"I think it's fuzzy": Exploring Definitions of Consent and Healthy Relationships Among College Students with Disabilities

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Abstract

Background: Rates of sexual violence (SV) and intimate partner violence (IPV) remain high among young people in the United States and are even higher among college students with disabilities (SWDs). A first step in tailoring interventions aimed at reducing rates of SV/IPV for vulnerable populations is developing a nuanced understanding of how these individuals understand the concepts of consent and healthy relationships and relate them to their own experiences.

Methods: This qualitative study focused on participants, 18-24 years old, who reported a disability or health condition while in college (n=49) and used thematic analysis to examine their definitions of consent and healthy relationships within a semi-structured interview.

Results: Six themes were produced from the data: 1) Healthy relationships require both mutual care for one another through trust, respect, support, and communication, as well as care for one's self as an individual through independence, self-confidence, and finding support outside the relationship; 2) Those experiencing unhealthy treatment by a partner may normalize the behaviors due to manipulation, denial, and their love for that person; 3) Dichotomous definitions of consent lead to misunderstandings and confusion about how to apply consent to real life experiences; 4) Within the context of a relationship, active consent can be facilitated through comfort and open communication but hindered by implied or assumed expectations and difficulty balancing one's own discomfort with the possibility of their partner feeling rejected; 5) Students assume that when

healthcare providers are asking about relationship health they are trying to elicit disclosure of abuse rather than facilitating a discussion of relationship health; and 6) Students are less likely to disclose abuse when they believe healthcare providers are fulfilling routine screening requirements rather than asking about their safety due to genuine concern, or, when they fear that disclosure will result in a loss of control over what happens next.

Conclusion: College SWDs have many of the same sexual and relationship understandings and experiences as other students, including some confusion about how to apply the concept of consent to their complex lived experiences and concerns about discussing abuse with healthcare providers. The public health significance of this study is in its implications for future SV/IPV prevention programming, healthcare provider interventions, and public health research related to consent and relationship health. Interventions that seek to reduce the high rates of SV/IPV in this population must address the complex nature of students' real sexual and romantic relationships and healthcare providers addressing relationship health with students should do so in a confidential, open, and non-judgmental manner. Further research on students' points of confusion around consent and relationship health is needed to inform future interventions.

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Preface

The decision to perform this study came from a decade of passion surrounding issues of sexual and relationship health as well as a new-found interest in qualitative research. I first began to engage with topics of sexual and relationship health through volunteer work as a peer educator in high school and then continued as an undergraduate student at Indiana University through my position as the Director of Activism in the Women's Student Association and my academic studies in Gender Studies, Psychology, and Human Sexuality. Through my employment at an HIV non-profit and internships in graduate school leading sexual health and relationship health programming, I have seen first-hand how young people grapple with understanding these complex issues and applying their understanding to their lives. Qualitative research has the ability to bring a richer understanding of adolescent and young adult perspectives to health professionals looking to improve health outcomes and reduce health disparities among marginalized groups of people.

I would like to thank those who were essential in my producing this work. First and foremost, I am grateful for the mentorship and training I have received from Dr. Carla Chugani who taught me the process of qualitative thematic analysis, worked closely with me throughout the process of conducting this research, and has encouraged and supported my professional growth. I would also like to thank my Committee Chair, Dr. Mary Hawk for her insights and supportive approach, Dr. James Egan and Dr. Robert Colter for their mentorship the past three years, and Dr. Elizabeth Miller for providing the qualitative data used in this research.

1.0 Introduction

Study Purpose and Public Health Significance

The purpose of this study is to examine how college students with disabilities (SWDs) define and discuss consent and healthy relationships and consider the implications for interventions aimed at reducing the disproportionate rates of sexual violence (SV) and intimate partner violence (IPV) experienced by young people with disabilities (Basile, Breiding, & Smith, 2016; Bonomi, Nichols, Kammes, & Green, 2018; Breiding & Armour, 2015).

Already high rates of SV and IPV in the United States are compounded when considering the additional risks faced by college students and people with disabilities. Most people first experience assault or abuse before the age of 25 (Black, 2011) and college students in particular are significantly more likely to experience SV than women of the same age not in college (Fantasia, Fontenot, Sutherland, & Lee-St. John, 2015). People with disabilities are more likely to report experiences of SV and IPV than those without disabilities (Basile et al., 2016; Breiding & Armour, 2015). These disabilities include a wide range of disorders including both physically and mental/emotionally limiting conditions (American College Health Association, 2016). With around one-fifth of college students reporting a mental health diagnosis for at least a year while in college (Auerbach et al., 2016), tailoring SV/IPV interventions to address the high risk faced by college SWDs is warranted.

Experiences of SV/IPV are associated with poor mental health outcomes such as anxiety and depression, maladaptive behaviors such as substance abuse, and poor physical health outcomes

in sexual health, injuries, and mortality rates (Fantasia et al., 2015; Smith et al., 2017). Higher rates of SV/IPV among people with disabilities not only results in a disproportionate burden of these health outcomes among this population, but the health consequences have been found to be exacerbated for those with a disability (Scherer, Snyder, & Fisher, 2016). Coping strategies to deal with the mental health challenges resulting from assault and abuse like increased alcohol use can serve to further increase the risk of SV/IPV people with disabilities face (Bonomi, Nichols, Kammes, Chugani, et al., 2018).

The Present Study

This descriptive study is a part of the larger College Health Study (CHS) through Elizabeth Miller's Lab in the University of Pittsburgh's Department of Pediatrics, Division of Adolescent and Young Adult Health. The CHS is a multi-site cluster-randomized trial evaluating the efficacy of a brief universal intervention to reduce alcohol related sexual violence on 28 campuses in PA and VW (Abebe et al., 2018). The CHS also included semi-structured interviews of college students about their experiences with alcohol use, SV, IPV, and campus prevention programming related to these topics which took place at student health centers on their college campuses or in Dr. Miller's secure lab facilities. A subsection of CHS interviews included students with a disability or health condition and investigated how disability intersected with the aforementioned areas of study.

The researcher for this study used thematic analysis to examine participant responses to questions regarding what "consent" and "a healthy relationship" means to them. Follow up questions prompted students to discuss how consent might be different within a committed relationship and how they would interpret a healthcare provider asking them about them about relationship health. Six themes emerged from the results of this analysis that demonstrate how the

context of relationships and sexual encounters can complicate the dichotomous definitions of consent and healthy or unhealthy relationships often taught in SV/IPV prevention programming and how healthcare providers can address these issues with their young patients.

2.0 Background

Rates of sexual violence (SV) and intimate partner violence (IPV) continue to be high among young people in the United States and are even higher among college students and those with disabilities. Prevention programming seeking to reduce these rates focuses on educating students about consent and relationship health. A first step in tailoring interventions relevant to vulnerable populations such as SWDs is to develop a nuanced understanding of how these individuals understand and experience the concepts of consent and healthy relationships. Although studies have displayed the prevalence of SV/IPV among this population, research exploring SWDs' perspectives has been limited.

The term disability in this study refers to all people who report having a physical, sensory, psychiatric/mental health, or neuropsychiatric/learning condition that limits their functioning in some way. Each study referenced had their own methods of determining disability status, although many relied on self-report. Given that some participants in this study had mental health conditions that were undiagnosed or may not identify as being "disabled," using self-report enabled the researchers to capture a wider array of individuals affected by a condition.

Sexual assault is defined in Pennsylvania law as a felony when "a person engages in sexual intercourse or deviate sexual intercourse with a complainant without the complainant's consent" ("18 Pa. C.S. § 3124.1.," 1995). Pennsylvania, along with over half of the other states in the United States, does not explicitly define consent in their statutes (Lawson, 2018), however a sex act is considered assault if coerced through physical force or threats of physical force; if the complainant was unconscious; if the perpetrator intentionally impaired the complainant's ability to resist through the administering of drugs, alcohol, or other intoxicants; or if the complainant has a mental

disability that renders them incapable of consent (Rainn.org, 2017). The American Law Institute has defined legal sexual consent as "a person's willingness to engage in a specific act of sexual penetration or sexual contact," but acknowledge that context and circumstances should also be considered (Lawson, 2018).

Intimate partner violence refers to any forms of physical, mental, or emotional abuse perpetrated by one person toward another in the context of a romantic relationship. This abuse may include physical harm, psychological control or manipulation, harassment in person or online, and control over where a person goes, who they talk to, and the resources available to them. Relationship health in this study refers to the ability of each person in a romantic relationship to have their own needs realized and respected by the other person(s) involved through mutual respect, trust, and support. The United States government details 13 qualities of a healthy relationship that will be discussed further in the literature review.

This study approached the issues of SV and IPV rates among college SWDs using the Ecological Model, which posits that people's behavior is determined by intrapersonal factors, interpersonal processes, institutional factors, community factors, and public policy (McLeroy, Bibeau, Steckler, & Glanz, 1988). Using this model, assault and abuse can be reduced by making changes to people's individual knowledge, attitudes, beliefs, behaviors, skills, and self-image as well as how people interact in their relationships when coping with stress and making behavioral decisions. Understanding how SWDs think about consent and healthy relationships can provide insight into how to best promote individuals' self-efficacy, self-esteem, and interpersonal skills to reduce rates of SV/IPV.

2.1 Sexual & Intimate Partner Violence Among Young People

Sexual violence experienced by adolescents and young adults in the United States persists as an issue that can affect the health and well-being of survivors for many years. According to the National Intimate Partner and Sexual Violence Survey (NISVS) of 2010, approximately 1 in 5 women (18.3%) and 1 in 71 men (1.4%) in the United States have experienced some form of rape (including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration) at some point in their lifetime (Black, 2011). About 13% of women and 6% of men have experienced sexual coercion through psychological means (i.e. unwanted sexual penetration after being pressured in a nonphysical way) in their lifetime and 27.7% of women and 11.7% of men have experienced unwanted sexual contact (Black, 2011). Of the women who have experienced rape, 79.6% reported experiencing their first rape before the age of 25 and 42.2% before the age of 18 (Black, 2011). College students are at particular risk for experiencing SV, due largely to party culture and heavy alcohol consumption (Fantasia et al., 2015). A study by Fantasia et al. (2015) found that among women 18-25, those on college campuses were significantly more likely to experience SV than women who were not on college campuses.

