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Establishment of safety paradigms and trust in emerging adult relationships

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Abstract

There is a critical need to understand the interplay between relationship trust and public health outcomes. The purpose of this study was to develop an understanding of emerging adult women's processes of establishing trust in sexual relationships. Twenty-five women aged 18–24 years participated in semi-structured interviews. Throughout the interviews, women compared and contrasted experiences in which they felt comfortable engaging in sexual intercourse with a partner versus times in which they did not feel comfortable. Analysis was based on a critical qualitative research orientation. When asked to speak to instances when they felt comfortable having sex, most women spoke about relationship trust. Many participants conceptualised trust based on past experiences with bad relationships or sexual violence. Based on their previous experiences of feeling unsafe or undervalued, emotional and physical security became prioritised in relationship development. Trust was developed through friendship, communication over time, and through shared life experiences. This research is among the first to qualitatively investigate trust formation and other impersonal dynamics related to sexual health decision-making. Insights from this study should be translated into future action by public health practitioners to promote healthy sexual relationships and communication about sexual health topics as a form of trust building.

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Introduction

Although the sexual health of emerging adults (age 18–25 years) has been a principal component of public health campaigns in the USA, research shows that emerging adults continue to engage in risky sexual behaviours – defined by the US Centers for Disease Control as having sexual intercourse without a condom and contraceptives and having sex with multiple partners (CDC 2012). Additionally, rates of unintended pregnancy and sexually transmitted infections (STIs) remain high among emerging adults (CDC 2012). Women in their early-20s have the highest rate of unintended pregnancy compared to other age-groups (Zolna and Lindberg 2012). Although young people aged 15–24 years represent 25% of the sexually experienced population in the USA, they account for an estimated 48% of new STI cases (CDC 2011). Given the persistent issues of unintended pregnancy and STIs among emerging adults, there is a continued need to focus research and prevention efforts on this age group.

In order to better understand emerging adults, it is important to examine their behaviours within a life course perspective that takes into account the unique context of this age group and the interrelatedness of transitional trajectories from youth to adulthood (Elder 1994). Emerging adulthood is a prime transitional period marked by departure from the childhood home and a decline in institutional structure and support (Arnett 2000). The conceptualisation of emerging adulthood reflects shifts in demographic patterns in the USA that have created a distinct life stage between adolescence and adulthood. These shifts in recent decades include: earlier age at first sexual intercourse, prolonged education and later age at first marriage and parenthood (Willoughby and Dworkin 2009). For example, high proportions of emerging adults have had vaginal sexual intercourse (84% [Regnerus and Uecker 2010]) and rates of casual sex among college students are also considered high, although reports vary in data from 20 to 80% (Willoughby and Dworkin 2009). However, most emerging adults have sex within the context of a committed relationship (Regnerus and Uecker 2010). Serial monogamy, or having a series of one-partner sexual relationships over time, is characteristic of young adulthood (Bolton, McKay, and Schneider 2010). Given this, it is important to investigate emerging adult sexual decision-making within relationships with a focus on the unique interpersonal expectations and goals of this population (Hirsch 2003).

The development of intimacy and romantic relationships is a key phase of emerging adulthood that arguably has lasting implications for adulthood (Zimmer-Gembeck and Petherick 2006). The development of intimacy is regarded as key for mental health and wellbeing, yet little is known about how young adults develop intimacy in sexual relationships (Montgomery 2005). In particular, little is known about the development of trust and its effect on decision-making (Hensel et al. 2011). Trust appears to be a common element in relationship scripts, with intrapersonal, interpersonal and social functions (Willig

1997). While trust is often taken as a given in longer relationships, there has been a lack of exploring its construction and meaning – both symbolic and enacted. For many people, trust may be constructed interpersonally and may change in context or in response to specific significant relationship events. Yet, trust in public health literature is often used as a yes or no variable, and the definition of trust is left up to the participant. For example, items like ‘Do you trust your partner?’ and ‘Do you worry that your partner might cheat on you?’ are common for establishing overall trust (Brady et al. 2009, 229). The Dyadic Trust Scale is a composed of eight items (Larzelere and Huston 1980) such as ‘There are times when my partner cannot be trusted’ and ‘I feel that I can trust my partner completely’. Research rarely describes the process or operationalisation of trust among young adults.

