for young women. Specifically an experience of a previous pregnancy, a HIV test in the past year and a diagnosis of a STI in the past year were statistically different between those with high and low grade averages at school. A similar association was not seen for young men. Overall, the analysis of the associations between the social determinants of health and the sexual health outcomes revealed few statistically significant results but some important patterns that point to future areas of inquiry. For both young men and young women a pattern was evident that suggests that perceived wealth has an impact on positive outcomes. For young men those in the wealthy reference group had statistically higher scores on the sexual assertiveness scale. For young women results for sexual satisfaction and sexual self-efficacy, while not statistically significant, point to a possible influence of perceived wealth on outcomes. A trend towards higher reports of pregnancy and physical violence was also seen among young women whose mothers have less than post-secondary education.

Overall, the associations that were statistically significant favoured the negative sexual health outcomes. Only one statistically significant difference was seen when the positive outcomes were compared by indicators of the social determinants of health. This raises the question of whether the social determinants of health have a similar impact on positive outcomes as they do on negative outcomes. As research in sexual health is often focused on negative outcomes this question remains largely unexplored.

Finally, previous research has shown the protective effects of several factors on sexual health outcomes for young people (Blum & Ireland, 2004; Chawning et al., 2001; Garwick, Nerdahl, Banken, Muenzenberger-Bretl, & Sieving, 2004). The factors studied by these

researchers were generally outside the sexual realm such as educational achievement and satisfaction with school, peer and role model influences. This dissertation builds on this work by examining the influence of both the social determinants of health and the gendered dynamics of power on positive sexual health outcomes for heterosexual adolescents. Further research is needed to investigate the possible protective effects of positive sexual experiences (Higgins & Hirsch, 2006; Horne & Zimmer-Gembeck, 2005) and the possible mediating role of the social determinants of health and the gendered dynamics of power on those effects.

Strengths and limitations of the dissertation

This dissertation situated the interrelated issues of power, the social determinants of health and adolescent heterosexual relationships within a holistic conceptualization of sexual health that focused on positive outcomes while considering negative outcomes. Approaching issues of adolescent sexual health positively is an underused approach to the study of adolescent sexuality. As a result of this approach this dissertation had five main strengths.

First, one of the major strengths of this dissertation is that it examined the issue of adolescent sexual health, an issue that is often associated with negative outcomes, from a more holistic perspective which included both positive and negative outcomes. This positive approach produced new findings regarding adolescent sexual health; raised important questions about how adolescent sexual health is studied and; advanced future areas of inquiry. This positive approach also included the examination of outcomes such as sexual self-efficacy, which situated adolescents, particularly young women, as active participants in their heterosexual relationships. Thus, a major strength of this dissertation is that it contributes to the gap in research on positive adolescent sexual health by shifting focus away from negative sexual health outcomes. This dissertation recognizes that sexual health is an integral part of human development that should extend beyond the absence of sexually transmitted illnesses or unintended pregnancies and that must include positive and equitable sexual outcomes.

Second, closely related to the focus on outcomes that resonated with young peoples' positive experiences of heterosexual relationships was the decision to include both qualitative and quantitative phases in this dissertation. The use of multiple data collection methods allows for the inclusion of young peoples' voices in addition to statistical information on outcomes, thereby creating a more complete picture.

Third, the inclusion of both young men and women and the explicit decision to sex disaggregate all data was an important strength of this dissertation. Young women are often positioned as sexual gatekeepers and bear a disproportionate amount of responsibility for negative outcomes. They, rather than young men, are the primary targets of sexual health research and intervention (Campbell, 1995). Consequently, less is known about young men's sexual health (Raine, Marcell, Rocca, & Harper, 2003), particularly their ideas about power within relationships and the influence of relationship power on young men's sexual health outcomes. Furthermore, often when research includes both young men and women, the analysis and presentation of outcomes is not presented separately by sex. Failing to provide sex disaggregated data hides important differences between young women and men and engenders a false sense of uniformity in their experiences.

Fourth, the explicit decision to use existing measurement tools rather than create new tools specifically for this dissertation is a strength of this work. The decision to use existing measures adds to the sexual health evidence base rather than thinning out this evidence base with new tools designed to measure similar concepts. This decision is particularly important when the limited research on young men's sexual health is considered. All of the scales used showed substantial internal consistency reliability for both the female and male samples (as measured by Cronbach alpha statistic). The corresponding drawbacks of using pre-existing tools are discussed below.

Fifth, I worked closely with the staff and managers at the City of Ottawa's Sexual Health Clinic to refine methods and used this clinic as a data collection site in both phases one and two. Prior to the first phase of data collection a consultation was held with clinic staff to discuss the

dissertation and solicit any suggestions for improvement. The input of staff led to the addition of an incentive for participation in phase one. Staff felt strongly that the young people should be compensated for their time and stated that incentives were the norm for research projects run at the clinic. I visited the clinic two to three times per week while the survey was running and was present full-time at the clinic during the interview phase of the dissertation. My presence at the clinic gave me important insight into the workings of the clinic, the pressure and constraints of the staff and the general characteristics of the clients. Most importantly, my presence at the clinic allowed me to interact with the staff and hear about any problems or issues with the study. I have presented the results of the both phases of the dissertation to the clinic staff in highly interactive sessions which were positively received by all staff. I plan to return to maintain my relationship with the clinic and continue to discuss the policy and practice implications of this dissertation. The involvement of the clinic is an important strength of this dissertation. Not only did their involvement help to bridge the knowledge practice gap between researchers and clinicians but it improved the project and helped to contextualize the results.

The strengths associated with researching new questions often come with related limitations. There are seven important methodological limitations of this dissertation that were discussed in earlier chapters. A brief review of these limitations will be presented here.

First, some of the scales used in the survey portion of the dissertation were previously untested or underused with a male sample. The scales in question are the sexual relationship power scale (SRPS) (Pulerwitz et al., 2000) and the sexual satisfaction scale (Impett & Tolman, 2006). The sexual satisfaction scale was designed for use with adolescent girls. Tolman and colleagues are some of the few researchers who have examined positive indicators such as satisfaction within adolescent heterosexual relationships and thus this scale was used in the absence of other suitable measures. The items on the scales were also deemed to be relevant for a male sample as they questioned whether their most recent sexual experience was physically and emotionally rewarding. The satisfaction scale showed substantial internal consistency reliability for both the young men and women as measured by the Cronbach alpha statistic but

future research should endeavour to further validate this scale with a larger, more diverse, male sample.

An extensive review of the literature and correspondence with the scale author revealed only two cases in which the Sexual Relationship Power Scale was used with a male sample. One study that included adult men in South Africa was found and the authors reported that the Sexual Relationship Power Scale was not as reliable with men as it has been with women (Jewkes, Nduna, Jama, & Levin, 2002; Pulerwitz, 2005). The scale was found to be reliable with adolescent men in New York (US), however this study was not published and further details on the sample are not available (J. Pulerwitz, personal communication, June 27, 2006). As the concept of power was central to this dissertation, the decision was made to use the Sexual Relationship Power Scale which had been widely used with female populations (Pulerwitz et al., 2000; Pulerwitz et al., 2002). In order to mitigate this weakness, concepts from the Sexual Relationship Power Scale were used in the interview guide for phase one. The Sexual Relationship Power Scale provided a conceptual guide for the interview discussions and as a result the congruence between the Sexual Relationship Power Scale and the opinions and language of the adolescent participants was assessed. In general, the underlying ideas about power in sexual relationships that are central to the Sexual Relationship Power Scale came up in my discussions with the participants. Participants saw power as a negative concept which was expressed by control, either over an individual or over the relationship in general. Further, the internal consistency reliability of the scale as measured by the Cronbach alpha statistic was substantial for both sexes. The use of the alpha statistic as the sole measure of validity should be interpreted with caution because it is calculated based on only one use of the scale and thus does not take into account other sources of variance (Streiner & Norman, 2003). As there is very limited research on young men and power it is difficult to determine the validity of the Sexual Relationship Power Scale using theoretically related variables. However, for young men we did see a statistically significant inverse relationship between scores on the SRPS and an experience of verbal or physical abuse from a partner in the past year. This relationship suggests that the

scale may be valid for young men because it is in the appropriate direction when the issues of relationship power and abuse are considered. Further research is needed to further validate this scale with larger male samples.

Finally, the scoring of the Sexual Relationship Power Scale was changed slightly for this dissertation. The decision making dominance subscale of the scale was rescored to give shared decision making a higher value than dominant decision making. This new method of scoring is considered a limitation because this scoring methodology is previously untested and requires further research and validation. As a result of this modified scoring the results presented here cannot be directly compared to previous research using the scale. Further, only the scoring on the decision making dominance subscale was modified. This modified subscale was combined with the relationship control subscale which was not modified as it was interpreted to apply to both shared and dominant relationship power depending on how one scored. Again, this positive interpretation of the scale and the combination of the modified and unmodified subscales was not validated and represents a limitation of this work. Importantly, this new scoring methodology sets the groundwork for new approaches to the measurement of power within adolescent sexual relationships that are based on shared rather than dominant conceptions of power.

Second, other scale and variable related limitations concern the indicators used to evaluate the social determinants of health. As described in the introduction, the social determinants of health have rarely been conceptualized from an adolescent perspective. Researchers have suggested that associations between the social determinants of health and health outcomes may vary across the lifespan particularly in adolescence when new behavioural patterns emerge (Hanson & Chen, 2007). For example, determining socioeconomic status is difficult with adolescents as they are most often reporting parental or familial status. The accuracy of parental information as an indicator of socioeconomic status may change when a young person leaves the familial home to attend university or college and may no longer be able to maintain the same standard of living. I chose to use multiple methods of obtaining socioeconomic status which has been recognized as a sound approach when studying

adolescents (Currie, Elton, Todd, & Platt, 1997). The use of multiple methods mitigated, in part, the limitation of the primary scale I employed for this purpose – the Family Affluence Scale (Boyce, Torsheim, Currie, & Zambon, 2006). The Family Affluence Scale was designed for use with school-aged children and youth and is used by the WHO global survey of children and youth. However, discussions with the participants in the interview portion of the study revealed that the questions may not be as reliable for those who no longer live at home as they are focused on the familial home and family activities. Therefore, the results of the Family Affluence scale as presented in chapters one and two may be limited. For the regression analysis, alternate indicators of the social determinants of health were used. These indicators were gender, perceived wealth, maternal education, grade point average and ethnicity. As discussed, the analysis of ethnicity was limited by the lack of ethnic diversity in the study sample. The grouping of ethnicity into white and non-white categories was a crude method of analysing this data and it is regrettable that a finer analysis with a larger and more diverse sample could not be completed. Finnish research revealed that adolescent's school achievement (grades) was the strongest predictor of health inequality and corresponded to self-rated social position (Koivusilta, Rimpela, & Kautiainen, 2006). I felt that using three related variables provided a more reliable and complete socio-demographic picture than the use of the Family Affluence scale alone. An American study of neighbourhood context and sexual behaviour found that responses for parental education from both adolescents matched 75% of the time, indicating good reliability (Cubbin, Santelli, Brindis, & Braveman, 2005). Furthermore, maternal education is known to be a good approximation of socioeconomic status (Bradley & Corwyn, 2002; Desai & Alva, 1998; Pueyo, Serra-Sutton, Alonso, Starfield, & Rajmil, 2007). I felt that in spite of the limitations of the Family Affluence scale as an indicator of socioeconomic status, other measures allowed for the creation of a reliable picture of the social determinants of health of the sample studied.