Intimate partner violence (IPV) is also a serious issue among young people in the United States. Nearly half of all women (48.4%) and all men (48.8%) in the United States have experience psychological aggression from their partner in their lifetime (Black, 2011). Over 1 in 3 women (35.6%) and 1 in 4 men (28.5%) experienced rape, physical violence, and/or stalking by an intimate partner in their lifetimes (Black, 2011). Most people who have experienced rape, physical violence, and/or stalking by a partner (69% of females and 53% of males) experienced some form of IPV for the first time before the age of 25 (Black, 2011), and 1 in 5 women and nearly 1 in 7 men first experienced some form of IPV between the ages of 11 and 17 (Tharp et al., 2013). In 2017, 8% of

high school students had experienced physical dating violence (9.1% of females and 6.5% of males) and 6.9% had experienced sexual dating violence (SV within the context of a dating relationship; 10.7% of females and 2.8% of males) (Center for Disease Control and Prevention, 2017). Experiences of SV and IPV have traumatic effects on a person that can last a lifetime. Since so many of these traumas occur this early in life, it is important that efforts aimed at preventing SV/IPV begin during these formative years, when young people are developing their identities, adult coping strategies, and expectations for relationships.

2.2 Sexual & Intimate Partner Violence Among People with Disabilities

People with disabilities also experience higher rates of SV and IPV than the general public, a risk that compounds among the high-risk group of young people. This heightened risk is found among people with a variety of disabilities, including those with a mental illness, which according to the National Institute of Mental Health (NIMH) is more prevalent among young adults (ages 18-25) than any other age group (National Institute of Mental Health, 2017). Diagnoses of depression and attention deficit hyperactivity disorder (ADHD) specifically have been associated with higher risk for SV among college women (Hossain, Memiah, & Adeyinka, 2014; Snyder, 2015). According to the World Mental Health Surveys conducted by the World Health Organization, one-fifth of college students report having a mental health diagnosis for at least a year while in college (Auerbach et al., 2016).

In the United States, about 23.8% of women and 20.1% of men report having a disability for more than one year (Basile et al., 2016). In a study of recent experiences of SV among people with and without disabilities, Basile et al. (2016) found of the 1.27 million women who had

reported being raped in the United States in the past 12 months, more than 39% reported having a disability at the time of the rape. When examining SV other than rape, 29% of the 6.64 million reports by women were from women with a disability and 24% of the 6 million reports by men were from men with a disability (Basile et al., 2016).

A study by Breiding and Armour (2015) used data from the 2010 NISVS to examine rates of SV and IPV among those with physical, mental, or emotional disabilities compared to those without a disability. The criteria for inclusion in the disability group were those who answered "yes" to either of the standard disability identifier questions from *Healthy People 2020* objective DSC-1, "Are you limited in any way in any activities because of physical, mental or emotional problems" and "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?", and reported having had such disability for at least a year (Breiding & Armour, 2015). Breiding and Armour (2015) found women with physical, mental, or emotional disabilities to be significantly more likely than women without a disability to report experiencing rape (adjusted odds ratio [AOR] = 4.5), sexual violence other than rape (AOR = 3.0), physical violence (AOR = 2.2), stalking (AOR = 2.9), psychological aggression (AOR = 1.8), and reproductive/sexual health control (AOR = 2.0), controlling for age, family income, race or ethnicity, and education level. Men with a disability were found to be significantly more likely than men without a disability to report experiences of stalking (AOR = 4.9) and psychological aggression (AOR = 1.7).

To get a richer understanding of the intersection between disability and SV/IPV, Bonomi, Nichols, Kammes, and Green (2018) conducted in-depth interviews with college women with mental health disabilities about their experiences of SV/IPV. These experiences took place in the context of casual sexual relationships as well as long-term romantic relationships, at times taking

place within multiple relationships. Women who had experienced chronic abuse in relationships described disability-specific abuse, social isolation, threats or intimidation, and technology-related abuse (i.e. harassment via social media or text). Alcohol misuse is a well-established factor in SV/IPV among college students and common among adults with disabilities, although few studies have examined how alcohol may function as a mediator in instances of SV/IPV among people with disabilities (Bonomi, Nichols, Kammes, & Green, 2018). Bonomi, Nichols, Kammes, and Green (2018) found that alcohol was a common facilitator in experiences of SV among their participants and that some participants described the perpetrator of the violence using alcohol and their disability to "manipulate a sexual connection" (Bonomi, Nichols, Kammes, & Green, 2018, p. 359). The authors posit that having a mental health condition makes women particularly vulnerable to SV/IPV given the stigma, isolation, and reduced self-efficacy they experiences (minority stress theory) (Meyer, 1995) and that being a part of several marginalized groups, being female and having a disability, can serve to amplify their risk for SV/IPV as their vulnerabilities can compound to create a unique abuse experience (intersectionality theory) (Bonomi, Nichols, Kammes, & Green, 2018; Crenshaw, 1989). The experience of living with these constant stressors can lead to alcohol use as a coping mechanism which can then serve to put these women at even higher risk for experiencing SV/IPV (Bonomi, Nichols, Kammes, & Green, 2018). Heavy alcohol use not only makes students more vulnerable in sexual situations, but can also worsen SWDs' mental health symptoms, serving to further increase their risk of assault or abuse.

2.3 Health & Behavioral Consequences of Sexual & Intimate Partner Violence

Experiences of SV or IPV are often followed by significant negative health and behavioral outcomes in the general public and even more so among those with disabilities. Experiences of SV are associated with poorer health outcomes among women such as anxiety, lower self-rating of health status, emotional problems, depression, and decreased work productivity (Fantasia et al., 2015). Intimate partner violence is a driver of negative health outcomes in sexual and mental health, substance use, physical injury, and mortality (Smith et al., 2017). Health consequences of IPV are exacerbated for those with a disability (Scherer et al., 2016). Scherer, Snyder, and Fisher (2013) found college women with a disability who had experienced IPV to have increased odds of internal depressive symptoms, external depressive symptoms such as suicide attempts and self-harm, and stress, compared with college women without a disability who had experienced IPV. In a qualitative study by Bonomi, Nichols, Kammes, Chugani, et al. (2018) college student women with disabilities described experiencing worsening mental health symptoms (e.g. depression, anxiety, post-traumatic stress disorder, suicidal ideation/attempts, stress) after exposure to violence, which often prompted the use of alcohol as a coping mechanism that in turn increased their vulnerability to more violence. The same study found these mental health symptoms to correspond to maladaptive behaviors (e.g. social isolation), physical symptoms (e.g. trouble sleeping, sexual and reproductive health concerns, physical injuries), and academic outcomes (e.g. skipping class, grades suffering) (Bonomi, Nichols, Kammes, & Green, 2018).

Experiences of abuse at a young age may affect the quality of future relationships as well. The quality of romantic relationships in mid-adolescence was found to predict the quality of romantic relationships in young adulthood in a longitudinal study of high-risk youth, controlling for relationships with parents and peers in a study by Madsen and Collins (2011). Participants who

reported better adolescent relationship quality were significantly more likely to report smoother dating processes and less negative affect within their young adult relationships (Madsen & Collins, 2011). Although the mediators of this association are lacking in empirical investigation, theorists have proposed the link may be explained by factors such as the development of relationship skills and improved knowledge about the self (Madsen & Collins, 2011). These outcomes demonstrate the long-term physical, mental/emotional, and interpersonal health challenges faced by young people with disabilities who have experienced SV/IPV and therefore the importance of early interventions that take their experiences and viewpoints into account.

2.4 Young People's Understanding of Consent & Healthy Relationships

Those seeking to address a wide variety of sexual health issues, such as consent, abuse, sexually transmitted infections, Human Immunodeficiency Virus (HIV), and unwanted pregnancy among youth in the United States are beginning to focus on relationship health as a mechanism for intervention (Tharp et al., 2013). This is due to the fact that educators require efficient methods for approaching these issues in settings with limited time and resources (i.e. schools) and the umbrella topic of healthy relationships can be used to touch on all of these important topics (Tharp et al., 2013). While past research has not examined views on consent and relationship health among disability populations specifically, the literature on young people's understanding of consent and how it is enacted in their sexual and romantic relationships demonstrates how interconnected and nuanced these topics can be.

Young adults in a study by Beres (2014) described the concept of consent more narrowly than how they appeared to enact consent with their sexual partners given their descriptions of their

lived experiences. This suggests that young people may not fully understand how the term consent relates to their real lives. The three major themes that emerged from this study were that participants viewed consent as a minimum requirement for sex, viewed consent as a specific event, and did not see consent applying to their committed relationships. Although these were the dominant perspectives, the same participants would describe behaviors that complicated these ideas, such as determining a partner's willingness in an ongoing fashion, communicating willingness through subtle non-verbal behaviors, and indicating willingness or consent for sex within relationships (Beres, 2014).

Brady, Lowe, Brown, Osmond, and Newman (2018), however, found that, "young people understood the complexity of sexual consent as an embodied process, which can be difficult to define, talk about or practice uniformly" (p. 35). Most participants in this study described the concept of consent as a positive agreement between partners, a shared willingness for sexual activity, or asking, giving, or receiving permission for sexual activity (Brady et al., 2018). While they could understand the concept in abstract terms, they did not find it particularly useful to their actual sexual encounters which were more complex (Brady et al., 2018). These young people understood sexual consent to be affected by various situational variables such as the sexual partners' relationship and previous encounters, their verbal communication, their body language, their behavior, and the context of the encounter (i.e. while intoxicated) (Brady et al., 2018). While they described consent as ideally involving explicit verbal communication, some noted that verbal permission does not always reflect what the person actually wants, explaining that some people might feel pressured to say yes when asked directly (Brady et al., 2018). Participants felt that neither verbal nor non-verbal communication were reliable ways of ensuring consent and that the context of the relationship would affect how consent might be communicated and interpreted

(Brady et al., 2018). Some felt consent within a romantic relationship was typically implied unless otherwise indicated, which could demonstrate the presence of a higher degree of communication within the relationship, but could also result in negative feelings of sexual obligation (Brady et al., 2018). Brady et al. (2018) illustrates how dichotomous definitions of consent understood through concepts such as "Yes means yes, and no means no" are too simple to be found useful to young people's actual complex experiences negotiating sexual consent.

Another study by Jozkowski, Marcantonio, and Hunt (2017) involving in-depth interviews with 30 college students at a large southern university discussed the way traditional gender norms influence how heterosexual young people understand and communicate about consent. The students' notions of consent included a sexual double standard in which "good girls" were not supposed to have sex, men were on a quest to obtain consent from women, women "owed" men sex once they "worked" for it, and women were supposed to put men's sexual needs over their own (Jozkowski et al., 2017).

In a study of college students in the United Kingdom, Camp, Sherlock-Smith, and Davies (2018) found women to have more explicitly positive views about consent than men and to be less likely to blame victims of sexual assault who had been drinking. Indicators of positive views included the belief that asking for consent is in their best interest, that it should occur verbally before any sexual activity, that verbal consent should be obtained for activities other than sexual intercourse, and that asking for consent does not spoil the mood. They also found those who reported enacting consent behaviors more regularly (ensuring a partner consents either verbally or non-verbally before engaging in sexual activity) in practice were more likely to have positive views of consent and have lower levels of blaming.

