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Trauma, Power, and Intimate Relationships Among Women in Prison

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Abstract

The present study, which included four focus groups of women (n = 21) in four New England prisons, aimed to understand how power impacted women's relationships, exposure to violence, and health. Women described power in three ways: (a) power as control over their sexuality and their sexual partners, (b) power emerging from emotional strength, and (c) power referring to a process of empowerment. Women's perceptions and experiences of power were informed by their trauma histories and influenced their sexual behavior and health. Our findings provide a framework for considering incarcerated women's experiences of power in trauma-informed interventions for this marginalized population.

Keywords

intimate partner violence; sexual violence; prisoners; sexual health; sexuality

Introduction

Women in prison are more likely than the general population to have experienced adverse childhood and adult experiences including child physical and sexual abuse, intimate partner violence, and sexual assault (Bradley & Davino, 2002; Green, Miranda, Daroowalla, & Siddique, 2005; Lynch, Fritch, & Heath, 2012; Zlotnick, 1997). These traumatic experiences may result in a number of negative health impacts on survivors. Research among

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incarcerated women has documented that trauma exposure increases women's risk for suicidality (Clements-Nolle, Wolden, & Bargmann-Losche, 2009), traumatic distress (including posttraumatic stress disorder and sexual problems; Messina, Grella, Burdon, & Prendergast, 2007), and substance use (Messina & Grella, 2006; Salgado, Quinlan, & Zlotnick, 2007), among other outcomes. Trauma exposure is also adversely associated with women's sexual and reproductive health, including sexually transmitted infections (STIs) and unintended pregnancy (Miller et al., 2014). Women's health in prison has traditionally been neglected due to the relatively small proportion of incarcerated women compared with men (King's College London & University of London, 2008). Given pervasive trauma exposure among incarcerated women, and the implications of trauma for women's health, more in-depth research is needed to focus on trauma-informed approaches to both intervention and health care provision among this vulnerable and underserved population (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

Researchers have assessed mechanisms linking trauma and health, with specific attention to sexual negotiation and women's limited power within their sexual relationships (Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002). For example, among clinic and community samples, studies have found that women who have experienced trauma often have limited self-efficacy to negotiate when and how they have sex, whether substance use is a contextual factor in their sexual relationships, and whether they use condoms and contraception with their sexual partners (Seth, Raiford, Robinson, Wingood, & DiClemente, 2010; Swan & O'Connell, 2012; Wingood & DiClemente, 1997). Yet, our understanding of power in sexual relationships—specifically, how power is defined, theorized, and measured—varies by discipline, hindering practitioners from effectively weaving concepts of power into trauma-informed sexual health interventions to mitigate harm. Studies explicitly attending to the health impacts of power within sexual relationships often employ the Sexual Relationship Power Scale (Buelna, Ulloa, & Ulibarri, 2009; Dunkle et al., 2004; Ragsdale, Gore-Felton, Koopman, & Seal, 2009), developed by Pulerwitz and colleagues almost 20 years ago (Pulerwitz, Gortmaker, & DeJong, 2000). This scale was informed by Raewyn Connell's Theory of Gender and Power and Social Exchange Theory, which together highlight the impact of gender-based inequities on shaping who has resources, control, and decision-making power in heterosexual sexual partnerships (Amaro, 1995; Byers & Wang, 2004; Wingood & DiClemente, 2002). Indeed, the Sexual Relationship Power Scale comprised two factors—relationship control and decision-making dominance (Pulerwitz et al., 2000).

As gender is a key organizing influence in women's lives, sexual relationship power can be understood within a larger structural framework (Risman, 2004). Specifically, inequality in intimate relationships is influenced by interactional expectations of gender at the cultural level, shaped by place, time, and context (Risman, 2004; Risman & Davis, 2013). Women's relative power is further compounded by intersecting domains of inequality related to race, ethnicity, social class, and sexual orientation, among others (Bowleg, 2012). Connell's later writings on gender and power, though, challenge a framework that assumes the global dominance of men and the global subordination of women (Connell & Messerschmidt, 2005), allowing space for women's agency, empowerment, and the ability to shape social norms about gender and sexuality. To be clear, this does not imply that women are negotiating their gender and sexual relationships outside of patriarchal social structures and

inequality (Jewkes & Morrell, 2012); rather, this framework allows space for nuance to emerge in women's lived experiences, including with queer and genderqueer sexual or romantic partners, which has received comparatively less attention in research on relationship power and violence victimization (Eaton et al., 2008; Ristock, 2003). Finally, theories of gender and power may be used in conjunction with sexual script theory to elucidate the gendered and developmental nature of sexuality (Simon & Gagnon, 1986), as well as how social norms shape women's perceptions of agency and power in their sexual relationships.