A third methodological limitation was the use of a self administered survey in phase two. The limitations of this method of data collection are the reliance on self-reporting, the possibility that some participants misunderstood questions, or did not have appropriate literacy skills to fully

understand the questions. As the survey was self-administered there was no opportunity for clarification. Self-report instruments may be limited by recall bias, participants do not remember events in the past, and/or social desirability bias, participants report according to social expectations. The survey did not include a measure of social desirability bias. It is unclear in sexual health research how social expectation/desirability affects reporting, for example, people may over report sexual behaviours in more masculine cultures or may under report because of embarrassment or social taboos (Catania, Chitwood, Gibson, & Coates, 1990).

The use of a cross-sectional survey means that causality between variables cannot be inferred and the directionality of the relationships between variables cannot be determined. In order to determine directionality, a prospective study would need to be conducted which is beyond the scope of this dissertation. Linked to the issues of causality are the differing time references for some of the measures on the survey. For example, some of the scaled questions asked participants about their most recent relationship while others asked about outcomes in the past year. As a result of these diverse time references some of the outcomes may not have occurred within the most recent relationship and thus the causality between outcomes cannot be determined. Nonetheless, there are also advantages of surveys for data collection. They are relatively inexpensive, may be less threatening than face-to-face interviews for sensitive subjects and may elicit a higher response rate (as compared to interviews) when researching sexual health with adolescents (Catania et al., 1990).

Fourth, for both phases of the research a convenience sample was used meaning that those who participated volunteered to do so and the sample was not randomly selected. The convenience sample was employed primarily due to limitations of the recruitment sites. The clinic operates on a walk-in basis and is open to all age groups thus the use of a random sample was not feasible. Further, at the clinic recruitment had to be passive, for example, all clients were given a survey and those who met inclusion criteria and wished to complete the survey did so. I was not able to actively solicit participants; interaction with the participants was limited to clinic staff. At the university contact with professors was made through the faculties. A general notice

was sent to professors who were teaching undergraduate classes. Faculties were not randomly sampled and I was limited to classes in which the professors agreed to host the survey. Since university recruitment relied on professor agreement a random sample of classes university wide was not feasible given the time and cost constraints of this study. As a result of these limitations, it is possible that the participants represent a distinct population and the results may not be generalizable to other groups.

Fifth, related to the voluntary nature of participation is the limitation resulting from the small sample of young men. In both phases the number of male participants was much lower than the female participants. At the clinic it was evident that fewer young men were accessing services. In phase two, I made a decision to recruit participants from the university setting in addition to the clinic primarily to increase the male sample. While this strategy did increase the male sample, young men were still underrepresented as compared to young women. The small male sample limited the power of the quantitative analysis to detect associations between variables. Our knowledge of young men's outcomes remains limited. Future studies should over sample for young men to ensure they are adequately represented, particularly in sexual health research.

Sixth, some limitations that are specific to the qualitative portion of the dissertation concern the lack of member checking of the analysis and interpretation of the qualitative data as well as the question of the influence of the sex of the interviewer on results. First, because the interview recruitment took place at a confidential walk-in clinic, the ability to reconnect with the participants and go over transcripts and analysis was limited. Therefore, according to qualitative methodologists (e.g., Lincoln & Guba, 1985) the internal validity of the qualitative data can be questioned. Second, I conducted all of the interviews personally. As a white, middle class female, some could argue that the participants, particularly the male participants, may have censored their comments when speaking to me. However, in a review of methodological issues in sex research (primarily research on HIV) Catania and colleagues (1990) found that significantly more information was reported to female rather than male interviewers (by both sexes) although the

reasons for this are unclear. Other female researchers working with young men have claimed that their sex had little or no influence on the amount of information participants reported (Gilmore, DeLamater, & Wagstaff, 1996; Bowleg, 2004). In fact, Gilmore and colleagues (1996) reported that the candid nature of the conversations with her participants and the amount of data collected were evidence that her sex did not adversely affect data collection. Also, Canadian research revealed that even though participants were offered the choice of a same sex interviewer, none took this option (Shoveller, Johnson, Langille, & Mitchell, 2004). Essentially, there is limited evidence on the influence of the sex of the interviewer and the resultant quality of the data.

Finally, participants were asked to self-define whether they were sexually active on the survey. A list of sexual activities was provided and participants were asked to indicate which of these activities they had engaged in and whether they considered engaging in these activities as being sexually active. The majority of participants had engaged in vaginal intercourse and defined this activity as constituting sexual activity. However, some participants engaged in lower risk activities such as kissing and oral sex and considered these activities to mean that they were sexually active. As a result, some of the participants who were included in the analysis may not have engaged in the high risk behaviours that can lead to outcomes such as a pregnancy or a sexually transmitted infection. This open question may explain why rates of negative outcomes were low among this sample and may represent a limitation. Importantly, the use of this question reveals the complexity of the term "sexually active" among adolescents and highlights the need to consider sexual behaviours beyond vaginal intercourse when conducting research with adolescents.

Contribution to Population Health

Research on sexual health is often focused on behavioural models that emphasize individual risk and responsibility, thereby neglecting the social and structural factors that increase

the vulnerability of adolescent males and females (Amaro, Raj, & Reed, 2001). This dissertation contributes to the Population Health research base by conducting research on adolescent sexual health that balances the behavioural issues of risk with the social determinants of health. Issues of gender, ethnicity and socioeconomic status were central to this dissertation although due to sample size limitations I was unable to make strong conclusions based on these issues.

Nonetheless, I believe that this dissertation contributes to Population Health in the following ways. The inclusion of male and female adolescents adds to our understanding of sexual health and advances our knowledge of gender as a primary determinant of health. Additionally, our understanding of sexual health is extended beyond outcomes with the consideration of the gendered dynamics of power. The positive approach of the dissertation pushes our understanding of sexual health beyond a negative risk focused one; and the use of both qualitative and quantitative methods and multiple disciplinary perspectives adds a further example of Population Health research to the evidence base.

First, this dissertation advances our understanding of gender as a primary determinant of health. Population Health research has been criticized for neglecting context laden determinants of health such as gender in favour of measurable determinants like income (Hayes & Dunn, 1998; Raphael & Bryant, 2002). However, gender is embedded in all other determinants of health. Improving our understanding of gender adds significantly to the Population Health evidence base. For example in sexual health research, it is known that women are less able to negotiate condom use if they are financially dependent on their male partners (Amaro, 1995; Gupta, 2002). Herein, the determinants of gender and income collude in exacerbating such women's vulnerability. Arguably, gender is one of the most significant determinants of health to consider when examining power and heterosexual relationships (Holland, Ramazananoglu, Sharpe, & Thomson, 1998). My findings revealed that while young people are not adhering as strictly to traditional gender expectations, these expectations still persist and may be putting young men and women at greater risk of negative sexual health outcomes. My findings also reveal an association between outcomes such as an experience of violence and sexual

communication and the gendered dynamics of power. It is believed that the analysis of gender provided by this dissertation highlights the importance of gender and it is hoped that it will spur more Population Health researchers to examine gender with similar rigour.

Second, rather than simply measuring sexual health outcomes this dissertation, in line with the Population Health focus on context, examined potential mediators of those outcomes, namely the gendered dynamics of power and various social determinants of health. Within heterosexual relationships researchers have shown that gendered power dynamics play a crucial role in determining sexual health outcomes, regardless of other social determinants (Pulerwitz et al., 2000). In some cases gendered power dynamics act with other social determinants of health to mitigate or worsen sexual health outcomes (Wingood & DiClemente, 2000). However, it is important to note that most previous research on the gendered power dynamics has been based on a have/have not analysis of power and thus, due to the positive orientation of this study, may not be directly comparable. In the analysis of the association between positive and negative sexual health outcomes and scores on the SRPS regression models were adjusted for indicators of the social determinants of health.

When the positive sexual health outcomes were considered across indicators of the social determinants of health, few statistically significant results were found. In fact, when the males were grouped by each social determinant of health indicator only one statistically significant difference was found across all positive and negative sexual health outcomes. For females, only results on the negative sexual health outcomes were different across grade point average. It has been suggested that the impact of the social determinants of health on outcomes may differ across the lifespan with adolescence being a particularly critical period of transition (Hanson & Chen, 2007). These results may be indicative that the social determinants of health have little influence on sexual health outcomes among this sample or may be a product of the small sample of adolescents clustered in each category. Nonetheless, by considering the interrelated issues of gendered power dynamics, sexual health, and the social determinants of health this dissertation has added to the literature on both young men and young women in the Canadian context.

Third, the positive approach to the examination of sexual health adds to the growing literature base on positive sexual health outcomes (Russell, 2005) and embraces a more holistic definition of sexual health as advocated by the World Health Organization and youth sexual health organizations (Flicker, Flynn, Larkin, Travers, Guta, et al., 2009). Shifting focus to positive sexual health outcomes while considering negative outcomes provides a more complete and multilayered picture of adolescent sexual health. This dissertation revealed high levels of positive sexual health outcomes among this sample. This result contrasts with the often alarming statistics on rising rates of sexually transmitted infections among young people (Canadian Federation of Sexual Health, 2007). While these negative outcomes are of great importance when considering sexual health for adolescents, knowledge of positive outcomes provides a more balanced view and allows for new point of engagement from which to structure interventions for young people. Moreover, Population Health as a field works from a comprehensive definition of health that is very similar to the definition of sexual health used here. Population Health research and intervention also has a tradition of working from an asset-based perspective to empower individuals to improve their health (Hancock, 2009). Thus, this dissertation makes a significant contribution to Population Health in that it focuses on an inclusive, positive definition of sexual health.