Consent, although an important component, does not address all aspects of relationship health. The literature focusing on young people's views on consent specifically is more extensive than that pertaining to the broader concept of healthy relationships. The United States government outlines 13 important components to a healthy relationship (adapted from the Center for Disease Control (CDC)): mutual respect, trust, honesty, compromise, individuality, good communication, anger control, fighting fair, problem-solving, understanding, self-confidence, being a role model, and sexually consensual (Youth.gov). Forenza, Bermea, and Rogers (2018) explored perceptions of healthy and unhealthy relationships among youth in foster care. These young people highlighted open communication, honesty, and support as being major elements of a healthy relationship, and considered an unhealthy relationship to be "controlling, abusive, and disrespectful" (Forenza et al., 2018, p. 225). Although the participants had very clear ideas about what made a relationship healthy, they admitted having difficulty enacting those behaviors consistently in their own relationships, at times not discussing issues with their partner in order to avoid conflict (Forenza et al., 2018).

Another study by Debnam, Howard, and Garza (2014) looked at the ways a group of 33 African American adolescent girls characterized healthy relationships. This study found similar themes, including trust, good communication, honesty, respect, compromise, understanding, individuality, and self-confidence. These themes represent eight of the characteristics of healthy relationships recognized by the CDC and were brought up without prompting by the researchers. However, the participants described some of these characteristics differently than described by the CDC (Debnam et al., 2014). For instance, the girls recognized compromise as being important in future relationships, but not necessarily a feature in their current relationships, which the author points out is congruent with their stage of development as adolescents, since it is not until late

adolescents when people typically become more inclined to compromise in the context of their identity development and increased independence (Debnam et al., 2014). When discussing the role of good communication in a healthy relationship, the girls believed direct, immediate, and honest communication was essential, differing from the CDC's definition that includes allowing for time and space for people to process alone before discussing issues with their partner. The theme of trust was discussed by the girls largely in terms of sexual dynamics and did not include the CDC's conceptualization of valuing who the other person is. The author pointed out that this made sense in the context of a period in which many adolescents are making decisions about their boundaries around sexual activity. Finally, trust was discussed mostly in the context of cheating, again related to sexual dynamics and the most prominent among girls who had experiences with unfaithful partners in the past (Debnam et al., 2014).

2.5 Patient Views on Healthcare Providers Screening for IPV

Previous research on patient views about healthcare provider interventions related to IPV describe what patients found helpful and not helpful in how providers inquired about, educated about, or responded to disclosures of abuse within relationships. A study by Battaglia, Finley, and Liebschutz (2003) looking at how survivors of IPV think providers foster trust with patients experiencing IPV identified five provider behaviors that provide a useful framework for looking at what patients find helpful from providers seeking to discuss IPV: 1) communication about abuse, 2) professional competency, 3) practice style, 4) caring, and 5) emotional equality.

Communication About Abuse

Patients appreciated providers that were willing to discuss abuse openly (Battaglia et al., 2003) and provide information, support, and relevant resources regardless of whether or not they disclosed IPV (Chang, Decker, et al., 2005; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Miller et al., 2017). Patients who had experienced IPV in a study by Chang, Decker, et al. (2005) highlighted that this provides an opportunity for providers to increase their patient's awareness about IPV, communicate compassion, and provide information that is useful to them without requiring they disclose abuse. Miller et al. (2017) found that patients who received IPV education as a universal intervention provided to all patients ended up feeling supported, less isolated, and empowered to help others who might be experiencing abuse.

Professional Competency

A healthcare provider's professional competency around addressing IPV specifically affected how the much the patient trusted them and how effective they were. Patients discussed the importance of asking about abuse and medical and social histories at the appropriate space and time (Battaglia et al., 2003; Zelazny, Chang, Burke, Hawk, & Miller, 2019). Adolescent and young adult participants in a study by Zelazny et al. (2019) recommended providers take care to address IPV in a private space, ideally where the patient and provider can each sit about two to three feet apart from one another. They also recommended easing into the discussion by bringing it up in the middle of the visit instead of at the beginning or rushed through at the end and felt it would be inappropriate to ask during a pelvic exam or as a part of a list of other questions (Zelazny et al., 2019).

Research provides useful information for providers on the importance of addressing signs of IPV and how to best ask questions about IPV when appropriate. When providers are responsive

to clues of IPV through empathetic responses and by providing “windows of opportunity” for patients to open up about sensitive information patients are left feeling more understood (Rhodes et al., 2007, p. 625). Survivors of IPV in a study by Liebschutz et al. (2008) who had not disclosed to their healthcare provider described how their provider’s failure to recognize or acknowledge signs of IPV during their visits left them feeling upset and often caused them to avoid seeking further healthcare.

The traditional IPV screener question: "Do you feel safe at home" was found to be largely ineffective at detecting abuse in a study by (Peralta & Fleming, 2003) when 80% of the participants who were experiencing physical violence in their relationship reported feeling safe at home. In a study that analyzed 293 recorded conversations between patients and providers that included screenings for domestic violence, patients were more likely to disclose experiences of abuse when providers used open-ended questions to initiate the topic and probed further by asking at least one follow-up question (Rhodes et al., 2007). The follow-up question may have been useful by communicating genuine interest to the patient or simply by providing the patient with more time to reflect and respond (Rhodes et al., 2007). The authors recommended providers ask a direct question pertaining to abuse, such as "Are you in a relationship where you have been hit or threatened?" allowing plenty of time for a response (Rhodes et al., 2007). If the patient says no or hesitates, they then suggest asking a question such as, "Has anyone ever treated you badly or made you do things you don't want to do?" to open up the discussion to broader abusive behaviors (Rhodes et al., 2007).

Practice Style

Patients benefit from healthcare provider practice styles that address their concerns about confidentiality and ease their fears over stigmatization of experiencing IPV, two major barriers to

disclosures of abuse (Battaglia et al., 2003; Chang, Decker, et al., 2005; Renker & Tonkin, 2006). In a study by Renker and Tonkin (2006) only 16.7% (11 out of 66) participants who had experienced IPV disclosed the abuse to their healthcare provider. Twenty-nine of those women reported they would have changed their response to the provider's inquiry if they had known their state did not obligate providers to report abuse "unless the victim was seriously injured or was wounded with a lethal weapon" (Renker & Tonkin, 2006, p. 348). Battaglia et al. (2003) explain that providers who directly discuss confidentiality practices with patients establish mutual understanding of expectations and build trust. Rhodes et al. (2007) and Chang, Decker, et al. (2005) encourage providers to first normalize the situation and reduce possible stigma by explaining why they are asking about IPV and that the questions are asked to all patients that come through their facility, addressing any concerns about confidentiality and expressing their support for the patient. Participants of provider IPV interventions appreciated when they accommodated patients in whatever stage of readiness they were at, not requiring a disclosure, presenting them with multiple options, and respecting their autonomy through collaborative decision making (Battaglia et al., 2003; Chang, Cluss, et al., 2005).

Caring

Providers' ability to make patients feel comfortable and cared for was another key component to effective conversations about IPV (Zelazny et al., 2019). Zelazny et al. (2019) found that feeling comfortable with and cared for by their provider was a major factor for adolescent and young adult women in discussing and disclosing IPV. Women who had experienced IPV emphasized the need for providers to cultivate an atmosphere of safety and support (Chang, Decker, et al., 2005) that demonstrates genuine concern for the patient by displaying compassionate body language and nonjudgmental attitudes, making empowering statements, and

showing their commitment to the patient through their persistence in asking about the abuse and expressing support and concern (Battaglia et al., 2003).

Emotional Equality

The healthcare provider's ability to communicate with their patient on an equitable level and make a connection beyond the professional patient-provider relationship was also found to be highly instrumental in promoting open discussions about IPV (Battaglia et al., 2003; Zelazny et al., 2019). Women who had experienced IPV in the Battaglia et al. (2003) study appreciated providers that positioned themselves more like a friend than an authority figure. The more a patient felt their provider could relate to them, due to their identity and personal experiences, the more supported and understood the patients felt (Battaglia et al., 2003). Self-disclosures from providers of relevant relationships and experiences as well as their emotions about the situation fostered trust between the pair that encouraged more open communication (Battaglia et al., 2003). This factor was particularly notable given that it was reported by several patients as being instrumental in their decision to leave their abusive partner (Battaglia et al., 2003). The trust this dynamic fostered between the patient and provider increased the patient's sense of support and ability to make a risky life change (Battaglia et al., 2003). Adolescents and young adults in the Zelazny et al. (2019) study expressed their desire for providers to use language that is straightforward instead of "sugar-coated," and appropriate for the layperson instead of using medical jargon (Zelazny et al., 2019, p. 5). They advised providers to speak in a tone that is casual, friendly, or conversational in a manner that is collaborative and minimizes any sense of power or authority over the patient (Zelazny et al., 2019).

Provider Responses

Studies also described what reactions from healthcare providers were reported as helpful and not helpful by participants who had disclosed their experiences of IPV. Feder, Hutson, Ramsay, and Taket (2006) explained, "Women's perceptions of appropriate and inappropriate responses partly depended on the context of the consultation, their own readiness to address the issue, and the nature of the relationship between the woman and the health care professional" (p. 22). Helpful responses from providers validated the abuse and were encouraging in a nonjudgmental and nondirective manner that took into account the unique complexities of the patient's situation (Feder et al., 2006; Liebschutz et al., 2008; Rhodes et al., 2007). Familiarity with the clinician due to an ongoing relationship, displays of respect, and relevant referrals were also reported as helpful by participants (Liebschutz et al., 2008). Liebschutz et al. (2008) found that participants who had experienced a beneficial reaction to their disclosure of IPV sometimes experienced shifts in self-esteem, perceptions of their relationship, or increased awareness of their options that enabled them to seek help independently.

Unhelpful responses to disclosures of IPV from healthcare providers not only fail to aid the patient, but can have detrimental effects to their emotional well-being and help-seeking in the future (Liebschutz et al., 2008). Liebschutz et al. (2008) found that some patients experienced fear of further endangerment, left their provider's care, or avoided or put off healthcare encounters in the future after an unhelpful response from their provider. Participants in this study did not appreciate providers that pushed for extreme "solutions" to the abuse, such as filing a police report or sending the police after the partner (Liebschutz et al., 2008). They were also disappointed when the provider's response lacked an emotional understanding, caring for the physical well-being of the patient without considering their mental and emotional well-being as well (Liebschutz et al.,

2008). Some providers also failed to communicate effectively about safety assessments, referrals, and follow-up (Liebschutz et al., 2008). Rhodes et al. (2007) observed unhelpful reactions that were awkward and displayed discomfort, sometimes changing the subject abruptly without acknowledging the abuse at all.