Developing an understanding of trust is important from a public health perspective as well. Research has shown that trust is highly related to risk assessment and subsequent condom use. Condom use has been found to be negated by: a desire for increased intimacy (Higgins and Hirsch 2008, 2007), a desire to form a relationship or show affection (Kirkman, Rosenthal, and Smith 1998) and perceived monogamous relationship status (Bralock and Koniak-Griffin 2007; Flood 2003). Emerging adult college students specifically have been found to report being in a long-term relationship and trusting a partner as reasons for not using condoms (Gibbs et al. 2013; Keller et al. 1993). Additionally, college students who report they love their partners are less likely to use condoms (Pilkington, Kern, and Indest 1994). Other research has shown how condom use can be understood to mean a lack of trust and love (Gavin 2000). As intimacy grows between a couple, the development of love and pregnancy ambivalence can led to decreased condom use (Edin and Kefalas 2005; Frost, Singh, and Finer 2007; Higgins, Hirsch, and Trussell 2008).

Furthermore, relationships can play a role in development of interpersonal communication skills and practice in healthy partner selection – both of which have important public health implications (Laborde, vanDommelen-Gonzalez, and Minnis 2014). Condom discussions between sexual partners have been shown to be associated with increased likelihood of condom use (Hock-Long et al. 2013). In a meta-analysis of psychosocial correlates of condom use, Sheeran and colleagues (1999) found communication about condom use to be the strongest correlate of condom use. Another meta-analysis, Noar, Carlyle and Cole (2006), reinforced these findings and added that self-assertiveness specifically was associated with condom use. Lack of communication between partners about preventing STI may also contribute to non-condom use (Crosby et al. 2000).

Remaining gaps and study hypothesis

Although the role of trust in relationships clearly mediates decisions about condom use, much less is understood about how trust is interpersonally constructed between emerging adults. The aim of this study was to investigate how emerging adult women form trust and commitment with sexual partners. Given persistent social gender inequalities that create harmful sexual health contexts for girls and women (Bates, Hankivsky, and Springer 2009) and gendered relationship roles (Harvey, Beckman, and Bird 2003), it is imperative to develop an understanding of trust and relationship formation from the perspective of young women. Public health literature has been criticised for not exploring women’s varied

purposes for having sex and what needs sex fulfills for women (Hensel et al. 2011; Higgins and Hirsch 2007, 2008; Sandfort and Ehrhardt 2004). By elaborating a detailed conceptualisation of trust, researchers can better understand how trust affects sexual health decision-making. Without a more comprehensive exploration of interpersonal trust in sexual relationship, it will be impossible to create meaningful sexual health and healthy relationship messages that resonate with emerging adult populations.

The study attempts to reframe traditional risk-focused public health models to explore how partners define safety paradigms. This reframing aligns with the call for an increased understanding of human behaviour as both rational and informed by cultural patterns (Gammeltoft 2002; Nathanson and Schoen 1992). Reframing risk as safety paradigms promotes a holistic, integrative and positive approach to current perspectives. This reframing allows for a better understanding of how individuals define risk in their own words and imagine consequences of particular sexual behaviours within the context of their sexual and/or romantic relationship.

Methods

Conceptual framework

Alongside the theory of gender and power (Connell 1987), this study is influenced by bargaining theory. Bargaining theory was imperative to this study because it allowed for attention to the enactment of women's agency within interpersonal dynamics, while maintaining a realisation of how larger macro structures may restrict women's agency. Bargaining theory draws on the economic and sociological traditions that approach people as rational actors seeking to maximise their own utility or satisfaction (Nathanson and Schoen 1992). Specifically, for this study, bargaining theory calls attention to gender as a characteristic of social organisations and highlights how gender-based power constrains women's options, while also showing how women maneuver within these constraints (Hirsch 2003). As a result, bargaining theory allows for an innovative combination of structure and agency frameworks by showing how women bargain for culturally constructed goals within socially shaped constraints (Hirsch 2003).