Fourth, Population Health researchers have advocated for research that is critical, includes an examination of the social determinants of health and adopts a multidisciplinary perspective to advance our understanding of social phenomena (Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005). This dissertation approached the issue of sexual health critically by questioning the interrelated associations between the gendered dynamics of power, the social determinants of health and positive sexual health outcomes while considering negative sexual health outcomes. The underlying framework of this dissertation was informed by several disciplines including Women's Studies, Population Health and Sociology. Each discipline contributed to the analysis of positive sexual health and the gendered dynamics of power in a unique way. Thus, this dissertation contributes to the field of Population Health by providing a

further example of Population Health research and the distinctive perspective that this type of research adds to the knowledge base.

Recommendations

Recommendations for practice

This dissertation examined several theoretical concepts but remained grounded by maintaining an effective relationship with the research partner, the sexual health clinic. As a result of this partnership, this dissertation makes recommendations for practice at the clinic and policy level.

There are important recommendations to be made regarding young men's sexual health. Results revealed between 8-25% of males and females reported an experience of physical or verbal abuse from a partner in the past year. Rates of verbal abuse were higher than physical for both sexes. Young men reported statistically higher rates of physical violence. We know little about young men and violence and it is possible that young men's ideas about violence are different from those of young women. Despite the possible issues of misinterpretation and over-reporting it may be important for practitioners at clinics to screen young men for experiences within intimate relationships with similar attention paid to screening young women for the same.

Further, young men reported lower scores on the Sexual Relationship Power Scale than young women. The limitations of the Sexual Relationship Power Scale with a male sample were discussed earlier and should be taken into account when interpreting these scores. However, these scores may indicate that young men are reporting less shared power in their relationships which may mean they are being dominant or are being dominated, a finding that may have implications for both young men's and young women's sexual health. Practitioners should not assume that the power within a relationship always rests with young men and should be aware of instances of controlling and disempowering behaviour on the part of both sexes within relationships.

Stereotypical notions about young men's and women's behaviour and agency within heterosexual relationships may also have important implications for public health prevention campaigns. Researchers have questioned the effectiveness of public health campaigns that are based on understandings of masculinity as dominant and femininity as submissive (Larkin Andrews, & Mitchell, 2006). It has been suggested that these campaigns may actually increase risk of HIV infection and other negative outcomes because they position young men as irresponsible and unconcerned about their health (Larkin et al., 2006; Campbell, 1995). If the images of young people presented in such campaigns do not resonate with young peoples' experiences or ideas of themselves then their effectiveness may be limited. Similar concerns have been raised previously by HIV researchers who questioned the effectiveness of HIV prevention strategies that rely primarily on condom negotiation by young women (Amaro, 1995). The findings of this dissertation present alternate understandings of young men's and young women's sexuality that, if considered, may improve the reach and effectiveness of public health campaigns dealing with sexual health for youth.

Young women continue to place themselves at increased risk by using sex as power and by forfeiting power to their male partners. Several young women spoke about how young women give away their power to their male partners. Others spoke of using sexual activities as the way in which they expressed power in their heterosexual relationships. Relinquishing control over sexual decision making and sexual behaviours leaves young women more vulnerable to negative outcomes. Positively, some women did speak of their power in ways that were conducive to health promotion, including only engaging in behaviours that they choose, respecting their bodies and openly communicating with their partners about their boundaries. Issues of empowerment and gender equity extend beyond the clinic context and may be difficult to address during a clinic visit. Nevertheless, they are important to consider when engaging in sexual health promotion and education for adolescents.

Emphasising positive aspects of sexuality and sexual health is a key issue for sexual health education. While Canada has yet to be exposed to the abstinence-based education

curriculum to the extent that the United States has, research suggests that the sexual health education that Canadian youth receive is inconsistent and limited (Canadian Federation for Sexual Health, 2007). Ensuring that young people have access to comprehensive sexual health education is a key recommendation of this dissertation. Education should include information on the emotional and relational aspects of sexuality, on power and gender expectations and on both positive and negative aspects of sexual behaviour at a minimum.

In summary, understanding both the positive and negative aspects of relationships are key to constructing effective public health and education campaigns. Relationship dynamics should also be included in sexual health counselling which may help practitioners further understand the risk taking behaviours of their clients.

Recommendations for research

Several recommendations for research were outlined in chapters one to four and will be summarized here. Primarily, more research is needed to improve our understanding of the gendered dynamics of power within heterosexual relationships and how or if today's young people are in relationships that are challenging traditional notions of power and gender. The relationships between power, seen as a negative concept by most participants here, and equity, a positive concept, remain unexplored. The relationship between the concepts of power and equity, are particularly significant in helping to advance gender equity between men and women globally.

Continuing to explore the issue of "girl power" and how young women's ideas about power are evolving in a society that increasingly sexualizes young girls and women is also vital. Working with this population to understand their perceptions of power and how these perceptions change as they enter sexual relationships may provide possibilities for intervention.

Further research, with larger and more diverse samples is also needed to explore the possible protective effect of positive sexual health outcomes such as self-efficacy, satisfaction and equity. This dissertation revealed that several positive sexual health outcomes were

associated with scores on the sexual relationship power scale for young women. We also know that women who report more power in heterosexual relationships demonstrate better outcomes than those with lower power scores (Pulerwitz et al., 2002; Pettifor et al., 2004). Therefore, it is important to continue to explore the gendered power dynamics and positive sexual health to determine if there are potential protective effects of these outcomes for young men and women.

Finally, more research is needed to further validate tools and scales designed to address positive sexual health indicators and the gendered dynamics of power. This study employed several scales that were previously untested with a young male sample and revealed interesting results. Further investigation is required to confirm the validity of these tools for use with young men. Moreover, tools and scales that measure positive sexual health indicators such as satisfaction, desire and equity remain underused and should be employed more often in studies of sexual health and behaviour to create a more complete picture of adolescent sexuality.

Conclusion

Throughout the process of this dissertation I endeavoured to examine gendered power dynamics within adolescent heterosexual relationships and their implications for sexual health. The impetus for this dissertation came from my sense that the current research on adolescent sexuality with its negative orientation was telling a limited tale. I believe that this dissertation has revealed that the large story of the participants' heterosexual relationships is multifaceted, fluid, evolving and has many positive features. I am indebted to all the young men and women who shared their thoughts and ideas with me. In listening to their stories, I have contributed to the research literature by presenting a fuller and more positively orientated picture of adolescent sexual health.

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Epilogue: Limitations & Lessons Learned

Arriving at the end of this dissertation allows me to look back and consider the limitations of my work and how I could have done things differently. This final section will review the limitations identified in previous chapters and propose ways in which these limitations could have been addressed by adopting new or modified research methodologies. This process of learning from the work done for the dissertation is an important step forward in the continued pursuit of my research interests.

To begin this process of reflection I considered the objectives of the project as a whole. The use of both qualitative and quantitative methodologies was a requirement of the Population Health Program within which I am based. The use of multiple methods of inquiry is an ambitious undertaking which inevitably involves a lengthy data collection process. Ideally, this dissertation would have been split into two separate projects, one qualitative and one quantitative. Each project could have then explored the issues of interest in a more in-depth manner. The qualitative phase could have been extended and expanded to include more questions and more participants. The quantitative phase could have included a pilot phase during which scales and measures could have been validated or tested. By combining the two phases, each phase had to be limited in scope in order to be feasible. The specific aspects of each qualitative and quantitative phase that may have been improved upon or done differently are addressed below.

The first phase of the dissertation employed interviews to explore issues of power and positive sexual health among adolescents. The sample of adolescents interviewed was convenience based. As a result of the convenience based sampling technique, adolescents were not sampled along purposeful or theoretical lines. The sampling strategy was primarily employed due to the limitations of the study site which was a drop-in sexual health clinic. As the researcher I was not able to communicate directly with participants; contact with clinic clients was limited to staff. Recruitment posters were placed in the waiting room and if adolescents were interested in participating they contacted the receptionist, who in turn, contacted me. This sampling strategy did not allow for purposeful selection of participants,

particularly by demographic characteristics or by indicators of the social determinants of health such as ethnicity or income.

In order to add depth to the qualitative results found in chapters one and two a purposeful sample could be employed. This type of sampling would allow for the selection of participants who meet identified criteria and would allow for the analysis of the data in a manner that explores the impact of these criteria on the results. For example, in chapters one and two, the reader will note the presence of self-identified bisexual women in the sample. These participants were included in the study because they spoke of their experiences in heterosexual relationships. However, the unique influence of their bisexual identity on their thoughts about power, gender and heterosexual relationships was not explored. In order to examine the influence of such factors on the participants' understandings of power larger and more purposefully selected samples are necessary. For example, young women who self-identify as bisexual could have been purposefully sampled so as to explore the influence of their self-identified status on their interpretation of power in heterosexual and same-sex relationships. A grounded theory approach to data analysis, rather than simply content analysis, would also be necessary to develop sound conclusions about the influence of factors such as sexual orientation, and/or sexual orientations, on the results. A grounded theory approach to analysis would include constant comparison and theory building and would be concurrent with data collection. This approach allows for new questions to emerge and be explored throughout the data collection process.

Purposeful sampling and the use of a grounded theory methodology would have added to the analysis of many issues in the qualitative phase including the influence of participant's self-identified ethnicity and socio-economic status on the results. The analysis approach that was used during the qualitative phase was not concurrent with data collection. As a result, further exploration of issues that were identified during the analysis could not be explored with subsequent participants. Future studies should adopt a concurrent analysis process as described above that would allow for the exploration of issues identified through the analysis.

A limitation that was common to both the qualitative and quantitative phase was the location of recruitment and the limited ethnic diversity of the sample. Since ethnicity has been identified as a key determinant of health particularly in sexual health research, it was deemed as an important determinant to examine in this study. However, in both phases there was a smaller sample of young men and the majority of participants self-identified as Caucasian. The lack of ethnic diversity in the sample was surprising as both the sexual health clinic and the university setting were thought to have good representation of various ethnic groups. In order to increase the sample of young men or to increase the ethnic diversity of the sample several strategies could have been employed. Oversampling of either of these groups could have been completed to increase their participation. Recruitment could have been conducted at sites wherein these groups could have been targeted. Such sites could have included community centres with male only programs or with focused activities for specific ethnic groups. Sampling strategies such as snowball sampling where participants are asked to refer a friend to the project may also have been an effective targeted recruitment strategy, particularly during the qualitative phase.