In summary, previous literature shows that the approach healthcare providers take in relationship building and discussions or responses to IPV with their patients has a big impact on patients' comfort in speaking openly, seeking help, and taking action related to IPV. Providers that are able to make a genuine connection with their patients build trust that make patients feel safe and supported. Discussions of IPV that are transparent, collaborative, and informative serve to empower patients to take whatever action is appropriate for them at that time.

2.6 Purpose of the Present Study

Previous research supports the disproportionate prevalence and effects of SV and IPV on young people with disabilities compared to the general population and indicates the importance of taking young people's perceptions and lived experiences of consent and healthy relationships into account when creating interventions to promote health and reduce disparities. A range of observational research methods have been effective in investigating these health issues through both quantitative and qualitative methods including surveys, in-depth interviews, and focus groups. While quantitative studies have demonstrated the prevalence of these issues and provide evidence for the existence of health disparities, qualitative studies have begun to explore how these disparities develop and how we can begin to address them. Lacking in the qualitative research on

SV/IPV, consent, and healthy relationships are studies that focus on the experiences and viewpoints of young people with disabilities.

Further exploration that includes the voices of those with disabilities is needed in order to better understand the conditions that place this population at higher risk for SV/IPV and how best to intervene. Given the complex nature of how consent and romantic relationships operate in the contexts of people's real lives and how they interplay with disability and adolescent/young adult development, more exploratory investigations can assist those designing and implementing interventions and add to the body of research involving this vulnerable population. The purpose of this study was to present the perspectives of college SWDs on consent and healthy relationships in order to learn how to better serve this population through interventions aimed at reducing rates of SV/IPV experienced by this group.

3.0 Methods

Participants and Procedure

The current study took place within the parent College Health Study (CHS) through Elizabeth Miller's Lab in the University of Pittsburgh's Department of Pediatrics, Division of Adolescent and Young Adult Health. The CHS is a multi-site cluster-randomized control trial evaluating the efficacy of a brief universal intervention to reduce alcohol related sexual violence on 28 campuses in PA and WV (Abebe et al., 2018). The CHS also included semi-structured interviews of college students about their experiences with alcohol use, SV, IPV, and campus prevention programming related to these topics. A subsection of CHS interviews included students with a disability or health condition and investigated how disability intersected with the aforementioned areas of study.

Ninety-six students participated in in-depth, semi-structured qualitative interviews as a part of the CHS, 57 of which reported having a disability/health condition and consented to speak about it. After providing informed consent to participate in the interview, students were given a list of common health conditions/disabilities and asked to identify any on the list they had experienced. Students who did not identify any condition or described experiences with conditions that had been resolved during childhood, and had therefore not influenced their college experience, were excluded from the disability-specific questioning and analysis in the study. This vetting process resulted in a sample of 51 students who reported a disability/health condition that intersected with their experiences in college, 49 of which were asked the questions relevant to this study (two were interviewed not due to time constraints) and are included in this analysis. Demographics of the sample can be seen in Table 1.

Table 1 Participant demographics at parent study enrollment (n=49)

	% (n)
Age	
18	24.5 (12)
19	24.5 (12)
20	26.5 (13)
21-23	24.4 (12)
Race	
Black or African American	4.1 (2)
White	77.6 (38)
Multiracial	18.4 (9)
Gender	
Male	16.3 (8)
Female	81.6 (40)
Other gender [a]	2.0 (1)
Any sex with same gender partner [b]	16.3 (8)
Year in school	
1st year undergraduate	26.5 (13)
2nd year undergraduate	30.6 (15)
3rd year undergraduate	22.4 (11)
4th year undergraduate	12.2 (6)
Other	6.1 (3)
Residence	
Campus residence hall	65.3 (32)
Fraternity or sorority house	4.1 (2)
Parent/guardian's home	4.1 (2)
Other	24.4 (12)
Member of [c]	
Fraternity/sorority	16.3 (8)
Sports team	16.3 (8)
Other campus group or organization	65.3 (32)
Disability type(s) [c]	
Physical/sensory	24.49% (12)
Psychiatric/mental health	65.31% (32)
Neuropsychiatric/learning disorder	40.82% (20)
Reported alcohol use at any time point during the study (12 months before or during)	
Yes	98.0 (48)
No	2.0 (1)
Reported binge drinking at any time point during the study (12 months before or during)	
Yes	98.0 (48)
No	2.0 (1)
Type(s) of sexual violence students reported experiencing [c]	
Unwanted sexual touching	89.8 (44)
Attempted unwanted sex	73.5 (36)
Unwanted vaginal sex	26.5 (13)
Unwanted oral sex	44.9 (22)
Unwanted anal sex	12.2 (6)
Unwanted penetration (e.g. with finger, object)	28.6 (14)

Percentages may not total 100 due to missing data.

[a] Includes transgender, non-binary, and other gender responses

[b] For students reporting sexual activity at baseline, (*n*=44)

[c] Response categories are not mutually exclusive

Participants were interviewed at student health centers on their college campuses or in Dr. Miller's secure lab facilities. They were compensated for their participation with a $50 gift card provided at the beginning of each interview as to allow them to end the interview at any time without fearing loss of compensation. The interviews were audio recorded and lasted from one to two hours, with the average interview length being 86 minutes. They were conducted by four highly skilled interviewers with substantial prior experience discussing sensitive topics with adolescents and young adults. All study procedures were approved by the Institutional Review Board (IRB) at the University of Pittsburgh, and by the IRBs at each participating institution, when required.

Thematic Analysis

Thematic analysis seeks to identify patterns in the data, provide rich description of the data, and offer interpretation of the larger meanings behind the data (Braun & Clarke, 2006). This analysis method is systematic yet flexible, allowing for a deeper understanding of an issue focused on what the researcher wants to know (Braun & Clarke, 2006). Inductive thematic analysis of in-depth interviews with college SWDs who have experienced SV or IPV allows for a more profound exploration of how this population views sexual consent and healthy relationships in the context of their own experiences.

The current study examined participants' answers to the following questions asked at the end of each interview:

1.What does a healthy relationship mean to you?

2.If someone asked you (like a nurse or doctor) whether your relationship feels healthy, what would that mean to you?

3.What does the word 'consent' mean to you?

4.How does being in a relationship with someone change that?

The coding method used was inductive, a bottom up method of exploring the patterns that exist in the data without attempting to code based on the researcher's preconceptions. Taking a semantic approach, which identifies themes from the explicit messages expressed in the data (Braun & Clarke, 2006), this study will largely focus on describing what participants said while still interpreting the data to identify the significance and broader implications of the themes established by the researcher.

The analysis process for this study followed the six phases of thematic analysis outlined by Braun and Clarke (2006) to explore the research question: How do college SWDs define consent and healthy relationships? First, the researcher deeply immersed them self in the complete data set to best understand the context and ensure all relevant excerpts were analyzed. This involved reading and re-reading the transcribed interviews, noting any initial ideas that came up in the process. Next, the researcher generated their initial codes to systematically sort the data into relevant categories. Using the qualitative data coding program Dedoose (Version 8.1.21), the researcher first sorted the data into initial areas of interest: definitions of consent, and definitions of a healthy relationship. They then generated more nuanced codes based on identified patterns to develop a more detailed code book including 48 different descriptor codes that were then applied where appropriate to each transcript. The complete codebook can be viewed in Appendix A. Once the final codebook was established, the researcher reviewed the data for a second time to ensure all codes were appropriately captured and applied. From here, the researcher sorted and combined codes into potential themes to determine important overarching ideas present in the data. After reviewing these themes to ensure they were applicable and representative of the coded excerpts as well as the entire data set, they generated clear definitions and names for each, refining the

specifics of each theme and the overall story. The codebook and themes were generated in consultation with a mentor who had acted as an interviewer and coder for the parent study and had substantial prior familiarity with the data.

4.0 Results

This study produced six themes regarding how SWDs define and discuss healthy relationships and consent: 1) Healthy relationships require both mutual care for one another through trust, respect, support, and communication, as well as care for one's self as an individual through independence, self-confidence, and finding support outside the relationship; 2) Those experiencing unhealthy treatment by a partner may normalize the behaviors due to manipulation, denial, and their love for that person; 3) Dichotomous definitions of consent lead to misunderstandings and confusion about how to apply consent to real life experiences; 4) Within the context of a relationship, active consent can be facilitated through comfort and open communication but hindered by implied or assumed expectations and difficulty balancing one's own discomfort with the possibility of their partner feeling rejected; 5) Students assume that when healthcare providers are asking about relationship health they are trying to elicit disclosure of abuse rather than facilitating a discussion of relationship health; and 6) Students are less likely to disclose abuse when they believe healthcare providers are fulfilling routine screening requirements rather than asking about their safety due to genuine concern, or, when they fear that disclosure will result in a loss of control over what happens next.

4.1 Defining a Healthy Relationship

Participant definitions of healthy relationships included mutual trust, respect, support, caring and open communication, as well as autonomy and personal growth. They asserted that any

type of abusive behavior was unhealthy, but that those within the relationship often do not recognize the issues as unhealthy due to normalization of the behaviors and relationship dynamic.

Theme 1: Healthy relationships require both mutual care for one another through trust, respect, support, and communication, as well as care for one's self as an individual through independence, self-confidence, and finding support outside the relationship.

Participants found it easy to describe the traits they believe to be healthy in a romantic relationship and were clear that any physical, mental, or emotional abuse was unhealthy. They understood healthy relationships to necessitate a base level equality, respect and trust for other characteristics to follow. One participant explained,

> I think if you respect someone, even more than loving them, I think if you respect someone just at a basic level, you're on your way to a healthy relationship. You're not gonna try to control them. You're not gonna try to make them do anything they don't wanna do.

Another said,

> You just need someone to trust. That's literally the number one thing. I know it sounds so cliché, but it literally is 'cause if you can't trust someone, you can't build anything else off of that because you can't joke around or mess around with or have fun with someone that you don't trust because in the back of your head, you're always gonna be like, what else are they thinking about? You don't want to be worrying about that.

Having trust in the relationship referred to being faithful to the expectations established about relationships with other people as well as trusting their partner to be honest, to be understanding of their feelings, to treat them with care and kindness, and not to hurt them intentionally.

Students emphasized the need for open and honest communication, described as involving good listening skills, understanding each other's point of view, and being able to go to their partner with any issues. They discussed the importance of this in expressing needs or desires, establishing boundaries and expectations, and working through conflict. One student explained,

> Now that we can communicate and talk to each other about what we're going through, about our problems, that makes us stronger. We don't fight. We just have discussions about

> what's going on and things that might be making me feel a certain way and then things that make her feel a certain way. It's like, okay, now we can meet at a middle ground and just move forward.