Participant recruitment and sample

The sample population was heterosexual sexually active emerging adult women between the ages of 18 and 25 years. To be eligible for the study, respondents must have had vaginal intercourse within the last three months and have been raised in the USA. Interview participants were selected using systematic ethnographic sampling (Hirsch et al. 2007; Mintz 1974). Systematic ethnographic sampling involves stratification of the sample by a variable of interest that has been shown to be related to outcomes of study. A heterogeneous group of women were selected based on different levels of relationship experience. Relationship status has been shown in previous research to relate to condom use. Recruitment took place until a minimum of eight women were interviewed in each of the following categories: single, new relationship (one year or less) and long relationship (over one year). In an effort to recruit a socioeconomic and educationally diverse sample, targeted recruitment took place at a multiple venues: specifically, a large Midwestern state university

and the local community college. Flyers recruiting for the study listed recruitment criteria, (i.e., age, sexual orientation, nationality and currently sexually active) and a prompt like: ‘As a woman in a relationship, how do you make decisions about your sexual health?’ and/or ‘Are you a woman between the ages of 18 and 25 and have had vaginal intercourse within the last three months? We’d love to talk to you.’ Women contacted the principal investigator by email to indicate interest in participation, and many participants were recruited through other respondents. No other information was collected (e.g. phone number or full name). Recruitment included information about compensation – a \$40 Mastercard gift card was provided to compensate participants for their time. All study procedures were approved by the Institutional Review Board at Indiana University.

Data collection and procedures

This study was qualitative in design. Qualitative research is best when the goal, as in this study, is to understand behaviours, opinions and decision-making processes in participants’ own words (Hennink, Hutter, and Bailey 2011). Qualitative data collection allowed the researchers to elicit rich detail about the dynamic meaning of concepts (e.g. trust) from the point of individual participants (Hensel et al. 2011). Semi-structured interview guides were used to collect data through face-to-face interviews with participants. The semi-structured interview guide centred around three topic domains: partner interactions, contraceptive use and STI prevention. The guide had a list of one lead-off question per domain and potential follow-up questions.

Interviews were conducted in a small, private conference room located on the large Midwestern university campus. Interviews lasted about 90 minutes. Before the interview began, participants gave verbal consent to participate after being given the study information sheet. All data collected was confidential and unmarked with identifying information other than a subject number.

At the end of the interview, participants completed a short questionnaire to assess demographic and relational variables for sample stratification and description as well as the examination of possible correlates with main topics of interest.

Data analysis

The digitally audio-recorded interviews were transcribed verbatim. Transcriptions were double-checked for accuracy against the recordings and then entered into NVivo to assist with data management and analysis.

Data were analysed using a critical qualitative research orientation. Critical qualitative inquiry allows for attention to the nature of social structure, power, culture and human agency, thereby allowing for refinement of social theory rather than simple description of social life (Carspecken 1996). Data analysis was organised around the stages of critical methodological research outlined by Carspecken (1996). For the most part, data analysis followed an inductive approach; codes were developed based on multiple close readings of the data (Green and Thorogood 2014).

Analysis for this paper focused on two main areas of the overall interview: (1) interviewees were asked to compare and contrast experiences in which they felt comfortable engaging in sexual intercourse with a partner to times in which they did not feel comfortable; these areas in the interview were analysed for themes and subthemes and (2) participants were also asked to elaborate any time they mentioned trusting their partner and/or not being worried about sexual health risks because of some aspect of their relationship or their partner (e.g. in a committed relationship). For the purposes of this study, the term ‘trust’ is used as a broad umbrella for examples where participants specifically mentioned trusting their partner and examples of feeling comfortable having sex and being intimate with a partner.