Several limitations regarding the scales in chapters three and four were noted. The primary limitations concern the male sample and the interpretation of the scales for use in this dissertation. Many of the issues related to the scales and measures are tied to the decision to use pre-existing scales. In some cases the scales employed different time references, sometimes due to the nature of the outcome being measured. For example, participants were asked if they had been diagnosed with a sexually transmitted infection (STI) in the past year while many of the other measures were concerned with the participant's current or most recent relationship. One of the implications of these differing time points is that the negative sexual health outcomes, such as a STI, may not have occurred in the participant's most recent relationship. As a result, the causal order of outcomes is unknown. In future studies this could be addressed by asking participants to clarify whether the outcome did occur in the most recent relationship in order to contextualize and interpret the findings more reliably. Another option would be to standardize all the time references so that the comparison point for all the outcomes is the same.

In addition, the question that evaluated whether participants were sexually active may have also led to skewed outcomes. Participants were provided with a list of sexual activities and were asked to identify which of the activities they defined as sexual activity, whether they were sexually active and which of the listed activities they were engaged in. As a result of the self-defined nature of sexual activity some of the participants who stated they were sexually active may have only engaged in low risk activities such as kissing or touching. This may have led to the low numbers of negative outcomes simply because a minority of the participants had not engaged in activities that could lead to these outcomes. Similarly, if some of the participants had not engaged in high risk activities they may have reported more positive outcomes as a result. While allowing adolescents the opportunity to self-define whether they were sexually active and opening this category to activities beyond intercourse is a strength of this project, a finer analysis may be needed to examine the subtleties in the participants' responses and the influence on outcomes.

Another scale issue that should be improved upon in subsequent projects relates to validation and interpretation. A strength of this dissertation was its positive approach to the measurement of relationship power and sexual health. This approach had corresponding limitations when existing scales, that may not have had a positive orientation, were used. In particular, relationship power was measured using the Sexual Relationship Power Scale (SRPS) (Pulerwitz, Gortmaker, & DeJong, 2002). As described in chapter four, the scoring of one of the subscales was modified to weight shared decision making higher than dominant decision making in line with the positive focus of this dissertation. The scoring of the second subscale (relationship control) was not rescored because this subscale was interpreted to measure either shared or dominant decision making depending on how one scored on the scale. This interpretation was based on the fact that the scale measures relationship power which is a relational concept. For example, if one scored very low on this subscale this could mean that he or she was in a dominant relationship with a lot or a little power. However, if one scored high on this subscale the score could also indicate a dominant relationship or a shared power relationship. While the original and subsequent papers on the SRPS focused on relationship power, the idea of shared or equitable power

was not addressed as the interpretation of the scale was based on a have/have not or dichotomous perception of power. Although this new scoring represents a strength of this dissertation future studies should endeavour to validate this new interpretation of the SRPS. The scope of the study on which this dissertation was based was quite broad and the addition of a validation study would not have been feasible. However, ideally, the interpretation of the scale and the construct validity of this new rescored version would have been tested in a pilot phase of the project. Pilot testing the scale would also strengthen the justification for using the scale with a male sample within which it was previously under tested.

The convenience based sampling strategy limits the generalizability of these findings. Given the settings within which the study recruitment took place random sampling was not practical. However, a random sampling strategy would have been the right method to increase the rigour and generalizability of the findings of this dissertation. Alternatively, as described above, a purposeful sampling strategy in which particular groups could have been effectively targeted would have addressed some of the inherent limitations. For example, the exclusion of those participants who were not sexually active during the quantitative analysis could have been avoided if only sexually active individuals were sampled in a purposeful manner.

Linked to the issue of sampling and generalizability is the issue of the study site. As described above, the study site could have been targeted to ensure adequate representation of underrepresented groups such as males and those individuals from diverse ethnic groups. Also, within the study sites oversampling techniques could have been applied to increase participation from these groups.

Overall, the limitations inherent in the methodological approach to this dissertation pose important limits to the generalizability of the findings and leave questions unexplored. I intend to continue to work on issues of gender, ethnicity, power, equity and sexual health. This dissertation, as I hope this epilogue has demonstrated, has allowed me to recognize and understand how to address the limitations of this current project in my future work.

Appendix A

Ethics Approval



Université d'Ottawa University of Ottawa

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for ethical approval for the research project **Girl Power? Contextualizing Positive Sexual Health among Heterosexual Canadian Adolescents – An Exploration of Gendered Power dynamics and the Social Determinants of Health (File # 02-07-03)** submitted by Marion Doull and supervised by Christabelle Sethna of the Institute of Women's Studies. The members of the REB found that the research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave the research project a Category Ia (Approval).

This certification is valid for one year from the date indicated below.

Catherine Paquet
Protocol Officer for Ethics in Research
For the Chair of the Social Sciences and Humanities REB
Richard Clément

March 16, 2007
Date



May 8, 2007

Research Ethics Board
Ottawa Public Health
100 Constellation Cres.
7th Floor West
Ottawa, ON K2G 6J8

Marion Doull
Institute of Population Health
University of Ottawa

Dear Marion Doull

Re: Project #114-07 Girl Power? Contextualizing positive sexual health among heterosexual Canadian adolescents – an exploration of gendered power dynamics and the social determinants of health

I am pleased to inform you that the changes to your project have been approved. Renewal is valid for a period of one year. No further changes, amendments or addenda may be made to the study protocol without the approval of the Ottawa Public Health Research Ethics Board.

The Tri-Council Policy Statement requires a greater involvement of Research Ethics Boards in research studies over the course of their execution. You must inform the Research Ethics Board of adverse events encountered during the study, or of significant new information that becomes available after the Research Ethics Board's review. The Research Ethics Board will review the new information to determine if the study protocol should be modified, discontinued or should continue as originally approved. Please do not hesitate to contact Katharine Robertson-Palmer, A/Manager, Education & Research Unit;

Sincerely,

Peter Monette ✓
Chair, Research Ethics Board
Ottawa Public Health

c.c. Catherine Paquet, Protocol Officer for Ethics in Research



Université d'Ottawa University of Ottawa

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for ethical approval for the research project **Girl Power? Contextualizing Positive Sexual Health among Heterosexual Canadian Adolescents – An Exploration of Gendered Power Dynamics and the Social Determinants of Health, Phase II (File # 09-07-11)** submitted by Marion Doull of the Institute of Population Health and supervised by Christabelle Sethna of the Institute of Women's Studies. The members of the REB found that the research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave the research project a Category Ia (Approval).

This certification is valid for one year from the date indicated below.

Catherine Paquet
Assistant-Director Interim (Ethics)
For the Chair of the Social Sciences and Humanities REB
Peter Beyer

September 27, 2007
Date



December 4, 2007

Research Ethics Board
Ottawa Public Health
100 Constellation Cres.
7th Floor West
Ottawa, ON K2G 6J8

Marion Doull
Institute of Population Health
University of Ottawa

Dear Marion Doull:

Re: Project #114-07 Girl Power Phase 2

I am pleased to inform you that the changes to your project, additional survey questions, have been approved. Renewal is valid for a period of one year. No further changes, amendments or addenda may be made to the study protocol without the approval of the Ottawa Public Health Research Ethics Board.

The Tri-Council Policy Statement requires a greater involvement of Research Ethics Boards in research studies over the course of their execution. You must inform the Research Ethics Board of adverse events encountered during the study, or of significant new information that becomes available after the Research Ethics Board's review. The Research Ethics Board will review the new information to determine if the study protocol should be modified, discontinued or should continue as originally approved. Please do not hesitate to contact me at

Sincerely,

Bev Wilcox
Secretariat, Research Ethics Board

cc: Peter Monette
Chair, Research Ethics Board
Ottawa Public Health

Appendix B
Phase One Documents

Appendix B

Phase One: Interview Guide

Questions:

1. What does the word power mean to you?
2. What does the word agency mean to you?
3. Can you describe a powerful girl to me? (ask opposite sex of group first)
4. Can you describe a powerless girl to me? Or a girl with no power?
5. Can you describe a powerful boy/guy?
6. Can you describe a powerless boy/guy? Or a boy/guy with no power?
- Q3-6 Probes:* What types of things can they do/not do? What do they look like? How do they act? How do they treat other girls/boys?
7. How do girls/guys express power in their relationships with boyfriends/girlfriends?
**Probes:* Deciding what the couple does? Deciding who the couple hangs out with? Telling their partner what to wear? Making all the important decisions? Violence/Anger? Equality? Respect?
8. How do guys/girls express power in sexual relationships?
**Probes:* Deciding when the couple has sex? Cheating, being unfaithful? Insisting on using protection? Saying no?
9. What about someone who you think is sexually powerful – can you describe this person to me?
Probes: What do they look like? Act like? Wear?
10. How do you express power in your sexual relationship (current or recent)?
11. Can you give me some examples of what your partner does in your own sexual relationship that you think is powerful?
12. How do you know if you have power in a relationship?
13. What does the term sexual health mean to you?
Probes: or healthy sexuality?
14. Can you give me some examples of positive sexual health outcomes?
Probes: In other words, can you give me some examples of what make a sexual relationship positive?



Université d'Ottawa • University of Ottawa

Institut d'études des femmes Institute of Women's Studies

Please fill out the following information about yourself.

1. Chosen alias or pseudonym _____
2. Sex (please circle one): FEMALE MALE
3. What is your age? _____
4. What is your racial or ethnic background? _____
5. In what country were you born? _____
6. If you were born outside of Canada, how many years have you lived in Canada? _____
7. How would you describe your sexual orientation?
 - a) Heterosexual (attracted to opposite sex partners)
 - b) Homosexual/Gay/Lesbian (attracted to same-sex partners)
 - c) Bisexual (attracted to both same and opposite sex partners)
 - d) I'm not sure
8. Are you currently in school?
Yes No
9. Which of the following best describes your work situation?
 - a) I work part-time
 - b) I work full-time
 - c) I don't work
10. Does your family own a car, van or truck?
 - a) no
 - b) yes, one
 - c) yes, two or more
11. Do you have a bedroom for yourself at home?
 - a) no
 - b) yes

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12. During the last 12 months how many times did you travel away on holiday with your family?