Another student explained how being able to have constructive conflict with a partner means they don't hold symptoms of their disability against them, saying,

> I know you're gonna get in fights in relationships, but someone that's not gonna hold your problems [against you], especially someone with issues. If someone were to be like, "Yeah. Well, you're just crazy. You are mental…." It's about knowing people's cons and their weaknesses and loving them for them.

Students' definitions displayed characteristics of connection between couples as well as independence as individuals. Many participants discussed the importance of having mutual displays of support and caring attitudes and behaviors "through thick and thin." In this regard, they saw this support as helping them through difficult situations and experiences, assisting them in reaching their goals, and encouraging their personal growth. One student explained,

> If you can look down the road and see yourself with that person throughout all the bullshit, then that's a healthy relationship. If you were being fulfilled—if they're supporting you—if they support your endeavors and they don't act like they know you to the point where if you changed they'd doubt that change…. Or as long as they're not holding you back. If they're supportive and caring, and willing to accept to for your faults.

To participants, personal autonomy within the relationship means that each person has a life and support network outside their partner, feels secure in their own sense of self, and has the ability to promote their own well-being. This also means avoiding co-dependence, clinginess, and letting insecurities formed in past relationships affect their current relationship. One participant explained how a person's own resilience and coping abilities are essential to cultivating healthy relationship dynamics, saying,

> …a healthy relationship is gonna be sad, and it's gonna be frustrating, and that's what's healthy about it, is you go through all those ranges of emotions, and you're able to deal with it in a healthy way where you're with someone else, making compromise, you're learning from your own mistakes, or being able to calm yourself down in these types of emotional situations.

Students described the importance of a bond that creates happiness, love, attraction, interest, or satisfaction on physical, emotional, and intellectual levels. Students didn't necessarily think a relationship must always be happy, but that a healthy relationship generally was a positive force in their life and that happiness was a good sign that other important components were present. Participants also spoke about the importance of being with someone whose company is comfortable, safe, and appreciated. This included simply enjoying being around one another, as well as feeling comfortable bringing up difficult issues while feeling safe and secure in the relationship. One student explained,

> You feel comfortable with the person and like you can go to them if you do have a problem with them or with anything else. You're not afraid to speak up or tell them that you don't feel like doing something, or you can't see them right now, or you don't want to have sex right now. I feel like there has to be this mutual trust and respect where you feel okay saying something that you feel like might disappoint them. You don't feel like you're going to disappoint them just 'cause it's something you think they might not want to hear. I think you should have that level of comfort, I guess.

Finally, a few students mentioned that a healthy relationship should involve a sex life that feels safe, consenting, physically healthy, open, and affectionate. Students felt other important aspects of relationship health such as open communication, respect, and trust should result in sexual interactions that are consensual and enjoyable.

Theme 2: Those experiencing unhealthy treatment by a partner may normalize the behaviors due to manipulation, denial, and their love for that person.

In their definitions of a healthy relationship, participants described indicators that a relationship was *not* healthy as well as ways in which unhealthy relationships are not always recognized by those involved. Participants were clear that any physical, mental, or emotional abuse in a relationship was not healthy, including behaviors that were manipulative, controlling, or threatening or that took advantage of their partner. Several students discussed certain signs that

indicate a relationship might not be healthy, such as escalating arguments, pushing each other's limits or feeling forced into things, being too clingy, or feeling weighed down by the relationship. One participant explained,

> I think there are certain words that people would say if they're in a relationship that isn't healthy, that might, just in conversation, or certain things—I hate when people are, like, "Oh, I can't do that because my significant other won't let me." I mean, "What do you mean, they won't let you?" I'm, like, "Wait, let's back up, let's flesh this out a little bit." Because I think, like I said, I think there's red flags. I think people are so normalized, or don't realize that there are red flags.

Another said,

> Love is not, "Oh, if you loved me, you would do this," or, "If you loved me, you would do that." Love is not selfish. It's not another person saying that stuff to you. It shouldn't ever make you feel pain. Love isn't pain, like everyone says it is. It actually helps you. It helps you a lot.

Some participants also discussed the fact that unhealthy relationships are not always recognized by those involved because they are in love, being manipulated or controlled, or the unhealthy behaviors have become normalized to them. One student explained, "…but an abusive relationship, a lot of the times, they'll convince themselves that they're happy and things are fine…. They're kinda being manipulated, so they think they're happy in the relationship." Another said, "I can look at my friend's relationship and be, 'Oh, my gosh, you gotta get the heck out of there,' and they can be, 'It's fine. This is normal. This is just how our relationship is.'" Many of these participants have experienced abuse in their relationships themselves or been privy to the abuse of others. They recognize that when immersed in a relationship, it is often hard to either see clearly or want to acknowledge to yourself or others that it is unhealthy. This idea is critical when considering healthcare provider assessments or interventions related to dating abuse that ask subjective questions about their relationship health. If a student views behaviors a healthcare provider would label unhealthy as normal, they will not feel the need or desire to disclose them.

4.2 Defining Consent: In and Out of Relationships

Participants in this study viewed consent as something that is ideally clearly established before any activity begins and that is engaged continuously throughout a sexual interaction and relationship, however they discussed ways in which the ideal standards for consent can become complicated by individual perceptions, communication, intoxication, and relationship dynamics. The dichotomous rules of consent students laid out in their definitions of the concept could not always be easily applied to their lived experiences, at times fostering misunderstandings or confusion about how consent functions in real life.

Theme 3: Dichotomous definitions of consent lead to misunderstandings and confusion about how to apply consent to real life experiences.

Students' definitions of consent often involve clear-cut "rules" that are meant to ensure ideal consensual experiences but can sometimes lead to confusion or misunderstandings about how to apply these rules to their real-life experiences. Some participants believed consent to be a black and white issue that must always be clear to all involved, such as a clear yes or no communicated, or a wanted or unwanted experience. Many described consent as involving a verbal agreement, typically expressed as "saying yes," with a few participants emphasizing that silence or anything falling outside a totally clear "yes" is not consensual. This verbalization was expected to take place without manipulation or coercion and required a reasonably or fully sober decision, unaffected by alcohol or drugs. Some explained that this agreement must also take place before any sexual actions are taken and that the process of eliciting and giving consent should take place continuously throughout the sexual interaction to ensure each party is comfortable moving forward. If someone

does say “no” or expresses a desire to stop, this should be immediately respected. One participant explained,

> It means me saying yes and it means me not saying no…. I’m not drunk; I’m not under the influence of anything else, I am 100 percent in a clear mind, and I can have sex, even if you’ve had a couple beers, I get that. A lot of people have sex when they’ve been drinking, but as long as it’s very clear you’re interested. Some guys will just try to ask. I appreciate that. Yes, this is what I wanna do, but you make the first move. Consent, it’s confusing sometimes, but if you ever hear the word no, if you ever hear the word stop, you’d better fuckin’ stop. If she’s pushing you away, that means no. Sometimes people will be like, “Well, she didn’t say no.” Okay, but she couldn’t move. She was asleep. She was pushing you away. Consent is when it is 100 percent clear that you want to have this thing happen to you and you can.

Another said,

> That means asking if you are okay with X, Y or Z. “Are you okay with this action?” Before the action happens. Affirmative consent would be, “Yes, I am okay with that.” I think that’s a gradual—a constant conversation that should be happening if the action is changing. Like something as simple as, “Hey, are you okay with this?” That is not hard to say. That was like two seconds.

Another participant described how alcohol clouds the ability to give ideal consent saying,

> …when I drank, I don’t know, I won't care as much. I won't be as aware, so I’ll be more, whatever, and maybe I don’t necessarily want it, but I’m just like, at the time, I’m not really having time to actually think and make a decision. I feel like consent is you’re actually having time to think it over and deciding that’s what you wanna do.

Participants defined consent in ways that displayed misunderstandings about what consent truly means, technically and legally. While participants typically described consent as involving a granting of *permission* to engage in a particular action, several students understood consent to necessitate actually *wanting* an action to happen and feeling good about it, sometimes conflating consent with having an experience they feel good about overall. One participant explained,

> I know the initial [definition] is like sexual consent, being like not just okay with, but also being wanting—a wanting to, as well…. Because you could very much be okay with it, but not want to. Yeah, a guess a wanting to, as well, and being happy about that wanting to, and feeling okay afterwards, as well.

Some participants explained that they may give permission for something they do not ultimately want to do, but still chose to do because of their relationship with the person or their own feelings of power, agency, security, or curiosity (discussed further in Theme 4).

Some students believed they can never give legal consent if intoxicated or that perhaps their feelings about the action after sobering up qualifies as their consent. One student thought this idea through saying,

> I would pretty much define it as in the end, regardless of the overall situation, the person's okay with it. If you say 'no' at the beginning because you're able to say no and you're—whatever mentally competent, as we would say—if you can say "no," from the beginning or you can say "yes" from the beginning, then that is your consent. If you're intoxicated and you're not aware of what's going on and maybe even in the moment you say yes because it's basically the alcohol talking but later on you realize what really happened and you're not okay with it, or in the end you realize what happened and you're okay with it, that's your form of consent. I think even in the law, it's written that…. Basically, you can't be penalized if you said yes intoxicated and then afterwards saying no because there was alcohol involved.

Another said,

> You can't be intoxicated while doing it. I don't know how you address the issue of consent, though, when you're both intoxicated and you both want to do it, and you both want to do it all the way through. I think that's a problem that a lot of couples [have]… what if we're both drunk and we've been together for so long. We both want to have sex. Technically, I raped you and you raped me. It doesn't make you feel very good about the situation.

These students expressed the idea that you cannot give legal consent when intoxicated. While one thought intoxicated sex is always legally sexual assault, the other thought the consent status of an action might be determined after the fact upon sober reflection.

Although most students could describe the "rules" of ideal consent, their real-life experiences often complicate applying those rules to their sexual encounters, causing them to feel that consent as a concept is not always as clear or precise as it is made out to be. Participants described ways in which consent can be more loosely defined and unclear in action depending on people's perceptions, communication, intoxication levels, and relationship dynamics. While some

had described a requirement for verbal communication of consent, others felt consent could be communicated through non-verbal cues and mutual awareness. This included incrementally progressing actions and an ability to accurately interpret the other person's body language and behaviors.

Some participants spoke about ways in which each individual's perceptions and ability to communicate their feelings can make ideal consent more difficult to achieve. Those who believe consent can be established through non-verbal communication also recognize that sometimes the subjectivity of that communication can cause misunderstandings and require forgiveness. One student explained how they believe behavioral cues and consenting to certain actions might be reasonably interpreted as an openness to initiations of further actions, and that consent communication that relies heavily on non-verbal cues may be breached due to misunderstandings rather than indifference or malicious intent:

> To me, it's not just about [verbally] or officially saying that this is okay. I think that there's a lot of consent through actions…. I think more in the context of a relationship, I do think that you consent to things. Like, if you act flirty towards someone, then you consent to them approaching you and asking you out or asking you home or something like that. If you, for example, if you kiss someone or something and you're, especially if you're in a private context, I do think that you consent to them maybe touching you. I do think that you're able to say, oh, I'm not okay with that. I don't think that you should be offended or that somebody did something wrong to you. If you put yourself in a situation where something felt natural and then they do that, I think there needs to be understanding both ways. That's often my issue with some of this black and white stuff, where it's too easy to feel like things that are natural about who you are and how you perceive things, make you a criminal.