Despite literature documenting extensive histories of violence victimization among women in prison (Messina & Grella, 2006; Moloney, van den Bergh, & Moller, 2009), few studies have examined how power is perceived, experienced, and achieved among this marginalized population of women. Moreover, public health research on the impacts of power on women's sexual relationships is largely quantitative in nature (Buelna et al., 2009; Dunkle et al., 2004; Ragsdale et al., 2009), precluding researchers from incorporating women's lived experiences into prevention interventions to reduce violence victimization and improve health outcomes. Trauma-informed qualitative research with women in prison, in particular, may help to understand how the prison environment may shape women's relationship experiences post incarceration. Time during incarceration may offer unique intervention opportunities, where women can gain perspective and build skills to leverage their sexuality and relationship power post incarceration for HIV and STI prevention and risk reduction gains (Johnson et al., 2015). Given women in prison have extensive histories of trauma, HIV and STI prevention interventions would benefit from critical attention to women's experiences of power in their communities and relationships, including whether and how trauma impacts their development and perception of personal and relational power.

The goal of the present study was to understand how incarcerated women with histories of trauma described power, how power manifested in their relationships, and how power impacted women's sexuality and sexual health. We consider "sexuality" to broadly include women's gender identities and roles, sexual identity, sexual attraction, sexual behavior, eroticism, pleasure, intimacy, and reproduction, which are influenced by biological, cultural, historical, and socioeconomic factors (World Health Organization, 2017). As described above, we used the Theory of Gender and Power and sexual script theory as guiding frameworks for the present study, as they focused on gender-based power imbalances with particular attention to the sexual division of power, which may be maintained through violence and coercion in relationships (Wingood & DiClemente, 2000, 2002). These theories helped organize women's lived experiences of trauma, incarceration, relationships, and sexuality to inform potential strategies for engaging women in prison in conversations about power to impact their sexual health post-incarceration.

Method

Participants for this focus group study were recruited in four women's state prisons in two Northeastern states between October 2011 and April 2012. Two were minimum security prisons and two were medium security prisons. At each site, an announcement was made in common areas, and interested women could anonymously request more information about

the study via paper slips. Trained research staff met with potential participants ($n = 47$) to inform them more about the study and screen for eligibility. To be eligible, participants had to (a) be 18 years or older, (b) have a history of physical or sexual violence victimization based on the Trauma History Questionnaire (Hooper, Stockton, Krupnick, & Green, 2011), and (c) report at least one episode of unprotected sex with a male in the 30 days prior to incarceration in a Timeline Followback (TLFB) sexual behavior interview (indicating some risk of HIV, as the parent study was focused on interventions to reduce HIV risk; Weinhardt et al., 1998). Of the 47 women screened for eligibility, 25 were deemed eligible for the study, while 18 were ineligible ($n = 6$ for no victimization, $n = 12$ for no unprotected sex), three were no longer interested, and one was unavailable for the focus group. Women eligible for the study provided written, signed informed consent. Of those women who completed the informed consent process, 21 completed focus groups. Participants were a mean age of 34.9 years. Women identified as non-Hispanic White (80%), Hispanic (10%), or multiracial (10%), which is roughly representative of incarcerated women in New England. The majority of the participants were serving short-term prison sentences, although sentences ranged from 90 days (for prostitution) to 9 years (for embezzlement). These sentences reflect the amount of time ordered to be served in prison, and not additional probation time. Study procedures were approved by the Brown University Institutional Review Board and each state's Department of Corrections review committees.

Four 90-min focus groups were conducted with three to eight women each to inform the adaptation of an HIV risk-reduction intervention for women prisoners who have experienced trauma (Johnson et al., 2015). Focus groups were audio-recorded and guided by study investigators and a co-facilitator, with a third team member taking notes. Semistructured focus groups were chosen over in-depth interviews because the overarching purpose of the study was on intervention adaptation. Specifically, the team aimed to understand how trauma might increase HIV risk behavior to tailor harm-reduction strategies for women with this history, identify needs regarding social support among women leaving prison, and ground the intervention in the lived experiences of women in prison. As such, the interview guide assessed (a) women's knowledge of and engagement in HIV risk behaviors; (b) condom use, including communication about condoms and perceptions of condom use; and (c) the role that trauma played in negotiating safe sex. Focus group recordings were transcribed verbatim, deidentified, and transferred into QSR International's NVivo 11 software for analyses.