- a) not at all
- b) once
- c) twice
- d) more than twice

13. How many computers does your family own?

- a) none
- b) one
- c) two
- d) more than two

14. What does being sexually active mean to you? (circle all that apply)

- a) Kissing on the mouth
- b) Touching another person under their clothes
- c) Touching another person not wearing clothes
- d) Being touched by someone under your clothes
- e) Being touched by someone with no clothes on
- f) Performing (giving) oral sex to a guy
- g) Performing (giving) oral sex to a girl
- h) Receiving (getting) oral sex from a guy
- i) Receiving (getting) oral sex from a girl
- j) Having penis-in-vagina contact with someone
- k) Having penis-in-anus contact with someone

15. Are you currently (now) sexually active?

Yes No

16. Have you been sexually active with anyone in the last 12 months?

Yes No



Université d'Ottawa • University of Ottawa

Institut d'études des femmes Institute of Women's Studies

Title of the study: Girl Power? Contextualizing positive sexual health among heterosexual Canadian adolescents - an exploration of gendered power dynamics and the social determinants of health

Researcher: Marion Doull
Graduate Student
Institute of Population Health
University of Ottawa

Supervisor: Christabelle Sethna
Professor
Institute of Women's Studies
University of Ottawa

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Marion Doull under the guidance of her supervisor Dr. Christabelle Sethna.

Purpose of the Study: The purpose of the study is to research power and relationships among young people. This project is looking at how young people understand and define power in the context of their relationships. This project is part of a larger study that is looking at the sexual health of young people in Ottawa. The larger study is being completed for the doctoral thesis project of the researcher, Marion Doull.

Participation: My participation will consist of attending one group discussion that will last about 1 hour to 1.5 hours. Prior to the group discussion I will be asked to fill out a short information sheet about myself. I will also be asked if the researcher can contact me after the discussion for a follow-up interview if she has more questions. During the group discussion the researcher will ask questions and the group will be asked to talk about what they think about the questions. The group discussions will be tape recorded and everything I say will be completely confidential. The group discussion will be held at the City of Ottawa Sexual Health Clinic at 179 Clarence St. in the Byward Market on the following dates: (to be determined).

Risks: My participation in this study will entail the sharing of some personal information, I may feel awkward about answering some of the researcher's questions. I have received assurance from the researcher that every effort will be made to minimize these risks. For example, all my answers will be kept completely confidential and I will remain anonymous by using a fake name. Also, I am free to leave the focus group at any time and stop participating if I am uncomfortable. Finally, the researcher will provide me with a list of contacts that I can call if I have questions or concerns after the discussions.

Benefits: My participation in this study will provide important information that will become part of a larger study on sexual health and young people. The information that I provide will help the researcher learn about how power is understood by young people and how this influences their relationships and the risks they take in their relationships. This information will advance our understanding of young people's sexual health and will help to improve services and programs for young people.

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Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the doctoral thesis project of the researcher and that my confidentiality will be protected. My confidentiality will be protected because I will use a fake name for the discussions and the discussions will take place in a private room. Also, I agree to respect the confidentiality of all other focus group participants. **Anonymity** will be protected by using fake names for the discussion and the researcher will keep this signed consent form separate from the information sheet that I complete so that the two cannot be linked. Also, the researcher will use my fake name if she quotes anything that I say in research publications so that I will not be identified. The researcher has informed me that if I disclose abuse or an intention to harm myself that she is legally obliged to report this information to clinic staff.

Conservation of data: The data collected, such as information sheets, tape recordings and written notes will be kept in a secure manner at the home of the researcher until completion of the study. After the study is completed the data will be kept in a secure manner at the office of Dr. Christabelle Sethna at the University of Ottawa for 10 years and then will be destroyed.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal (my information sheet, anything that I said in the group discussions) will not be used by the researcher in her project.

Information about study results: Once completed a summary of the results of this study will be posted online at the Institute of Women's studies website at the University of Ottawa. Please refer to the 'Conferences, Research, and Publications' section of the website at: http://www.socialsciences.uottawa.ca/womenst/eng/conf_res_publ.asp. Results will also be available by contacting the researcher at the number listed above.

Acceptance: I, _____, agree to participate in the above research study conducted by Marion Doull of the Institute of Population Health at the University of Ottawa, who is under the supervision of Dr. Christabelle Sethna

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5

Tel.: (613) 562-5841

Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature : _____ Date: _____

Appendix C
Phase Two Documents

Sexual Health & Relationships Survey

PURPOSE OF STUDY: This research is being conducted by Marion Doull, a graduate student from the University of Ottawa to increase our understanding of youth sexual health and relationships. This survey asks you about yourself, your relationships and your ideas about sexual health. Please help by answering the questions below, it should take you about 20 minutes to complete.

IMPORTANT: This survey is confidential and anonymous. Your participation is VOLUNTARY and will not affect the services you receive. You do not have to answer any questions that you do not want to. When you are finished please FOLD THE SURVEY in half, staple it and RETURN IT TO THE FRONT DESK. **Thank you for your help.**

Part 1: Questions about you...

This section will ask you some general information about yourself. Please answer honestly and remember that all your responses are **confidential** and **anonymous**.

1. How old are you?

2. Are you (circle one):

Male Female

3. How would you describe your sexual orientation?

- a) Heterosexual (attracted to opposite sex partners)
- b) Homosexual/Gay/Lesbian (attracted to same-sex partners)
- c) Bisexual (attracted to both same and opposite sex partners)
- d) I'm not sure

NOTE: This survey is focused on Heterosexual youth, if you answered 'b' or 'c' to the above question, you do not have to complete the rest of this survey, just return it to the reception. Thank you.

4. What is your racial or ethnic background? (For example, Latina? Somali? First Nations? Lebanese? Chinese? Caucasian/White? Black?)

5. In what country were you born?

6. If you were born outside of Canada, how many years have you lived in Canada?

7. What is the **highest** grade level you have completed in school (circle one)

Elementary	Junior High	High School	College/University
0 1 2 3 4 5 6	7 8	9 10 11 12	1 2 3 4 5 6

8. Are you currently in school?

- a) No
- b) Yes

8b. If yes, what is your grade average at school?

- A (80-100%)
- B (70-79%)
- C (60-69%)
- D (50-59%)
- F (0-49%)

9. Which of the following best describes your current work situation?

- a) I work part-time
- b) I work full-time
- c) I don't work
- d) I volunteer

10. Which of the following best describes your living situation?

- a) I live alone
- b) I live with my mother and father
- c) I live with my mother only
- d) I live with my father only
- e) I live with my mother and stepfather
- f) I live with my father and stepmother
- g) I live with my grandparents
- h) I live in with foster parents
- i) I live with my boyfriend/girlfriend
- j) I live with roommates/friends
- k) I live in residence at university or college
- l) I am homeless or live in a shelter
- m) Other - please tell me:

11. Do your parents and/or guardians give you money to help pay your rent and/or expenses?

- a) Yes
- b) No
- c) I live with my parents/guardians

12. Does your father work?

- a) I don't know
- b) No
- c) Yes

If yes, what does he do? (for example, he is a teacher, taxi driver, plumber, lawyer)

13. Does your mother work?

- a) I don't know
- b) No
- c) Yes

If yes, what does she do? (for example, she is a teacher, taxi driver, plumber, lawyer)

14. Are you or your family on social assistance (welfare)?

- a) Yes
- b) No

15. Would you say that your family is:

- a) wealthy
- b) middle class
- d) poor
- e) I don't know

IMPORTANT:

IF you live at HOME with your parents/guardians answer these questions:

16a. Does your family own a car, van or truck?

- a) No
- b) Yes, one
- c) Yes, two or more

17a. Do you have a bedroom for yourself at home?

- a) No
- b) Yes

18a. During the last 12 months how many times did you travel away on holiday with your family?

- a) Not at all
- b) Once
- c) Twice
- d) More than twice

19a. How many computers does your family own?

- a) None
- b) One
- c) Two
- d) More than two

IMPORTANT:

If you have moved out and DO NOT live at home with your parents/guardians answer these questions:

16b. Do you own a car, van or truck?

- a) No
- b) Yes, one
- c) Yes, two or more

17b. Do you have a bedroom for yourself where you live?

- a) No
- b) Yes

18b. During the last 12 months how many times did you travel away on holiday?

- a) Not at all
- b) Once
- c) Twice
- d) More than twice

19b. How many computers do you own?

- a) None
- b) One
- c) Two
- d) More than two

20. What is the **highest** level of education your mother has completed? (circle one)

- a) Elementary school (grade 1-6)
- b) Junior High School (grade 7-8)
- c) High school (grade 9-12)
- d) College degree
- e) University degree
- f) I don't know

21. What is the **highest** level of education your father has completed? (circle one)

- a) Elementary school (grade 1-6)
- b) Junior High School (grade 7-8)
- c) High school (grade 9-12)
- d) College degree
- e) University degree
- f) I don't know

22. I think a powerful **girl** is: (circle all that apply)

- a) Smart
- b) Successful
- c) Abusive
- d) Respectful
- e) Bitchy
- f) Independent
- g) Controlling
- h) Confident
- i) Violent
- j) Attractive
- k) Knows what she wants
- l) Mean
- m) Responsible
- n) Ugly
- o) Assertive
- p) Stupid
- q) Strong

23. I think a powerful **guy** is: (circle all that apply)

- a) Smart
- b) Successful
- c) Abusive
- d) Respectful
- e) Cocky
- f) Independent
- g) Controlling
- h) Confident
- i) Violent
- j) Attractive
- k) Knows what he wants
- l) Mean
- m) Responsible
- n) Ugly
- o) Assertive
- p) Stupid
- q) Strong

Part 2: Questions about your current or most recent relationship(s)

Important:

If you are in a relationship or dating someone NOW answer the questions about this person.

If you are NOT in a relationship or dating someone now answer the questions about a person you have been with before.

If you have multiple partners choose ONE partner and answer the questions about this person.