Another student explained how their own self confidence and internal understanding of what they want and are allowed to assert can be a barrier achieving the ideal definition of consent, saying,

> I think it's fuzzy, because ideally, consent would be like, "Yes, I do want do to this. Yes, it is okay to do this. Yes, I am comfortable with what's happening." Then I think of my experience, and yes, I always consented. I always was at the point where I said, "Okay, fine, let's do this," but really, I didn't want to. While I was giving consent out loud—I don't know, I almost—it was like—what's that called?— dissonance or whatever. It wasn't

> what I wanted. Ideally, it would mean you say it and you mean it. Yeah, I don't know if that's how it's always—actually is, though.

These examples highlight how students' sense of self and subjective perspectives play a role in developing and utilizing the communication skills needed to achieve ideal consent.

Students spoke about the ways in which alcohol use muddles establishing consent as well. They explained how even with the best intentions, intoxication can complicate your ability to achieve clear consent in an encounter. One participant explained,

> Especially when I talked about--like I talked bringing that guy home, I blacked out. I don't remember being, like, "Let's go back to my room." If anything had progressed, I mean, thankfully by the time we did get back to my room, I was back, like, wasn't blacked out anymore. If I had woken up in the middle of this, I would have been, like, I didn't--I don't remember this. I wouldn't have been able to be, like, yes, I gave consent. …like, I don't know if he gave consent.

Another said,

> I would be lying if I said…it was always fair…. I think there are guys who don't have bad intentions who really get screwed in a situation because we girls have—I know from experience that I've done the same thing where things just start changing in an instant. It's hard to communicate and you're drunk on top of it. It's halfway through. It becomes messy.

These descriptions demonstrate how consent can be a moving target that can change quickly and be particularly challenging when decision-making is impaired. This was not always seen as somebody's "fault," as it might be in a black and white view of consent, but rather a complexity of the situation.

It is also worth noting how traditional lessons about consent do not typically discuss the complexities of navigating consent in situations that do not adhere to normative societal sexual expectations and behaviors. Young people who have only learned a dichotomous definition of consent may not know how to apply it to their non-traditional experiences. One student who was in a BDSM (bondage/discipline, dominance/submission, sadism/masochism) relationship said,

> My relationship with [my ex] brought a fuzzy area because it was the BDSM thing and there were those power dynamics. It would be like even though if I would've—I don't think I ever said no, but even if there were points where I wanted him to stop, I was definitely feeling nervous that it wouldn't be taken seriously because we were in that power dynamic of "No. Shut up, bitch. You're gonna like this," because that was part of—at least initially, that was part of the game. The sexual fantasies.

Theme 4: Within the context of a relationship, active consent can be facilitated through comfort and open communication but hindered by implied or assumed expectations and difficulty balancing one's own discomfort with the possibility of their partner feeling rejected.

Although participants expressed the belief that consent is required in any sexual encounter, regardless of romantic involvement, they also described ways in which consent functions differently within relationships. Consent within relationships can be easier to navigate due to comfort, safety, deeper understanding, and more open communication. However, it can also be less clear-cut due to implied consent within relationships, nuanced or non-verbal communication, and people's concerns about pleasing or hurting their partner.

Participants described how open communication within the relationship about their sex life in general, including feelings, needs, and desires as well as any misunderstandings or health concerns, can lay the groundwork for cultivating deeper levels of consent as they learn about what their partner likes, what their boundaries are, and how to best understand what they're wanting and feeling in the moment. One student explained,

> I mean, I think that your sexual activity should just be a discussion in general, 'cause you don't want it to get stale, number one, and you don't wanna be selfish, 'cause it might feel great for you just 'cause you're in a relationship and she wants to make you happy. You wanna make sure that you're both getting everything that you could possibly get out of it.

Another said,

> It also creates a lot more confidence in consent with each other. Introducing a new part of your sexuality is always something that causes a lot of anxiety for people. Broaching that

> subject again is something that will be much more comfortable [in a relationship]. Whether it's very early sexual experiences in the first place, and you don't know how to ask for something at all, or if you have very specific needs [and are] realizing how to vocalize those. All of that belongs in consent…. Yeah, so I think that a relationship can definitely build your definition of consent and build your comfort in talking about consent.

Students discussed how consent in relationships is often communicated or understood based on a deeper awareness of your partners feelings and desires that may not require verbal communication. One participant explained,

> It's just you can tell when someone's into it and when they're not in a relationship, 'cause you get to know each other so well, or even just the way they hold their one shoulder might indicate that they're a little standoffish that day, whereas if you're at a party, cramped in a corner, you can't tell their body language one way or the other, so consent is a lot easier to tell when you know the person super-well, and you know the way they usually act in that situation.

While some students felt consent should never be implied in a relationship, others said in reality it generally *was* implied unless one person indicates otherwise. Those who said it shouldn't be implied seemed to be expressing the belief that it should not be expected, while those who described it as implied described how partners generally start at a base level understanding of comfort and desire that allows for initiations of sexual activity without the same expectations of consent prior to activity that they would have in a casual hook-up. One student explained,

> You don't wanna go through a relationship—every single time you kiss somebody, "Can I kiss you now?" I'm like "Do you wanna have sex?" It's like sometimes it just—it just starts to happen, but always, I think more so, having that policy between us of, "Hey, you tell me when you want me to stop, and I will never be offended by that." That being like a ground rule.

Another student described how implied consent may lead to unwanted experiences within the relationship that need to be addressed with understanding and open communication, saying,

> I think there are a lot more implied yeses in a relationship. That doesn't mean they're all implied yeses. I would say that…I've had sex…in a relationship…when I didn't quite want to. I definitely didn't consider it sexual assault because it wasn't—I wasn't very uncomfortable with it either. It was usually just like, "I don't feel like it, but okay." I think that consent gets a little bit of a looser definition. If the couple has a problem, I would still

> need to go and say, “Look, I didn’t really want to do that last night. You weren’t paying attention to that. We need to talk about that.”

The implied approach was predicated on the idea that consent in a relationship includes the ability to say no to sex without having to fear a negative reaction from their partner. One participant explained, “…if I say, ‘Listen, I'm really not in the mood,’ it's not like he's like, ‘Oh, come on.’ It's like, ‘Okay. That's fine.’ Same with him.” Another said, “I know through experience if I ever verbalize any like, ‘I’m not comfortable,’ or, ‘Can we not?’ it’s always immediately respected. I think that comes with years of that respect.” This, again, conveyed the idea that sex should never be expected or pushed, even in a relationship.

Students also, however, talked about how saying no can actually be *more* difficult in a relationship due to concerns over creating conflict, hurting or disappointing your partner, or feeling the expectation to want to have sex. When asked how consent differs within a relationship, one participant simply said, “You feel obligated to say yes.” Another explained,

> I feel like it's expected to have sex all the time and you expect the other person to want to have sex with you whenever you're ready. It's definitely portrayed that way in our culture and in movies and in film and TV and stuff that two people are gonna have sex because they both wanna have sex. You never see the parts where it's like, one person wants to have sex and then the other one doesn't and then it ends well. It's always a fight or it becomes aggressive. Yeah. I feel like it's just what surrounds us and what we see is that, if somebody doesn't wanna have sex, it's the end of the world.

A third student said,

> It doesn't change, but people think it does change because they feel like they can't say no because they don't want to deprive somebody—whether it's sex or anything else. They don't want to upset their partner. Even if they don't want to do anything they'll still do it just to make the other person happy which, I mean, it's still not good. It's just very hard to try to fix that, I guess.

Here, participants demonstrate how because they are more concerned with their partner’s feelings than the feelings of a casual hook-up, it can be harder to deny or withdraw consent with a partner

for fear of making them feel rejected when they want them to feel loved or wanted. In this way, young people may consent with their partners based more on the partner's desires than their own.

Students also described how once a level of comfort and safety has been established in a relationship, they might simply feel more comfortable making compromises that they typically would not want to consent to in a casual hook-up. One participant explained,

> After being with somebody for a while and feeling safe with them, you feel okay to do things that maybe they wanna do, and maybe you don't have interest in…. They've proven themselves to you…. Or just in general, you've given to each other a little bit, to make the other person happy. Whether that's like doing something just in general, like going to an activity that normally—you hate.

Another participant, explained the ways in which ideal consent can be both harder as well as truer to what she really wants when taking place in a relationship, saying,

> If I was with a stranger and I didn't wanna do it, I would absolutely say, "No, no, no, no." Since he's my boyfriend and I know that I should wanna have sex, and I know that it is at least a safe environment, it changes what my consent feels like, I guess. In that sense, it makes consent a little even fuzzier, but at the same time, because I am comfortable with him, and now because I am on the healing side of things, it makes the consent even more true to what I want now, because now I would definitely say no if I didn't want to.

While she might feel more justified in saying no to sexual actions with a stranger than with a more serious partner, she also explains how having a higher level of comfort and understanding in her relationship enables her to communicate more deeply and detailed about what she really wants.

4.3 When Healthcare Providers Ask About Healthy Relationships

Participants assume healthcare providers asking about their relationship health are interested in assessing for the presence of unhealthy behaviors and not in their patient's understanding of what *is* healthy. When these inquiries are perceived as routine screeners for abuse

in which any disclosures of abusive behaviors would result in the patient's loss of agency over the situation, students are less likely to provide honest responses.

Theme 5: Students assume that when healthcare providers are asking about relationship health they are trying to elicit disclosure of abuse rather than facilitating a discussion of relationship health.

While students typically framed their personal definitions of a healthy relationship in terms of the presence of characteristics reflecting mutuality and autonomy, they often assumed healthcare provider questions relating to relationship health to be assessing for the presence of abusive behaviors. Most felt this would pertain to any kind of abuse, whether mental, emotional, or physical. Students often worded this as "abuse", "feeling afraid", or "feeling safe" in your relationship from physical violence, sexual violence, emotional harm, or psychological manipulation. One student said,

> It would mean that I'm not afraid to go home, that I can probably reasonably tell you how my boyfriend's gonna react to me coming home or to what I say, that I'm not afraid of what he might do, that there's no chance of violence, emotional or physical. Just that I'm not worried about setting him off and getting into a tough situation. That I can be confident. That I can go home and live my life, and that my boyfriend's not gonna make it harder on me. The very minimal expectation.