Results

Participants

A total of 25 women participated in interviews, ranging in age from 18 to 25 years, with a mean age of 20.7 years. Of the participants, 11 attended a local community college, one woman was not enrolled in any institution, and the other women attended a large Midwestern State University. Five of the women were first-generation college students, and all of these students except for Two attended the community college. Five of the women were first-generation college students, and all of these students except for two attended the community college. The majority of participants were White, but seven participants identified as belonging to a minority racial category. Of the seven non-White participants, three identified as Black, one as Asian and the rest as mixed. Participant demographic information is listed in Table 1 with pseudonyms, selected by the author, applied to all participant and partner names.

Types of trust

When asked to speak to instances where they felt comfortable having sex, most of the women spoke about relationship trust. None spoke about assessing sexual health risks until specifically asked about thoughts and behaviour regarding STIs. During the interviews, topics such as condom use and STI testing never arose in reference to deciding to have sex with a partner. Instead, women focused on describing their decision to be involved with a partner based on emotional and physical safety, often summarised as ‘trust’.

Friendship and relationship trust—Friendship was a common theme discussed by several women. These women described that friendship with a partner built the trust to start a sexual relationship and that trust developed over time. Women talked about knowing a partner valued friendship over sex and often spoke of a sexual partner as a best friend. Some women saw partners as supportive and spoke of working together to negotiate and achieve personal goals. For example, Jill, 19 years old, described her eight-month partnership: ‘I mean it’s really nice to have that support when I am stressing over something and he’s like “You’re gonna do great!” It’s nice to have that extra person kinda being your cheerleader every now and then.’ Almost all of the women saw their partner as supportive of their personal goals and understanding that personal goals took precedence. In summary, women saw trust as something that was intrinsic to their relationship and the foundation of their relationships.

Absence of trust

The absence of trust was described by participants to be detrimental to the relationship. Kristen, who was 18, spoke of a relationship in which her partner would yell at her or get mad if another man made advances toward her. She described that relationship as unhealthy and compared it to a more recent partnerships:

From my last relationship, I really liked the amount of trust that we had between each other. I was never asked ‘where are you going, what are you doing, why is he looking at you, who is texting you,’ it was never like that. So I definitely liked that I had a lot of trust with past last boyfriend.

Distrust, in this account, can be seen as closely associated with abuse or at least unhealthy jealousy. Kristen did not clarify if she engaged in sexual activities with this partner, even though there was a lack of trust, but only expressed how important trust was for relationship maintenance. Participants saw distrust as negative to relationships and trust as an indicator of a strong relationship.

How trust is established

Several common themes emerged related to how sexual comfort, being comfortable enough to have sex with a partner, was established in their interpersonal relationships. Trust was a combination of previous experiences and current experiences with partners over time, especially communication with the partner.

Experiences with previous partners—For many women, ideas of trust had been established based on previous negative experiences. Past sexual experiences seem to teach women how to manage new relationships in a way that impacted the formation of trust. Participants described how learning from bad relationships had improved their ability to negotiate for a better relationship the next time. Cathy, a 21-year-old woman in a new relationship, described this process of growth. In the quote below, Cathy recounts a formative experience in which a partner stopped speaking to her after sex and that that shaped how she felt about sexual health:

You know, I definitely learned some lessons, especially the first time because I was really kind of sad because I was talking to this guy and I thought we had a lot in common but it wasn't really something that he cared about but it was something that I rarely picked up on. So, having gone from that to really talking to people more before letting them into my life like that actually. There is a moment where you are taking that as learning about yourself, and other people, and relationships, and life from maybe your first few experiences of love and then obviously learning from that and growing on that instead of remembering not to be reckless. It is so personal and those things stick with you.

Throughout the interview, Cathy described how her new, current, relationship was so much stronger because of what she learned from previous experiences. Relationships, for her, were not only about learning about your partner, but learning about yourself.