Please answer honestly

24. What does being sexually active mean to you? (circle all the things you think apply)

- a) Kissing on the mouth
- b) You touching another person under their clothes
- c) You touching another person not wearing clothes
- d) Being touched by someone under your clothes
- e) Being touched by someone with no clothes on
- f) Performing (giving) oral sex to a guy
- g) Performing (giving) oral sex to a girl
- h) Receiving (getting) oral sex from a guy
- i) Receiving (getting) oral sex from a girl
- j) Having penis-in-vagina contact with someone
- k) Having penis-in-anus contact with someone

25. Based on what you answered to the last question - are you currently (now) sexually active?

- a) Yes
- b) No

26. Have you been sexually active with anyone in the last 12 months?

- a) Yes
- b) No

27. Which of the following behaviours have you done? (circle all that apply)

- a) Kissed someone on the mouth
- b) Touched another person under their clothes
- c) Touched another person not wearing clothes
- d) Been touched by someone under your clothes
- e) Been touched by someone when you had no clothes on
- f) Performed (given) oral sex to a guy
- g) Performed (given) oral sex to a girl
- h) Received (got) oral sex from a guy
- i) Received (got) oral sex from a girl
- j) Had penis-in-vagina contact with someone
- k) Had penis-in-anus contact with someone

28. Which of the following *best* describes your current or most recent partner situation?

- a) I am not in a relationship with anyone
- b) I have a boyfriend/girlfriend
- c) I live with my boyfriend/girlfriend
- d) I am married
- e) I have a casual partner who is not my boyfriend/girlfriend
- f) I have more than one partner
- g) Other (please describe): _____

29. How long have you been with this partner?

- a) Less than one month
- b) Between a month and 3 months
- c) Between 3 and 6 months
- d) 6 months to one year
- e) More than one year

30. Are you sexually active with this partner?

No

Yes

31. What is the sex of your current or most recent partner?

Male

Female

32. How old is your partner?

33. Do you think that your partner has had other sexual partners at any time during your relationship with her/him?

- a) Yes
- b) No
- c) I don't know

Thinking about your current or most recent partner circle one answer:

34. If I asked my partner to use a condom, he/she would get violent

Strongly Agree

Agree

Disagree

Strongly Disagree

35. If I asked my partner to use a condom, he/she would get angry

Strongly Agree

Agree

Disagree

Strongly Disagree

36. Most of the time, we do what my partner wants to do

Strongly Agree

Agree

Disagree

Strongly Disagree

37. My partner won't let me wear certain things

Strongly Agree

Agree

Disagree

Strongly Disagree

38. When my partner and I are together, I'm pretty quiet

Strongly Agree

Agree

Disagree

Strongly Disagree

39. My partner has more say than I do about important decisions that affect us

Strongly Agree

Agree

Disagree

Strongly Disagree

40. My partner tells me who I can spend time with

Strongly Agree

Agree

Disagree

Strongly Disagree

41. If I asked my partner to use a condom, he/she would think I'm having sex with other people

Strongly Agree

Agree

Disagree

Strongly Disagree

42. I feel trapped or stuck in our relationship

Strongly Agree

Agree

Disagree

Strongly Disagree

43. My partner does what he/she wants, even if I do not want him/her to
Strongly Agree Agree Disagree Strongly Disagree
44. I am more committed to our relationship than my partner is
Strongly Agree Agree Disagree Strongly Disagree
45. When my partner and I disagree, he/she gets his/her way most of the time
Strongly Agree Agree Disagree Strongly Disagree
46. My partner gets more out of our relationship than I do
Strongly Agree Agree Disagree Strongly Disagree
47. My partner always wants to know where I am
Strongly Agree Agree Disagree Strongly Disagree
48. My partner might be having sex with someone else
Strongly Agree Agree Disagree Strongly Disagree

Thinking about your current or most recent partner – circle one answer:

49. Who usually has more say about whose friends to go out with?
My Partner Both of us Equally Me
50. Who usually has more say about whether you have sex?
My Partner Both of us Equally Me
51. Who usually has more say about what you do together?
My Partner Both of us Equally Me
52. Who usually has more say about how often you see one another?
My Partner Both of us Equally Me
53. Who usually has more say about when you talk about serious things?
My Partner Both of us Equally Me
54. In general, who do you think has more power in your relationship?
My Partner Both of us Equally Me
55. Who usually has more say about whether you use condoms?
My Partner Both of us Equally Me
56. Who usually has more say about what types of sexual acts you do?
My Partner Both of us Equally Me

Thinking about your current or most recent partner – circle one answer:

57. I find some sexual matters are too upsetting to talk about with my primary partner
Strongly agree Agree Disagree Strongly Disagree
58. I think it is difficult for my primary partner to tell me what he/she likes to do sexually
Strongly agree Agree Disagree Strongly Disagree

59. It is easy for me to tell my primary partner what I like or don't like to do during sex
Strongly agree Agree Disagree Strongly Disagree

60. My primary partner hardly ever talks to me when I want to talk about our sex life
Strongly agree Agree Disagree Strongly Disagree

61. My partner really cares about what I think about sex
Strongly agree Agree Disagree Strongly Disagree

62. Talking about sex with my primary partner is usually fun for both of us
Strongly agree Agree Disagree Strongly Disagree

In the past year have you:

63. Asked a new partner how he/she felt about using condoms before you had intercourse
Always Almost always Sometimes Never

64. Asked a new sex partner about the number of past sex partners he/she had
Always Almost always Sometimes Never

65. Told a new sex partner about the number of past sex partners you have had
Always Almost always Sometimes Never

66. Discussed with a new sexual partner the need for both of you to get tested for HIV before having sex
Always Almost always Sometimes Never

67. Talked with a new sexual partner about not having sex until you have known each other longer
Always Almost always Sometimes Never

68. Asked a new sex partner if he/she has ever had a sexually transmitted infection (like chlamydia, herpes, gonorrhoea)
Always Almost always Sometimes Never

Part 3: Health and Behaviour Questions
Please answer honestly

69. Are you currently using any kind of birth control?
a) No
b) Yes

If yes, what do you use?

- a) Birth control pill
- b) Injections ("the shot", Depo-Provera)
- c) Diaphragm
- d) Condoms
- e) Other – please tell me:

70. In the past 12 months, have you had sexual intercourse?
a) No
b) Yes

71. If **yes** to last question, how often did you use a condom?

- a) All of the time
- b) Most of the time
- c) Some of the time
- d) Never

72. In the past 12 months have you been told that you have a sexually transmitted infection (STI)? (for example: chlamydia, gonorrhoea...)

- a) No
- b) Yes
- c) I don't know

73. Have you ever been tested for HIV?

- a) No
- b) Yes

74. Has your partner (boyfriend/girlfriend) been tested for HIV?

- a) No
- b) Yes
- c) I don't know

75. Have you or your girlfriend/partner ever been pregnant?

- a) Yes
- b) No

76. Have you ever exchanged sex for money, favours or gifts?

- a) Yes
- b) No

77. In the past 12 months how many sexual partners have you had?

78. In the past 12 months has your partner hit, punched, kicked, slapped or been physically violent with you?

- a) Yes
- b) No

79. In the past 12 months has your partner insulted you, called you names, or been verbally abusive towards you?

- a) Yes
- b) No

For the next four questions (#80-83) tell me whether you strongly agree, agree, disagree or strongly disagree:

80. I have access to condoms when I need them

Strongly Agree Agree Disagree Strongly Disagree

81. I would know where to get the birth control pill if I needed it

Strongly Agree Agree Disagree Strongly Disagree

82. If I were uncomfortable I know I could refuse a sexual experience that my boyfriend/girlfriend wanted me to try

Strongly Agree Agree Disagree Strongly Disagree

83. I'm sure I could ask someone I was having sex with to use protection (condoms or birth control)

Strongly Agree Agree Disagree Strongly Disagree

Thinking about your most recent sexual experience answer the questions by choosing one of the options: strongly agree, agree, disagree, strongly disagree

84. My most recent sexual experience made me happy

Strongly Agree Agree Disagree Strongly Disagree

85. My most recent sexual experience was good a experience

Strongly Agree Agree Disagree Strongly Disagree

86. My most recent sexual experience made my body feel good

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

87. My most recent sexual experience made me feel closer to the person I was with

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

88. My partner respects my choices when it comes to sex

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

89. I respect my partner's choices when it comes to sex

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

90. I think that in a sexual relationship both the girl and the guy should be equal

Strongly Agree Somewhat Agree Somewhat Disagree Strongly Disagree

91. Please read each item carefully and decide how much it describes you. Check one box in the table for each item:

	A) This does not describe me.	B) This Slightly describes me.	C) This Somewhat describes me.	D) This Moderately describes me	E) This Totally describes me
I have the ability to take care of any sexual needs and desires that I may have					
I am able to make sure that my sexual needs are fulfilled					
I have the skills and ability to ensure rewarding sexual behaviours for myself					
I am able to cope with and to handle my own sexual needs and wants					

	A) This does not describe me.	B) This Slightly describes me.	C) This Somewhat describes me.	D) This Moderately describes me	E) This Totally describes me
I have the capability to take care of my own sexual needs and desires					
I'm very assertive about the sexual aspects of my life					
I'm not very direct about voicing my sexual needs and preferences					
I am somewhat passive about expressing my own sexual desires					
I do not hesitate to ask for what I want in a sexual relationship					
When it comes to sex, I usually ask for what I want					

YOU ARE NOW DONE THE SURVEY. THANK YOU.



Université d'Ottawa • University of Ottawa

Institut d'études des femmes

Institute of Women's Studies

Letter of Information

Title of the Study: Girl Power? Contextualizing positive sexual health among heterosexual Canadian adolescents - an exploration of gendered power dynamics and the social determinants of health

Principal Investigator:

Marion Doull
Graduate Student
Institute of Population Health
University of Ottawa

Supervisor

Dr. Christabelle Sethna
Professor
Institute of Women's Studies
University of Ottawa

Invitation to Participate: You are invited to participate in the study mentioned above. This research is being conducted by Marion Doull from the University of Ottawa.

Purpose of the Study: The purpose of the study is to research power and relationships among young people. This project is looking at how young people understand and define power in the context of their relationships. This project is also looking at how much power young people have in their relationships and the results of this. This project is part of a larger study that is looking at the sexual health of young people in Ottawa. The larger study is being completed for the doctoral thesis project of the researcher, Marion Doull.

Participation: If you wish to participate in this study, please complete the survey that is attached to this letter. If you complete and return this survey this means that you have consented to participate in this research. If you do not wish to participate just leave the survey blank and return it. The survey should take you about 20 minutes to complete. You do not have to answer any questions that you do not want to. When you are finished, please fold the survey in half, staple it at the front desk and hand it to the receptionist.