Findings emerged using a thematic analysis approach. First, each transcript was independently coded by members of the study team, who all hold doctoral degrees in different disciplinary fields (e.g., clinical psychology, anthropology, and social policy). This open coding process was driven by the semistructured interview guide. Then, codes were reviewed and verified during group meetings, with differences reconciled via team consensus. Themes emerging from the individual and consensus coding processes were reviewed by a fourth coder (H.L.M., a social epidemiologist), who generated specific subcode concepts and then subsequently clustered these concepts into unifying themes. Summaries of these themes were written by H.L.M. and verified by F.R., S.H., C.C.K., and J.E.J. While the overarching goal of the study was to inform intervention adaptation (described in Rosen et al., 2018), it became clear that participants' perceptions and

experiences of power were important to understand their relationship histories and needs post incarceration.

Results

Trauma and Substance Use as Contextual Factors

While all participants had a history of trauma, focus groups illustrated the ways trauma impacted women's sexuality and relationships. Sexual violence, in particular, was common, though women did not necessarily define their experiences as abuse if it happened in the context of their relationship. For example,

> Sometimes, when you don't want to have sex with them, he might give you Xanax and make you fall asleep, and then have sex with you how he wants. If you don't give it to them, they're gonna get it one way or another, and is that really considered rape just because—well, you're with somebody?

Another woman shared, "You say no, and they're still getting it from you. That's how it happens to a lot of women. It's happened to me a few times." Negotiating sexuality in the context of abuse was difficult. One woman stopped asking her partner to use a condom after experiencing abuse. She rationalized her abusive partner's reaction: "It's my fault. I should have never asked him to put a condom on." Women described the ways trauma had long-lasting impacts on their sexuality and relationships. One woman shared,

> My husband became abusive in the last years of marriage… He would strangle me or hit me, punch me, then those same hands wanted to be tender to me. They were the hands that were hurting me, so I didn't want him to touch me anymore because they weren't tender hands anymore.

Substance use was another common factor in women's environments and relationships. One participant explained, "When I choose the drugs, I also choose the men that come along with it. Within those relationships I find security, because I can't find it anywhere else …" Another participant shared that substance use was a common part of her casual sexual relationships, "If I'm having a one night thing, I'm usually inebriated or under the influence." Trauma and substance use were commonly entangled in women's descriptions of their relationships, "[My husband] hit me this year right before I came in. Now, I've been here three months, and I am really clean, and I'm not sure what's gonna happen."

The Many Meanings of "Power"

In discussions about their intimate relationships, women reflected on power, including how women got power (i.e., sources of power) and how women used power vis-à-vis their sexuality. These references generally aligned with three meanings of power: (a) power as control, both of their own bodies and over their partners, (b) power emerging from emotional strength, and (c) a process of empowerment.

Power as form of control.—Women commonly reflected on power in terms of *control* over their partners and their decisions about sex. Women often felt like they were using their partners for sex, and in turn, their partners were using them. One participant shared,

> I use sex as a way to cover up my feelings with feelings, just like an addiction. I use it to manipulate other people or to get what I want, because that's what I know. For me to think about having sex and enjoying it, that's not the first thing I think about… It's like, "Hmm, if I have sex with them, I wonder what benefits I'm going to get from it," whether it's just getting off or getting drugs, money. What can I get from that besides just the pleasure of it?

Another woman had similar sentiments, "I don't have regular sex… People use me, I'm using people. I don't know how to feel powerful on top of that." Many women in these focus groups had a history of sexual relationships with both men and women and described these relationships quite differently. Women often described their sexual relationships with men as "easy" and a means to an end (the end being sexual pleasure or drugs), while they described their sexual relationships with women as more intimate. One participant explained,

> My relationships with women are so much more intimate. You become friends with them, you get to know them. I feel that there's more of a connection than with men. I feel like men are easy, easy to figure out, easy to get what you want from. They're just easy.