Participants frequently commented about whether a partner treated them ‘right’ or ‘how they should’. Participants seemed aware that men should treat them in a certain way or different than they were being treated, yet, had trouble articulating exactly what the expectation was for partners. Isabel, aged 18 years, described how her new relationship was dissimilar to previous negative experiences:

Well, I guess my first relationship wasn’t ideal. It was kind of ... I would say it just wasn’t ideal. So, I mean, he didn’t treat me the way that he should have. And Adam, he is just a complete gentleman, I mean, just really nice and just wants me to be happy. It’s a huge difference. My parents notice it and everyone around me notices it. I’m a lot happier than I was then.

Like Isabel, women described negative experiences that were not necessarily traumatic but still impactful to their understanding of relationships. Isabel did go on to elaborate how her new partner was supportive of her personal goals and attentive to her desires.

Beyond negative experiences, many of the women had experienced abusive relationships, unwanted sexual advances or rape. These women talked about the difficulty in establishing trust in relationships, but that the contrast in behaviours heightened respect for a partner who was not abusive. These participants described feeling comfortable with a partner because he did not create guilt about past sexual experiences. Trust was built after the man did not take advantage of the women. Mary, aged 24, described her relationship with her partner of three months:

It’s one of those, sex is kind of ... I instigate it, I initiate it. Mostly because he recognises where I’ve been and that there are times where I’m going to look at you and tell you ‘No, not interested,’ and that’s okay. For the first time that’s okay. I can say no. I can say, ‘Hey, you know what? Not feeling it tonight.’ He’s, ‘Okay, can we cuddle?’ Well yeah, but does it lead to? And it doesn’t lead to. It’s one of those, I finally might have found a good guy.

In contrast to Cathy’s words above, Isabel and Mary described knowing that they were in better situations, but articulated the process almost as trial and error until they found the right partner. Like Mary, Georgia, 21, describes similar trust building experiences with her current partner after a previous rape by another partner shaped her feelings about trusting men sexually:

Um, I fell asleep on him one night. At first I was pretending to be asleep. Just to see if he was trying to make any move on me. But he didn’t. I think that is what really got me feeling closer to him. Because he thought I was sleeping, but I wasn’t, and he didn’t make any move on me. He was there the whole time and he didn’t do anything. He would wait for me to ask him and that made me feel comfortable. I was like, hmm, let me see if he is going to pull a move on me if I started to fall asleep or act like I am falling asleep. But he didn’t so that is what helped me make my decision [to have sex with him].

Georgia actively tested her potential partner for trustworthiness. She started with the assumption that she could not trust the partner, but modified this assumption when her partner’s behaviour differed from expectations created by experience with other partners.

Disclosure of negative experiences was common, but not necessarily before first sexual intercourse.

Even for women without forced sexual experiences, many described establishing trust based on feeling respected for their sexual autonomy. For example, Olive, aged 21, described how she decided to let casual partners into her home:

I feel a lot more comfortable when it comes to guys for me to initiate it just because the first time ... I guess when it comes to my own body, I'd like to think I made that decision. I guess some guys can be pushy. If they're pushy, if I get that vibe from them, I'm just, 'No, we're not doing that, whatsoever.'

Like Olive, many women felt confident having sex with a partner because the man did not push and allowed them to make the decision, whereas previous partners had been controlling and pressuring. As much as being able to be the initiator was described as being important in relationships, a few women also pointed out that knowing they could refuse their partner was important to building their comfort. Being able to say no – sexually and in other instances – was key to trust building.

Development of trust over time—Over time, participants had formative life experiences they shared with partners. Leaning on partners during difficult times strengthened relationship trust. One woman described how her partner had been by her side during her grandfather's illness and eventual death. She commented that her family, seeing how he supported her during this difficult time, began to validate the legitimacy of their relationship and him as a partner. Another woman had a child with her partner and spoke of his help with the child. She mentioned her faith in him grew as he stayed present in their lives.