Other elements students thought providers would be asking about included inequality in the relationship, controlling behaviors, and sexual health pertaining to protection against STIs and pregnancy as well as consent. A student explained,

> …also I think sexually safe. Do you know that the person that you're with is free of STD's and STI's? Are you in a relationship where you feel comfortable to say, hey, no not right now, or not tonight, or I don't really wanna' try that. I think that those things are important.

A few participants thought a healthcare provider would only really be concerned with any physical abuse in their relationship. One participant explained,

> I usually associate that kind of stuff like, is anybody abusing you, hurting you? 'Cause especially in nursing, especially in the ED, you ask, is anybody—do you feel safe in your home? Are you in a relationship? Do you feel safe in your relationship? Is anybody hurting you at home and stuff like that? I associate that with physical health, not so much as mental.

Another said,

> I feel like that would be like, "Are they hurting you? Are they assaulting you? Are they physically hurting you?" I mean it's a nurse. They're not asking you, "Do you feel fulfilled in your relationship?" They're asking you is there anything wrong with you physically because of this relationship.

These responses indicate that participants believed healthcare providers would be interested in finding out if there were any present health concerns associated with their patient's relationship, but not necessarily intending to establish or discuss distinctions between a healthy and unhealthy relationship in an effort to help patients avoid abusive relationships. The approach of looking to treat a problem rather than prevent a problem is common in our healthcare system and likely influenced participants' perceptions of questions pertaining to their relationship from healthcare providers.

Theme 6: Students are less likely to disclose abuse when they believe healthcare providers are fulfilling routine screening requirements rather than asking about their safety due to genuine concern, or, when they fear that disclosure will result in a loss of control over what happens next.

While participants expressed positive views about a healthcare provider asking their patients about the health of their relationships, some expressed concerns or skepticism and several discussed why they or someone else might lie to a provider. Students stated not wanting to feel judged based on their answer, not wanting the provider to report any disclosed abuse and feeling like providers typically do not really care but are just following necessary protocol. One student said,

> I mean honestly, would I answer? Probably not, if it was actually happening to me 'cause then they're just gonna call the cops. You know what I mean? Plus, when they go through those answers…. They're not even listening. They're just checkin' the bubble 'cause they don't expect you wanna actually be like, "Actually, look at this bruise."

Another participant explained that she would not want to be forced into getting help from others and would rather deal with the situation on her own, saying, "I mean, if I said no, I don't think it's healthy, then they're gonna make me deal with it. Probably. That's the kind of person I am, where I'm like, I can do it. It's fine. Yeah. It's fine."

Several participants offered advice on how a healthcare provider could best ask their college student patients about their relationship health. Some commented on how the demeanor of the provider would affect their answer. One student explained, "Depends on the person I'm talking to. The person's coming off as standoffish and a jerk? I'm liable to not give much of any answer. If the person's more relaxed, calmer, more open-ish, then I'm probably apt to give the same answer [I gave you]." Some advised using more open-ended questions in order to capture a broad range of relationship health concerns. One student said,

> I think something even more broad, like, "Can you tell me how you feel in your relationship?" Then people have the liberty. They can say, "I feel safe. I feel happy. I feel okay. I feel unhappy." Then you can probe from there, and then you can narrow it down to what you wanna get to, I think.

Another student advised using language that is more specific, saying,

> I think it's easy to lie about general questions, which sounds bad, but when [you say], "Do you feel safe in your relationship?" Sure. Okay. Do they respect you? You know what I mean, I guess making it more personal, more than a just, "Do you feel safe in your relationship?" Okay. Thanks, bye.

Cursory questions about relationship health from providers seem unlikely to elicit a meaningful response from college student patients. While a more open discussion might be welcomed by many students, they emphasize the need to perceive the provider as caring and non-judgmental as well as to understand the repercussions of disclosing any abusive behaviors in the conversation.

5.0 Discussion

This study adds to the body of knowledge on SWDs' understanding of the concepts of consent and healthy relationships and how to apply those concepts to their lived experiences. While the results of this study were not unique to college SWDs, they serve to intentionally highlight the perspectives of a group of people who are disproportionately affected by SV/IPV. Despite the evidence of higher rates of SV/IPV experiences among those with disabilities, interventions tailored to this group are lacking, possibly partially due to the common stereotype that people with disabilities do not have sex or romantic relationships.

Consent

The results of this study aligned with past research that found young people to have a narrower conceptualization of consent than how they enact consent in their sexual encounters and that these narrower understandings of consent are not particularly useful when attempting to apply them to more complex life experiences. Unlike in the Beres (2014) study, many of the participants in this study explicitly recognized consent as taking place throughout a sexual interaction and relationship, instead of as a singular event that only took place in casual hook-ups. Participants in this study described how they execute consensual sexual interactions in similar ways to participants in the Brandy, Kessler, and Grabarek (2018) study, discussing how situational and relationship contexts influences the methods of communication used (i.e. verbal or non-verbal), behaviors such as initiating sex or having sex while intoxicated, expectations of explicit versus implicit consent, feelings of safety and comfort, and assumptions around desires and responsibilities toward one's partner.

There were several aspects to the findings from this study that are particularly noteworthy when considering the implications for future interventions and research. Participants described sexual consent as necessitating both mutual permissions to proceed as well as a mutual wanting to proceed. While ideally young people are only granting permission to engage in acts they want to engage in, this is not always the case and can create gray areas in understanding consent and how to apply it to sexual encounters. It is important for young people to understand how they can promote an alignment of permission and desire in how they elicit and provide consent as well as the relevant legal distinctions.

The concept of verbal consent was also complicated by perceived expectations, obligations, and gender dynamics. Participants in the Brandy et al. (2018) study described how verbal permission for sexual activity, typically thought to be ideal for ensuring consent, may be the result of feeling pressure to respond with a "yes" when faced with a direct question rather than an actual desire. Students in the Jozkowski et al. (2017) study discussed the expectation that women prioritize the needs of male partners over their own. Students in the current study frequently described verbal consent as involving one person asking for permission and the other person granting permission. Our societal norms around heterosexual sexuality have taught men to be more active (the askers of permission) and women to be more passive (the granters of permission) in sexual encounters. Although this dynamic is not as socially enforced as it once was, this pattern in the data points to an idea that young women are often not expressing their desires without first being prompted by men. The cultural expectation that women are supposed to satisfy men's sexual desires may also play a role in participants' experiences of agreeing to sex that they did not want in order to please their partner. It is important for programming around consent to emphasize the importance of ensuring your partner wants to do what you want to do by asking

questions and creating opportunities for them to express themselves, however it would also be beneficial to teach young people, particularly young women, how to actively assert what their desires are and are not without feeling they must first be prompted to do so by someone else.

Students also discussed ways in which consent may be communicated through on-verbal cues such as body language and behavior, but how the success of this type communication depends on accurate interpretation of those cues. Programming should acknowledge the legitimacy of this type of communication, since it is so often a part of young people's real sexual experiences, while also addressing its challenges. While non-verbal communication provides useful clues to what someone may want, relying solely on them risks misinterpreting what they want or the possibility of missing important cues that communicate they do not want to do something. Interventions should discuss what factors increase the risk of relying on non-verbal communication of consent, such as intoxication, being with a new sexual partner, being in a situation where someone might feel pressure to consent, or when a partner's messages appear unclear or mixed. Interventions promoting sexual consent can begin to address all these issues by developing young people's self-confidence and the communication skills needed to establish ideal consent.

Participants in this study expressed misconceptions about how consent functions when alcohol is involved, expressing ideas such as all intoxicated sex is rape or that a person's consent to sex depends on how they feel about having had sex after they have sobered up. Students' confusion about how consent functions when one or both parties are intoxicated may be influenced by sexual assault programming that emphasizes the fact that people cannot always give legal consent when under the influence of drugs or alcohol. Although this is an important concept to teach to prevent abuse of someone in a vulnerable state, it also may give students a false impression of how consent can and cannot be established when mind and body altering substances are

involved. Again, making the legal distinctions clear to young people can help them understand how to apply the common and complicating factor of alcohol use to their lived experiences.

Finally, students' sexual experiences in relationships do not always match traditional heteronormative societal expectations and programming around consent and healthy relationships needs to take that into account. Although the student whose relationship included BDSM practices may appear to be an outlier, several students described sexual experiences that included BDSM dynamics or polyamorous relationships. These are not the only ways in which young people's real experiences may diverge from the traditional messages and perspectives offered by interventions addressing consent, but they demonstrate the need to have programming that helps students learn how to apply consent in experiences as diverse as their own.

Healthy Relationships

When discussing what characteristics comprise healthy relationships, participant answers in this study and past studies largely matched the characteristics of healthy relationships presented by government health organizations (mutual respect, trust, honesty, compromise, individuality, good communication, anger control, fighting fair, problem-solving, understanding, self-confidence, being a role model, and sexually consensual) (Youth.gov). While they find it easy to identify relationship traits that are healthy and unhealthy, some young people are less able to apply these ideas to their own relationships. This may be due to several factors. Adolescents are still developing their sense of identity, self-esteem, and independence; their judgement and decision-making skills; and their sexual identities, desires, and self-efficacy (Spano, 2004). Additionally, those experiencing an abusive relationship are frequently psychologically manipulated by their partner and may normalize the abusive behavior (Aghtaie et al., 2018; Bonomi, Gangamma, Locke, Katafiasz, & Martin, 2011; McCarry & Lombard, 2016; Wood, 2001). Students in this

study recognized that this often happens and that a partner can "hold your problems against you," using their disability as a tool for manipulation and control.

Interventions for young people seeking to promote healthy relationships need to address both the common normalization of abusive behaviors and the ways an abusive partner may use someone's physical or mental health condition against them in a manner that engages students to relate the ideas to their own lives. Because students' relationship experiences are so varied, these interventions should include opportunities for participants to discuss the complex situations that make identifying and rejecting abuse difficult and to gain skills in healthy conflict resolution and self-advocacy.

Intervention from Healthcare Providers

Feedback from participants in this study pertaining to discussions of relationship health with healthcare providers mirrored previous literature on the subject while also providing insight on what young people assume providers would want to discuss with them. Student responses displayed the belief that healthcare providers asking about what a healthy relationship means to them would be interested in eliciting a disclosure of abuse rather than engaging in a discourse around the characteristics of a healthy relationship. Although they largely felt positively about healthcare providers asking about relationship health, they were concerned about receiving judgement or losing control over the situation once they disclosed. As participants stated in past literature by Battaglia et al. (2003), Chang, Decker, et al. (2005), Liebschutz et al. (2008), and Miller et al. (2017), students wanted healthcare providers asking about IPV to display genuine care about their well-being, respect for their autonomy, transparency about the process and consequences of disclosure, and to provide useful information and support regardless of disclosure. This requires providers to not only be skilled in fostering open conversations, but to be

knowledgeable about the varied sexual and relationship experiences students have that may be non-traditional or affected by their disability.