Women described exchanges of power and control, as they and their partners negotiated and performed hegemonic gender roles, "I'm not the decision-maker. I adapt to—I'm usually, when it's with males, I'm the dependent partner. It's not my choice." While most of the dialogue focused on relationships outside of prison, women did reflect on how gender roles manifested in their relationships in prison. One participant explained,

> It's a role reversal thing; because the girls that appear to be very masculine and play the male role are the ones who find women that are the feminine kind that will take care of them. We use men in the real world and we come in here and the guy-girls use us.

Discussions occurred in all focus groups regarding women's control of their sexuality, including exerting power to determine where, when, and how women had sex. Some women reflected on the intentional choice to abstain from sex to strengthen their relationships and make meaning of previous experiences, "I feel like I'm gaining power within myself, the longer that I'm abstinent, so that maybe the next time it will mean something and I won't make those fucked up decisions that I was making." Women described feeling power in communicating their preferences and desires regarding sex, "I believe that the only way that women are powerful in sex is if it's a consensual thing… Both want to do it, both understand each other." Others described feeling powerful by their choice to carry condoms with them. Some described this choice in the context of transactional sex, while others described this in their relationships with their regular partners, "When you're out there working on the streets, it makes you feel more powerful to have your own supplies and have your own condoms." Finally, women repeatedly mentioned the importance of recognizing and exerting their boundaries, "I think it's really important… to know where their boundaries lay. If you don't know those things about yourself, I don't think having a healthy relationship is possible."

Power emerging from emotional strength.—Women also reflected on power in terms of *strength*, which was largely interpreted as emotional strength in the context of their

relationships, influencing their ability to exert relationship power. Similar to women's differing experiences in their sexual relationships with women and men, one participant expressed fear of women's power in this realm,

> I'm afraid to have relationships with girls, because they are very much powerful and strong, emotionally. You say they're not, but they are. They're not guys. [Guys] are easy to manipulate and to do—make them do what you want. Girls are not. They're not easy.

Some participants were still struggling with this form of power (i.e., feeling emotional strength), expressing self-doubt and reluctance of their worth. While reflecting on their past risky sexual behavior, one woman stated, "Why don't we just skip right to being hopeless again, because you know you're going to end up there." However, some participants expressed feelings of hope, specifically related to experiencing a new-found independence and ability to exert relationship power:

> I know what I want. I know what I deserve, and I don't have to accept something to be in a relationship. If I want to be in a relationship, I know what I will accept, and I know what I won't take. I don't need a man to help me pay my rent. I don't need a man to take me out to dinner. You have to be independent and like yourself. You don't want to have to be in a position where you need somebody else's help to survive.

Empowerment as a process.—Women also described a process of empowerment, which frequently happened over time during the course of their incarceration, and had the potential to impact their relationships and health post incarceration. In some cases, a feeling of empowerment emerged with their sobriety as they sought help with their addiction, perceiving comfort in the discomfort that comes with recovery. This was described as a series of "firsts." For example,

> For the first time in my life, I feel confident in all aspects of my life, standing completely alone. This is the first time I've wanted help, accepted help, asked for help, admitted I needed help. It's the first time I've had any recovery. I've completely stood alone this time and it's the first time anything's ever worked for me. So, everything is uncomfortable to me right now and it's the first time anything's worked for me.

Women frequently referenced prison-based programs, which helped them explore their past experiences of relationships and trauma and reach a new level of self-awareness. When asked how women in prison can experience empowerment after trauma, several participants reflected, "in a place like this, you find it with the programs and the strength of other women." Finally, while sex and relationships were generally not referred to in terms of empowerment, there was a notable exception:

> It took me this long to know that it's about enjoying yourself, about loving each other. It's not sex, it's love, so when you make love, it's a whole different scenario. It's not like the beating or the pain, it's the pleasure. It's every word changed to another word.

Discussion

While the overarching purpose of these focus groups was to inform the adaptation of an HIV risk-reduction intervention among women leaving prison (Rosen et al., 2018), participants could not describe their relationships and histories of trauma without reflecting on how power manifested and impacted their sexuality and, ultimately, their health via sexual risk behavior. Women described power in three distinct ways: (a) power as control of their sexuality and over their sexual partners, (b) power emerging from emotional strength, and (c) empowerment as a process, which, in many cases, they experienced for the first time in prison.