Risks: If any questions make you uncomfortable or if there are questions that you do not want to answer, just leave them blank. You do not have to answer any questions if you don't want to.

Confidentiality: All your answers will be kept confidential and will be only be used for the purposes of this research. The only people who will have access to the research data are Marion Doull and her supervisor Christabelle Sethna. The staff of this clinic will not have access to your answers. You will not be asked to provide your name.

Anonymity: Anonymity is guaranteed since you are not being asked to provide your name or any identifying information.

Conservation of data: The surveys will be kept in a locked filing cabinet at the home of the researcher and then at the University of Ottawa for a period of 10 years at which time they will be destroyed.

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Voluntary Participation: You do not have to participate and if you choose to participate, you may refuse to answer questions that you do not want to answer. Completion and return of this survey by you means that you have agreed to participate in this study.

Information about the Study Results: Once this study is done the results will be posted online at the Institute of Women's Studies website at the University of Ottawa. Please look for the 'Conference, Research and Publications' section of the Institute of Women's Studies website at:

http://www.socialsciences.uottawa.ca/womenst/eng/conf_res_publ.asp

Results should be posted there by Fall 2008. Also, please feel free to contact Marion Doull or her supervisor by phone to ask about study results if you cannot access the internet. Remember, we are not collecting any information that can identify you so the results will be anonymous.

If you have any questions or need more information about the study, you may contact the researcher or her supervisor at the numbers found at the top of the page.

If you have any questions with about the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5, tel.: (613) 562-5841 or ethics@uottawa.ca.

Please keep this form for your records.

Thank you for your time and help with this research, it is appreciated.

Appendix C – Detailed Description of Scales¹

Health Protective Sexual Communication Scale

Centre for AIDS Prevention Studies (CAPS), University of San Francisco

Purpose

The Health Protective Sexual Communication Scale assesses perceived communication with a new primary partner regarding safe sex and sexual histories. This scale distinguishes communication that has health protective consequences from communication related to sexual satisfaction.

Conceptual Basis

Verbal communication is conceptualized as a key part of the “enactment-negotiation” process used in negotiating safer sex practices. Individuals who have a commitment to safer sex may have to negotiate protection with a partner or partners who do not have such a commitment. Verbal communication has been shown to be integral to models of HIV reduction and birth control management. Evidence suggests that individuals who are better able to communicate about their desires, sexual histories (of partner and self) were most likely to use condoms (Catania, Coates, & Kegeles, 1994).

Description

The full scale has 10 items that are assessed on 4-point likert scale. Scores can range from 10-40. Possible responses are: never (1 point), sometimes (2 points), almost always (3 points), always (4 points). Responses are summed for a total score. Higher scores represent greater communication. A brief 3-item version of the scale has also been used extensively.

Reliability

The full 10-item scale had excellent internal consistency (Cronbach’s alpha = 0.844). The brief 3-item scale also had good internal consistency (Cronbach’s alpha = 0.70).

Validity

The full scale was significantly correlated with condom use with primary (OR=1.10, $p<0.001$) and secondary (OR=1.08, $p<0.01$) partners. Factor analysis was conducted and revealed a dominant initial factor (eigenvalue =4.21) and a second, much smaller factor (eigenvalue =1.17), suggested a subscale structure. The authors decided to score the scale as a single score due to the low amount of variance accounted for by the second factor and the high correlation between the two factors ($r=0.58$).

Reference Standards

Scores for several large and diverse population groups can be found in the chapter by Catania (1998). Scale has been used in several large U.S. and international studies with adult and adolescent populations. Women generally score higher than men.

Scale Properties – Current Study

Originally 10 items; 6 items were used here to narrow focus for this population and remove redundant items.

¹ Formatting of the scale descriptions is modeled after: McDowell, I. (2006). Measuring health: A guide to rating scales and questionnaires 3rd Edition. Oxford: Oxford University Press.

Cronbach's alpha male = 0.789 (n=67)
Cronbach's alpha female = 0.845 (n=238)

Median (interquartile range), Male = 12.0 (8, 15)
Median (interquartile range), Female = 14.0 (10, 18)

Scale Items

- Asked a new partner how he/she felt about using condoms before you had intercourse
- Asked a new sex partner about the number of past sex partners he/she had
- Told a new sex partner about the number of past sex partners you have had
- Discussed with a new sexual partner the need for both of you to get tested for HIV before having sex
- Talked with a new sexual partner about not having sex until you have known each other longer
- Asked a new sex partner if he/she has ever had a sexually transmitted infection (like chlamydia, herpes, gonorrhoea)

References

Catania, J. (1998). Health Protective Sexual Communication Scale. In C. Davis, W. Yarber, & S. Davis (Eds.), *Handbook of sexuality-related measures* (pp. 544-547). Thousand Oaks, CA: Sage.

Sexual Communication Scale

Centre for AIDS Prevention Studies (CAPS), University of San Francisco

Purpose

The sexual communication scale evaluates the perceived quality of sexual communication with a primary partner.

Conceptual Basis

The scale draws from models of HIV-prevention behaviour change and proposes communication as a key factor in the adoption of safer sex behaviours. The authors draw from cognitive social learning theory to propose three processes or stages in the formation of sexual relationships (labelling, commitment and enactment). Communication is considered part of the enactment stage, the stage in which safer sexual practice are developed and used. Those with better communication skills are hypothesized to engage in less risky behaviours than those with poor skills (for example, multiple partners, less condom use).

Description

The scale has 6 items and scored on a 4 point likert scale. Possible responses are strongly agree (1); agree (2); disagree (3); strongly disagree (4). Items are summed for a total response with a range of 6-24 points. Some items are reversed scored and higher scores represent better communication.

Reliability

The scale has shown good reliability with diverse samples. For example, unmarried American adult heterosexuals aged 18-44, (Cronbach's alpha = 0.71); American adolescent females aged 12-18 years (Cronbach's alpha = 0.77); adult American heterosexuals aged 18-49 (Cronbach's alpha = 0.844).

Validity

The scale has been shown to be positively correlated with multiple sexual partners. Authors theorized that this relationship may be due to the ability of good communicators to procure new partners.

Reference Standards

In a sample of adult heterosexuals, males scored higher than females (male mean 19.7; female mean 19.0).

Scale Properties – Current Study

Cronbach's alpha, male = 0.713 (n=68)

Cronbach's alpha, female = 0.745 (n=244)

Male, mean(sd) = 18.76 (2.62)

Female, mean (sd) = 19.54 (2.90)

Scale Items

- I find some sexual matters are too upsetting to talk about with my primary partner
- I think it is difficult for my primary partner to tell me what he/she likes to do sexually
- It is easy for me to tell my primary partner what I like or don't like to do during sex
- My primary partner hardly ever talks to me when I want to talk about our sex life
- My partner really cares about what I think about sex
- Talking about sex with my primary partner is usually fun for both of us

References

- Catania J.A., Dolcini M.M., Coates T.J., Kegeles S.M., Greenblatt R.M., Puckett S. (1989). Predictors of condom use and multiple partnered sex among sexually active adolescent women: Implications for AIDS related health interventions. *The Journal of Sex Research*; 26(4): 514-524.
- Dolcini M.M., Coates T.J., Catania J.A., Kegeles S.M., Hauck W.W. (1995). Multiple sexual partners and their psychosocial correlates: The population-based AIDS in multiethnic neighbourhoods (AMEN) study. *Health Psychology*; 14(1): 22-31.

Sexual Satisfaction

Impett & Tolman (2006)

Purpose

The sexual satisfaction scale is intended to measure overall satisfaction with the most recent sexual experience. Impett and Tolman (2006) specifically assessed satisfaction with most recent experience of sexual intercourse among young women.

Conceptual Basis

The scale was developed within a feminist conceptual framework which asserts that young women's desires and experiences of pleasure within sexual relationships are silenced and rarely investigated. Conceptually the authors worked from a feminist perspective which explicitly acknowledges young women's agency within sexual relationships and positions this agency as key to healthy outcomes, including satisfaction. Working from this conceptual basis the authors developed a four question scale that explicitly assessed sexual satisfaction.

Description

The scale has four questions about an individual's most recent sexual experience: 1) It was a good experience; 2) It made me happy; 3) I liked how my body felt; 4) It made me feel closer to the other person. Response categories are yes (1), no (0) and are summed for a total score.

Validity

Sexual satisfaction was significantly associated with sexual self-concept and with approach sexual motives (engaging in sexual experiences because of personal motives, as opposed to pressure for example) among a sample of young women. These findings were in the expected direction given the conceptual basis of the scale which asserts that young women who are aware of and express their own needs and desires in relationships will experience more satisfaction. These relationships were consistent even when socioeconomic status, pubertal timing and religiosity were controlled for.

Reliability

The scale had adequate reliability (Cronbach's alpha = 0.75) with a sample of young women (aged 16-19 years).

Reference Standards

When used with a diverse sample of young women (aged 16-19 years) the majority reported their most recent experience as sexually satisfying. Responses to each individual question were varied: 80% reported that their experience made them happy; 64% reported it was a good experience; 54% reported that it made them closer to the other person and; 43% reported that they liked how their body felt.

Scale Properties – Current Study

Cronbach's alpha, male = 0.771 (n=70)

Cronbach's alpha, female = 0.886 (n=243)

Male, median (interquartile range) = 4.0 (4, 4)

Female, median (interquartile range) = 4.0 (4, 4)

Scale Items

- My most recent sexual experience made me happy
- My most recent sexual experience was good a experience
- My most recent sexual experience made my body feel good
- My most recent sexual experience made me feel closer to the person I was with

References

Impett E.A., Tolman D.L. (2006). Late adolescent girl's sexual experiences and sexual satisfaction. *Journal of Adolescent Research*; 21(6): 628-646.

Sexual self-efficacy

Snell 2001

Purpose

The sexual self-efficacy scale is a subscale of Snell's Multidimensional Sexual Self-Concept Questionnaire (MSSCQ). The MSSCQ is a self-report measure designed to measure 20 psychological aspects of human sexuality. The full scale is composed of 20 subscales: 1) sexual anxiety; 2) sexual self-efficacy; 3) sexual consciousness; 4) motivation to avoid risky sex; 5) chance/luck sexual control; 6) sexual preoccupation; 7) sexual assertiveness; 8) sexual optimism; 9) sexual problem self blame; 10) sexual monitoring; 11) sexual motivation; 12) sexual problem management; 13) sexual esteem; 14) sexual satisfaction; 15) power other sexual control; 16)

sexual self schemata; 17) fear of sex; 18) sexual problem prevention; 19) sexual depression; 20) internal sexual control. Sexual self efficacy is defined "as the belief that one has the ability to deal effectively with the sexual aspects of oneself".