Prevention programming for students can help to encourage open conversations with healthcare providers by educating students on what to expect and fostering their self-advocacy skills. If students are knowledgeable about the process of reporting abuse and restrictions on confidentiality and feel confident asking questions about their unique relationships and health, they will be more prepared to have needed conversations with their healthcare providers.

6.0 Conclusion

College SWDs have higher rates of SV/IPV than those without disabilities but seem to understand and apply the concepts of consent and healthy relationships in generally the same way as others their age. They can describe the essential aspects of consensual sex but cannot always easily apply these aspects to their lived experiences when situational and relationship factors complicate the concept. While dichotomous messaging around consent can provide useful rules for these young people to follow (i.e. yes means yes and no means no, and overly-intoxicated people cannot consent), they are not very useful when faced with the nuances of real-life experiences. Although able to identify characteristics of healthy and unhealthy relationships, young people are not always able to recognize abusive behaviors in their own relationships while actively engaged in them. Programming aimed at reducing SV/IPV and promoting consent and healthy relationships can better serve young people by teaching verbal and non-verbal communication skills, promoting self-efficacy and self-confidence, providing information that is inclusive of diverse identities and experiences, providing information on the legal implications of consent and disclosing abuse and local resources for those who have experienced SV/IPV, and allowing for open discussions that can address young people's real experiences and concerns.

This study was limited by its lack of diversity in some aspects of participant demographics. Over 78% of participants in this study were white and over 83% were female. While it is not surprising that a majority of participants would be female given the parent study's focus on experiences of SV/IPV, it does limit the male perspectives gained in this study. Further research on consent and healthy relationships would benefit from having a more equal balance of women and men and more participants of color.

Given that the data collection was not conducted with this specific research question in mind, the timing and follow up questions may have limited the detail students gave in their answers. The questions asked regarding this data came at the end of a one to two-hour interview often detailing difficult experiences with assault, abuse, health, and substance use. While many participants gave substantial answers to the questions, others were more succinct. It is possible that some participants were fatigued at this point and may have provided a more in-depth response had the question been asked earlier. That being said, asking these questions at the end of the interview enabled participants to reflect on the experiences they had just discussed that were relevant to the topics of consent and relationship health. Future studies focused on these topics could tailor data collection more specifically to provide richer data.

A final limitation was that the questions were not always worded, ordered, or understood in the exact same way. The question, If someone asked you (like a nurse or doctor) whether your relationship feels healthy, what would that mean to you? was also asked as, "If someone asked you (like a nurse or doctor) whether your relationship feels safe, what would that mean to you?," "If someone asked you (like a nurse or doctor) whether your relationship feels healthy, how would you feel about them asking that question?" and "If someone asked you (like a nurse or doctor), how do you think your answer would be different/would that mean something different to you?" The variety in the wording of this question may have influenced the answers participants gave. After the participant gave their definition of consent, the interviewer asked the question, How does being in a relationship with someone change that? Some participants interpreted this question to be asking how their *definition* of consent changes, while others interpreted it to be asking how consent *functions* differently in a relationship. While some variation in wording and understanding

might be expected in semi-structured interviews, future studies on these topics may benefit from more uniform wording to ensure they indicate the exact questions they mean to explore.

Despite the high risks of SV/IPV faced by SWDs, research and programming aimed at reducing this disparity has been lacking. Prevention programming needs to include information and conversations relevant to the factors that put this population at high risk and knowledge and skills that can help students protect themselves and each other against SV/IPV. Addressing assault and abuse is never simple, and prevention programing should reflect the complicated experiences real diverse groups of young people encounter and grapple with.

Appendix Codebook

Table 2 Codes on the Topic of Health Relationships

Code:	Definition:
Healthy	Participant describes factors that make up a healthy relationship.
Equal/Balanced	Participant describes a healthy relationship as involving balance, equality, or reciprocity.
Open Communication	Participant describes a healthy relationship as involving open and honest communication that may involve listening skills, understanding each other's point of view, and going to your partner with any problems.
Constructive Conflict	Participant describes a healthy relationship as involving conflict that is handled in a constructive and collaborative manner that may involve compromise, patience, and acceptance.
Expectations/Boundaries Understood	Participant describes a healthy relationship as involving mutually agreed upon and respected expectations and boundaries.
Respect	Participant describes a healthy relationship as involving mutual respect and sense of value for the other person.
Trust	Participant describes a healthy relationship as involving trust or loyalty.
Support	Participant describes a healthy relationship as involving supportive and caring attitudes and behaviors.
Comfortable Presence	Participant describes a healthy relationship as someone whose company is comfortable, safe, and/or appreciated.
Sexual Health & Well-being	Participant describes a healthy relationship as involving a sex life that feels safe, consenting, physically healthy, open, and/or affectionate.
Positive Bond/Happiness	Participant describes a healthy relationship as involving happiness, love, attraction, interest, and/or satisfaction.
Independently Secure	Participant describes a healthy relationship as needing independence from your partner or feeling secure in your own individual well-being.

Table 2 Continued

Growth	Participant describes a healthy relationship as encouraging growth or allowing for change.
Unhealthy	Participant describes factors that make up an unhealthy relationship.
Physical Violence/Abuse Unhealthy	Participant describes an unhealthy relationship as involving physical abuse.
Mental/Emotional Abuse Unhealthy	Participant describes an unhealthy relationship as involving mental/emotional abuse (i.e. controlling, manipulating, threatening, taking advantage)
Unhealthy Not Always Recognized	Participant describes ways in which an unhealthy relationship may not always be recognized by those involved.
Signs Unhealthy	Participant describes signs that may point to an unhealthy relationship (i.e. uncommon issues, pushing limits, making others uncomfortable, clinginess, feeling weighed down)
Healthcare Provider Asking	Participant describes what they a healthcare provider would mean if they asked them if their relationship was/felt healthy.
Same Meaning as Personal Definition	Participant expresses feeling a healthcare provider asking if their relationship felt healthy would refer to the same issues they expressed in their definition.
Am I Happy?	Participant thinks a healthcare provider would want to know if they are happy in their relationship.
Am I an Equal?	Participant thinks a healthcare provider would want to know if they feel like they have equal respect and/or control in their relationship.
Do I Lack Control?	Participant thinks a healthcare provider would want to know if they feel a lack of control in their relationship.
Am I Afraid/Abused? (Mental/Emotional/Physical)	Participant thinks a healthcare provider would want to know if they have experienced any types of abuse (physical/mental/emotional) in their relationship.
Am I Being Physically Abused? (Specifically)	Participant thinks a healthcare provider would want to know if they have experienced physical abuse specifically in their relationship.
Am I Sexually Healthy?	Participant thinks a healthcare provider would want to know if their relationship is sexually healthy (i.e. STI protection, reproductive protection, consent).

Table 2 Continued

Concerns About Intention	Participant expresses concern or skepticism about why the healthcare provider would be asking if they felt their relationship was healthy.
Advice on How to Ask	Participant describes how a healthcare provider could best ask about the health of their relationship.

Table 3 Codes on the Topic of Consent

Code:	Definition:
Misunderstandings of Consent	Participant expresses ideas about consent that represent misunderstandings about what consent truly means (i.e. that you can't consent if you've been drinking; that consent is decided after an activity takes place)
Conflating "good experience" with "consent"	Participant describes consent as requiring the experience to be fully positive or enjoyable.
Consent Definition	Participant discusses how they would define consent.
Not Clear	Participant describes feeling that consent is difficult to define or often unclear.
Clear – Black & White	Participant describes consent as a clear understanding and black and white issue (i.e. a yes or a no, wanted or unwanted).
Verbal Agreement	Participant describes consent as a verbal agreement, permission.
Non-verbal Understanding	Participant says consent can be a non-verbal understanding communicated through actions, body language, or mutual awareness.
Permission	Participant describes consent as an agreement or giving of permission. (Some participants may describe giving permission even for something they do not really want.)
Wanted	Participant describes consent as [mutual] wanting to participant in an activity.
A No is Respected	Participant describes consent as a no being respected by the other person without pressure.

Table 3 Continued

Continuous Process	Participant describes consent as a continuous process. This may include communicating about consent

Table 3 Continued

	throughout an activity or relationship and being able to say no at any time.
Prior to Any Action	Participant describes consent as taking place before any physical activity begins.
Own Decision	Participant describes consent as being your own informed decision, free of coercion, pressure, expectation, manipulation, power differentials or force.
Know What They're Doing	Participant expresses the need to be in a frame of mind to fully understand what you are doing or agreeing to for consent to occur. They may see this as requiring a reasonably or fully sober mind.
Consent in a Relationship	Participant describes how consent is different or not in a relationship.
Consent Definition in a Relationship	Participant describes how their definition of consent does or does not change when taking place in a relationship.
Doesn't/Shouldn't Change	Participant expresses the view that consent doesn't or shouldn't change when taking place in a relationship.
Definition is Less Clear	Participant expresses the view that the definition of consent in a relationship is less clear than their general definition.
What Consent is Like in a Relationship	Participant describes what consent looks like in a relationship.
More Complex in a Relationship	Participant describes the feeling that or ways in which consent is complicated in a relationship.
Safer in a Relationship	Participant describes how the feeling of safety in a relationship affects consent.
Communication in a Relationship	Participant describes how communication in a relationship is important to consent.
Easier/More Comfortable	Participant describes communication around consent as being easier or more comfortable when in a relationship.
Open Communication About Sex Life	Participant describes the importance of having open communication about your sex life in a relationship in general (i.e. feelings, needs, desires, misunderstandings, health).
Non-verbal Understanding	Participant describes consent in relationships as typically/often being communicated or understood

Table 3 Continued

	based on a deeper awareness of your partners feelings and desires that may not require verbal communication.
Explicit vs. Implicit	Participant describes whether they think consent must be explicit or can be implicitly communicated in a relationship.
Shouldn't be Implied/Assumed	Participant expresses the view that consent should never be implied or assumed in a relationship.
Generally Implied	Participant expresses the view that consent in relationships is generally implied unless otherwise stated.
Saying No	Participant describes what it is/can be like to say no to sex with a partner in a relationship.
Saying No May Be an Issue	Participant describes ways in which saying no can/may be difficult in a relationship, such as concerns over it creating conflict, hurting or disappointing your partner, or feeling pressure to have sex.
Compromising Desires	Participant describes ways in which you may make compromises in your sex life in a relationship to please your partner.
No Fear Over Partner Reaction	Participant describes consent in a relationship including the ability to say no to sex without fearing a negative reaction from your partner (i.e. If I don't want to he's fine with it and we just watch a movie instead).

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