Understanding women's histories of trauma, guided by the Theory of Gender and Power (Amaro, 1995; Connell & Messerschmidt, 2005; Wingood & DiClemente, 2002), helps place their reflections in context. Bolstering evidence from epidemiological literature, women's histories of sexual violence were extensive. Women rarely recognized and labeled such victimization as sexual assault or rape, which studies suggest is more likely when survivors endorse myths about rape (e.g., if they do not fight back, it is not rape; Peterson & Muehlenhard, 2004) and when the perpetrator is a regular sexual partner (e.g., husband or boyfriend; Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). This problematic normalization is not uncommon among trauma survivors (Wood, 2001) and is often accompanied by feelings of self-blame. In our sample, women expressed doubting their self-worth, which research suggests is associated with sexual risk behavior, via mechanisms including limited self-efficacy to communicate with sexual partners about sex and condom use (Salazar et al., 2004). The normalization of substance use as a contextual factor in women's relationships and sexual lives was common, and research suggests that substance use increases women's sexual risk behavior and is associated with sexual violence victimization (Livingston, Testa, Windle, & Bay-Cheng, 2015).

Intersections of trauma and sexuality were apparent in women's reflections on power as a means of control, most often over their sexual partners. Some women described using this power as a coping mechanism, while others described this behavior as a result of modeling behavior they witnessed in their families of origin. These findings are an example of how our cultures, communities, and trauma histories shape scripts regarding relationships and sexuality, and how sexual script theory (Simon & Gagnon, 1986) may be used to understand the relationship experiences of this marginalized population. Sexual scripts are culturally defined social norms or directives that guide intimate relationships (Bowleg, Lucas, & Tschann, 2004). In our study, women replicated gendered, heterosexual sexual scripts whereby women were gatekeepers and responsible for maintaining relationships, and they felt powerful in that role when they were generally disempowered in other domains of their lives. They also described their sexual partners using them for sex as normative, illustrating that even when women felt powerful asserting sexual agency, their experiences were shaped by patriarchal social norms which prioritize men's sexual pleasure and dictate and police women's sexuality (Bay-Cheng, 2015). One of the more common sources of power women described in these focus groups was their decisions to carry condoms, whether that was in the context of transactional sex or in the context of sex with regular partners. Women generally said they felt comfortable asking sex partners to use condoms, though some

women described violence as a result of condom negotiation, again highlighting the potential impact of abusive relationships on women's health.

Women in our sample commonly had sexual experiences with both women and men, and they described the contexts of these experiences differently. Relationships with men were focused on sex, with women feeling confident that they could "get what they want" from their male partners. They described these relationships as "easy." Their relationships with women were perceived as more intimate and, interestingly, challenging because women felt less able to control (i.e., exert power over) their female partners in the way that they could control their male partners. Research on sexual subjectivity and sexual script theory suggests that social and cultural norms which prioritize heterosexual sex may influence women's perceptions about their relationships with both men and women, including experiencing anxiety and fear about sexual relationships with women (Ussher & Mooney-Somers, 2000). Within the prison context, women also described relationships with other prisoners that were characterized by the performance of masculinities and femininities, driven by hegemonic (i.e., traditional) gender roles. In particular, they described how their gender performance could shift depending on their context (prison vs. home community) and partner (man vs. woman). Both Connell's and Risman's theorizing on gender and power are helpful to understand women's intimate experiences within and outside of prison, as they describe the social embodiment of dynamic masculinities and femininities that are influenced by local, regional, and global contexts and the structural forces that shape one's environment (and relative power) at any given time (Connell & Messerschmidt, 2005; Risman, 2004; Risman & Davis, 2013). Research, informed by intersectionality theory, has also found that the performance of gender in intimate relationships is also shaped by racial/ethnic identities and social class, which were important contextual factors we were unable to unpack in this study but were undoubtedly present in women's histories and experiences (Moore, 2006). In our focus groups, we were not able to determine how women identified their sexual orientation or gauge whether these perceptions about their relationships with men and women impacted their sexual behavior and health. That said, a growing body of evidence suggests that women who have sex with women and men are more likely than women who have sex with men only to report a number of sexual and reproductive health outcomes, including pregnancy (Charlton et al., 2013; McCauley et al., 2015). Future research is needed to understand whether women's perceptions about their sexual relationships with men compared with their relationships with women, such as those expressed in the current study, and their dynamic gender performance in these different relationships influence their sexual risk behavior, including the likelihood of using condoms and contraception with their sexual partners. This critical work to understand gender performance (and related power) in relationships with partners of various genders is needed to inform sexual health interventions for women in prison.