Conceptual Basis

The MSSCQ is based on the idea that one's sexual self concept consists of cognitive features (e.g. sexual self-efficacy), affective aspects (e.g. sexual depression) and motivational components (e.g. sexual motivation). The sexual self-efficacy subscale is conceptually based in Bandura's theories of self-efficacy.

Description

The full MSSCQ has 100 items arranged in 20 five item subscales. Each subscale is scored on a 5 point likert scale. Response options are: not at all characteristic of me (0); slightly characteristic of me (1); somewhat characteristic of me (2); moderately characteristic of me (3); very characteristic of me (4). Higher scores indicate greater amount of relevant subscale tendency. Scores on each subscale can range from 0-4.

Validity

The validity of the full MSSCQ has been tested with a sample of male and female American university students. The relationship between the MSSCQ and men and women's contraceptive behaviours and beliefs, sexual behaviours and attitudes, romantic attachment tendencies, the contributions and benefits of sexual relationships, initial sexual experiences and demographic factors were tested. Among females long term effective contraception was positively associated with the sexual self-efficacy subscale. For males sexual self-efficacy was related to the importance placed on a sexual relationship and the belief that one should wait before becoming sexually involved with a new partner. For women, sexual self-efficacy was related positively to the contributions and benefits given and received in a sexual relationship.

Reliability

The internal consistency of the subscales has been shown to be adequate as measured by Cronbach's alpha statistic. For male and females grouped together alpha values ranged from 0.72 to 0.94; for females 0.63 to 0.93; for males 0.66 0.93. For the sexual self-efficacy subscale specifically the Cronbach's alpha was 0.80 for males and 0.87 for females.

Reference Standards

In addition to the samples used in developing and testing the MSSCQ several published studies have also employed the MSSCQ or its subscales. Results from these studies are varied. For example, results on the sexual self-efficacy subscale for undergraduate females was 2.63(0.96) and males 2.76 (0.74).

Scale Properties – Current Study

Cronbach's alpha, male = 0.910 (n=67)

Cronbach's alpha, female = 0.931 (n=236)

Male, median (interquartile range) = 3.40 (2.4, 4)

Female, median (interquartile range) = 3.00 (2, 3.8)

Scale items:

- I have the ability to take care of any sexual needs and desires that I may have
- I am able to make sure that my sexual needs are fulfilled
- I have the skills and ability to ensure rewarding sexual behaviours for myself
- I am able to cope with and to handle my own sexual needs and wants
- I have the capability to take care of my own sexual needs and desires

References

Snell, W. E., Jr. (1998). The multidimensional sexual self-concept questionnaire. In C. M. Davis, W. L. Yarber, R. Bausenman, G. Schreer, & S. L. Davis (Eds.), *Handbook of sexuality-related measures* (pp. 521-524). Newbury Park, CA: Sage.

Snell, W. E., Jr. (2001). Chapter 17: Measuring multiple aspects of the sexual self-concept: The Multidimensional Sexual Self-Concept Questionnaire. In W. E. Snell, Jr. (Ed.), *New directions in the psychology of human sexuality: Research and theory*. Cape Girardeau, MO: Snell Publications. WEB: <http://cstl-cla.semo.edu/snell/books/sexuality/sexuality.htm>.

Sexual assertiveness (Snell)

Purpose

The sexual self-efficacy scale is a subscale of Snell's Multidimensional Sexual Self-Concept Questionnaire (MSSCQ). The MSSCQ is a self-report measure designed to measure 20 psychological aspects of human sexuality. The full scale is composed of 20 subscales: 1) sexual anxiety; 2) sexual self-efficacy; 3) sexual consciousness; 4) motivation to avoid risky sex; 5) chance/luck sexual control; 6) sexual preoccupation; 7) sexual assertiveness; 8) sexual optimism; 9) sexual problem self blame; 10) sexual monitoring; 11) sexual motivation; 12) sexual problem management; 13) sexual esteem; 14) sexual satisfaction; 15) power other sexual control; 16) sexual self schemata; 17) fear of sex; 18) sexual problem prevention; 19) sexual depression; 20) internal sexual control. Sexual assertiveness is defined as: "the tendency to be assertive about the sexual aspects of one's life".

Conceptual Basis

The MSSCQ is based on the idea that one's sexual self concept consists of cognitive features (e.g. sexual self-efficacy), affective aspects (e.g. sexual depression) and motivational components (e.g. sexual motivation). Conceptually, sexual assertiveness is seen as a key aspect of an individual's self-concept as it measures whether he/she can assert his/her needs within a sexual relationship.

Description

The full MSSCQ has 100 items arranged in 20 five item subscales. Each subscale is scored on a 5 point likert scale. Response options are: not at all characteristic of me (0); slightly characteristic of me (1); somewhat characteristic of me (2); moderately characteristic of me (3); very characteristic of me (4). Higher scores indicate greater amount of relevant subscale tendency. Scores on each subscale can range from 0-4.

Validity

The validity of the full MSSCQ has been tested with a sample of male and female American university students. The relationship between the MSSCQ and men and women's contraceptive behaviours and beliefs, sexual behaviours and attitudes, romantic attachment tendencies, the contributions and benefits of sexual relationships, initial sexual experiences and demographic factors were tested. Among females long term effective contraception was positively associated with the sexual assertiveness subscale. For males sexual assertiveness was positively associated with several relationship factors including number of sexual partners, the importance placed on a sexual relationship, the belief that one does not have to wait before becoming sexually involved with a new partner, and commitment. For both women and men sexual assertiveness was related positively to the contributions and benefits given and received in a sexual relationship and to more diverse and extensive sexual experiences.

Reliability

The internal consistency of the subscales has been shown to be adequate as measured by Cronbach's alpha statistic. For the sexual assertiveness subscale specifically the Cronbach's alpha was 0.78 for males and 0.86 for females.

Reference Standards

In addition to the samples used in developing and testing the MSSCQ several published studies have also employed the MSSCQ or its subscales. Results from these studies are varied. For example, results on the sexual assertiveness subscale for undergraduate females was 2.16 (1.00) and males 2.29 (0.78).

Scale Properties – Current Study

Male, median(range) = 2.4 (1.8, 3.1)

Female, median(range) = 2.6 (2, 3.4)

Cronbach's alpha, male = 0.735 (n=66)

Cronbach's alpha, female = 0.798 (n=235)

Scale items:

- I'm very assertive about the sexual aspects of my life
- I'm not very direct about voicing my sexual needs and preferences
- I am somewhat passive about expressing my own sexual desires
- I do not hesitate to ask for what I want in a sexual relationship
- When it comes to sex, I usually ask for what I want

References

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Sexual Relationship Power Scale

Pulerwitz, Gortmaker & DeJong (2000)

Purpose

The Sexual Relationship Power Scale (SRPS) was developed to measure relationship power dynamics. The scale was originally designed for use with women.

Conceptual Basis

The SRPS is based on the idea that the level of a woman's power within her sexual relationship is the key factor that determines the positive and negative outcomes of that relationship. Originally conceptualized around the idea of condom negotiation the SRPS also extends to issues of decision making power and relationship control.

Description

The SPRS has 23 items and two subscales. The relationship control subscale has 15 questions and measures relationship issues such as disagreements, infidelity, social relationships and condom use. The decision making dominance subscale has 8 questions and measures who in the

relationship controls decisions around condom use, sex acts and what the couple does together. Responses on the decision making subscale are: strongly agree (1); agree (2); disagree (3); strongly disagree (4). Responses on the relationship control subscale are: me (3 points); both of us equally (2 points); my partner (1 point). Responses are summed for a total score and rescaled according to author instructions.

Validity

The scale has been widely used with female samples, internationally and in the United States. Scores on the SRPS are significantly associated with the following factors among a diverse female sample: inversely with history of physical violence in current relationship and history of sexual violence in current relationship; directly with educational level of respondent; directly with satisfaction with current relationship and current safer sex behaviours, including consistent condom use. In a South African study scores on the SRPS were associated with condom use for both men and women.

Reliability

The internal consistency reliability of the full scale with a diverse sample of American females was 0.84.

Reference Standards

In the majority of studies that employed the SRPS raw scores were grouped into low, medium and high power for analysis and as a result raw scores for comparison are limited. In a South African study the mean for women was 39.84 (8.45) and for men 43.07 (5.51). This study used a modified version of the scale.

Scale Properties – Current Study

Scoring for the decision making dominance subscale was changed slightly for this study to reflect its positive nature. Response options became: me (1 point); both of us equally (2 points); my partner (1 point). Essentially the decision making dominance subscale was rescored so shared decision making the highest score. Scoring for the relationship control subscale did not change.

Cronbach's alpha full scale, male = 0.791 (n=65)

Cronbach's alpha full scale, female = 0.839 (n=230)

Males, mean(sd) full scale = 3.14(0.46)

Females, mean(sd) full scale= 3.24 (0.53)

Scale Items

Relationship Control Subscale

- If I asked my partner to use a condom, he/she would get angry
- Most of the time, we do what my partner wants to do
- My partner won't let me wear certain things
- When my partner and I are together, I'm pretty quiet
- My partner has more say than I do about important decisions that affect us
- My partner tells me who I can spend time with
- If I asked my partner to use a condom, he/she would think I'm having sex with other people
- I feel trapped or stuck in our relationship
- My partner does what he/she wants, even if I do not want him/her to
- I am more committed to our relationship than my partner is
- When my partner and I disagree, he/she gets his/her way most of the time
- My partner gets more out of our relationship than I do
- My partner always wants to know where I am
- My partner might be having sex with someone else

Decision Making Subscale

- Who usually has more say about whose friends to go out with?
- Who usually has more say about whether you have sex?
- Who usually has more say about what you do together?
- Who usually has more say about how often you see one another?
- Who usually has more say about when you talk about serious things?
- In general, who do you think has more power in your relationship?
- Who usually has more say about whether you use condoms?
- Who usually has more say about what types of sexual acts you do?

References

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