Communication to establish and maintain trust—Communication was one of the most common underlying themes when speaking about sexual interpersonal relationships. Cathy described how she negotiates with her current partner:

Yea, it is really nice. Initially we ... we will just talk about the relationship and how we feel about each other, pretty regularly, so it is just like you know something, more time goes by, we talk about it again. Are you happy with this? You can usually tell, you can see it. I feel like we will just sit down and talk to each other. We don't make it really stressful or anything.

Cathy went on to describe verbally establishing and periodically checking on established boundaries with her partner. Many women described being able to talk to their partners about anything. One woman, Erin, 23, had discussed instances of outside attraction with her long-term partner, and a few women expressed knowing their partner was committed to the relationship because of communication about the topic. In the instance of disclosing the attraction, communication created a tension in the relationship, but led to an increase in trust after the issue had been resolved. The increase in trust, however, was based upon the person being honest about their attractions and behaviours with another, but without having sexual intercourse. For example, Erin, described when she confessed a crush to her current partner:

I think he appreciated that I told him because I did feel really guilty about it and I knew that it was going to go away I felt really sad, I didn't feel totally comfortable, but I felt comfortable knowing I wasn't going to act on it, so that made me feel more comfortable.

Part of the confidence in communicating, therefore, resulted from knowing they or their partners would not follow through with sexual infidelity.

Trust and self-identity

Trust in partners was often talked about as being comfortable with a partner, and often this was related to relationships as a source of self-identity and self-confidence. A couple of women discussed having shared interest with their partner; they talked about how their partners made them laugh and made them feel good about themselves. Diana, aged 22, described how her partner of seven months makes her feel more comfortable with him and confident in her body, 'because he would be like, "I don't know why you are so self-conscious you are so beautiful" and stuff like that.' Diana felt that she had grown more confident and self-assured from being in a relationship. Trust wasn't just an external category that was applied to a partner, but was created from a combination of relationships. For example, of two women in long-term relationship, Sarah, 22, talked about how she knew she trusted a partner when parents were introduced, and Isabel, 18, discussed when friends also trusted and befriended the partner.

Discussion

This study is among the first to qualitatively investigate trust formation and other impersonal dynamics related to sexual health decision-making. This study explored emerging adult women's experiences establishing trust and safety in relationships, furthering the goal of addressing the gap in research on subjective feelings and experiences regarding emerging adult relationship trajectories (Gammeltoft 2002). It serves to begin development of a theoretically-informed empirical body of literature on interpersonal trust, as called for by Bulloch (2013).

Overall, the results suggest that women have multiple mechanisms for establishing comfort and deciding to become sexually involved with a partner. Participants' descriptions of establishing trust and comfort with sexual partners provided a contrast to typical conceptualisations of trust, and, conversely, risk, as measurable static attitudes. Trust can be seen, through these women's stories, as a varied concept, with no uniform process in which couples negotiate trust in relationships. Women's understanding of trust, as we can see in these results, is developed through individual expectations created from past experiences as well as the current significant relationship, and implicit notions of what a healthy relationship should look like. What it means to trust, therefore, as a concept, cannot be separated from the context of personal history. The varied accounts of trust and sexual comfort cannot simply be combined into a simple concept with assumed shared meaning across women, and different forms of trust may have differential influence on other subsequent sexual health decision-making, like condom use. This research is in dialogue with previous effort to show, for most people, sexual decision-making is not about health,

but rather a range of emotional and physical desires (Bajos and Marquet 2000). Similar to the work of Gammeltoft (2002) in building an understanding of the meanings behind behaviours, findings from the interviews illustrate how women's sexual and relationship decision-making is informed by a range of emotional goals.

For these participants, safer sex is more multifaceted than a focus on disease-models of risk. Physical safety and sexual autonomy were key concerns for many of the women; based on their previous experiences feeling unsafe or undervalued, participants prioritised emotional and physical security over disease prevention (Pinkerton and Abramson 1992). These women did not so much assess risk, as build safety paradigms. Women who have history of unwanted sexual experiences may use a different system of evaluating the costs and benefits related negotiation of safer sex within relationships than do women without such a history (Hammer et al. 1996). These findings reinforce the call for a more comprehensive view of sexual health that includes general safety and wellbeing in sexual interactions and relationships (Pinkerton and Abramson 1992). The link between past sexual experiences, trust and risky sexual behaviours is not clearly understood in research and deserves more attention.