Empowerment was a gradual process that often emerged while women were in prison. In many cases, their incarceration was the first time in their lives that they felt this sense of power. Previous work has documented the potential for the prison environment to be stabilizing for women with histories of trauma and substance use (Bradley & Davino, 2002; Douglas, Plugge, & Fitzpatrick, 2009). In a study of 65 incarcerated women, more than a third (38.5%) felt that prison was safer than home, citing substance use and violence as key

contextual factors in their communities. They further described prison as a place of growth (Bradley & Davino, 2002). Other studies have suggested that prison can be difficult for women, especially those with mental health disorders (Harner & Riley, 2013), so the experience and process of empowerment is not necessarily universal. Researchers have challenged the ability of institutions (in this case, prisons) to promote empowerment without reproducing existing power structures in which incarcerated women are situated, even when prisons use "woman-centered" or gender-based approaches (McKim, 2008). For example, studies have highlighted that the criminal justice system's approach to working with incarcerated women and men is quite different and, ultimately, gendered. Specifically, incarcerated women are perceived by the system to struggle with developing and maintaining boundaries, emotional health, and relationship instability, while work with incarcerated men focuses on promoting economic stability post incarceration (Wyse, 2013). If women are not able to obtain employment or achieve housing stability upon release from prison, empowerment gains will not matter. Some participants in our sample echoed this concern, explaining that even if they felt empowered, there were still system barriers that would set them up for failure post incarceration. For example, they would not be able to get a job because they have a felony conviction, or they experienced barriers to violence-related resources despite being ready to seek help. These concerns highlight the need for trauma-informed services and programs to assist women with transition needs post incarceration, including balancing programs that promote stability in multiple domains of women's lives. Finally, women generally did not perceive sex as empowering and rarely discussed the prioritization of their own pleasure in their sexual relationships (aligning with dominant narratives, or scripts, regarding women's sexuality) warranting further research to understand whether and how empowerment-based interventions translate into women's sexual experiences.

These findings should be considered in light of several limitations. First, a majority of participants identified as non-Hispanic White, with no participants identifying as African American. While this is generally reflective of incarcerated women in New England, our findings are not generalizable to the experiences of women incarcerated in other regions of the country. Also, the sensitive nature of the focus groups may have hindered women from sharing honestly, especially given the potential power structures that exist within this closed community and the positionality of the researchers. In-depth interviews may have produced different narratives. To participate in the study, women had to report unprotected sex with a male in the 30 days prior to incarceration. Therefore, women who had not engaged in recent penetrative sex or who were having sex with women only were not recruited into the study and these findings cannot be generalized to their experiences. Also, speakers were not identified in the transcripts by their demographic characteristics, and we cannot know their identities that shaped their perceptions and experiences.

Despite these limitations, these narratives are important as the prevalence and impacts of violence against women are at the center of current cultural discourse (Maas, McCauley, Bonomi, & Leija, 2018), yet often exclude the experiences of incarcerated women. Our findings emphasize the need to incorporate conversations about power, gender, and sexuality into trauma-informed sexual health interventions for women in prison, a population that is at elevated risk for trauma exposure. This is especially important given the burgeoning female

prison population (Sabol, Minton, & Harrison, 2007) and the call for attention to improving the provision of women's health care in the prison setting. Women's perceptions and experiences of power are complex, informed by their trauma histories, and influence their sexual behavior and sexual and reproductive health.

A trauma-informed approach to assist in an intervention adaptation is rooted in recognizing the impact trauma has on women's experiences and aims to promote empowerment of survivors (Elliott et al., 2005). Our findings provide a critical framework for how to understand women's experiences of power to inform future sexual health interventions for this marginalized and underserved population.

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Caroline C. Kuo, DPhil, MPhil, is an associate professor of behavioral and social sciences and associate dean for Diversity and Inclusion at Brown University School of Public Health. Her global health research focuses on building the resilience of youth and families from underserved communities. This has included the development and testing of culturally and contextually appropriate interventions to address health disparities in the areas of sexual and reproductive health, sexual violence prevention, and mental health using research approaches that celebrate and showcase community knowledge.

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