Inherent in participants' references to friendship and personal goal fulfillment when asked about sexual comfort are multiple identity claims. Emerging adulthood has been described as a period marked by self-exploration and growth (Arnett 2000), and this context may influence definitions of trust. For many emerging adult women, it may be important to construct a narrative in which relationships also allow them to meet the socially acceptable goals of self-growth and self-exploration. Participants are describing an overlap between relationship and emerging adult norms in which the establishment of trust becomes part of social regulation. Women themselves might also be concerned with reconciling relationship goals with personal career and educational goals. Although little research has examined the ways emerging adults navigate person and relationship goals, one study of university students found that 75% of the women and 71% of the men given forced-choice options choose relationship goals over life goals (e.g. travel and finance) (Hammersla and Frease-McMahan 1990). The only exceptions to the relationship preferential by both men and women, though, were education and an unspecific 'personal life goal'. Given this, threats to the validity of the trust in their relationships might also be interpreted as threats to their own identity and process of self-growth.

Findings from this study have several important public health implications. First, the undesirability of a lack of trust in relationships makes it obvious that public health needs to begin with a framework that trust is healthy and a natural part of relationship building. There has been a call for public health to promote safer sex practices within a context that enhances trust, rather than threatening relationships by emphasising distrust (Hammer et al. 1996; Lear 1995). Participants' stories about communication highlight how public health can utilise building communication between partners as a means of building trust within a sexual health framework. Public health practitioners can work to build curricula that include how to develop trusting relationships through better communication, thereby establishing the public health framework as a tool for creating healthy relationships, and part of the focus in these curricula would be communication about sexual health topics. Curriculum and similar

campaigns could be a step in reframing public health as complementing relationship and trust building instead of describing trust as undermining public health goals when it comes to sexuality.

The Trusted Partner Regional Behaviour Change Communication is an example of one campaign that aimed to increase condom use among ‘trusted’ partners in Lesotho, Mozambique, Uganda and Zambia. The programme promoted examples of bad ways to establish trust in relationships and encouraged sexual caution. The campaign showed images of young people who had attributes that had been deemed trustworthy in focus groups (e.g. good student, man who takes relationships seriously and tells a partner he loves her, a woman who waits a while to have sex with a partner) and ends by revealing that the person is really HIV-positive. The TV, radio and billboard commercial ends with the tag line, ‘Anybody can catch HIV. Everybody can prevent it.’ The programme had mixed results in changing condom behaviours (Hattori, Richter, and Greene 2010). In part, researchers attributed the mixed results to exposure to the advertisement on a couple-level, given that trust may be interpersonally constructed. The researchers also indicated that longer exposure and time would be necessary before changing deep-seated beliefs about trust.

The current study has several limitations that are important to note. While the institutional setting did provide more privacy and attention to confidentiality, it might also decreased participants sense of empowerment (Green and Thorogood 2014). As a result, participants may have sought to give expected answers. Given the semi-structured interview guide, not all participants were asked the same questions and, therefore, participants’ responses or lack thereof may be related to interview variability. Some of the women spoke retrospectively about relationships, which may introduce a bias to the stories; women may have chosen to present past partners in a more positive or negative light. Similarly, it is difficult to tease out the establishment of trust in casual versus committed relationships as many women’s initial casual sexual partners were now their established partner, and many young adults describe fluidity between relationship types (Allen 2004; Raine et al. 2010). Given the focus of this study on interpersonal and contextual models of sexual health decision-making, a serious limitation of this study is the focus on only women. Future research should include men and couples in dyadic analysis. This study is of a small group and seeks only to explore these issues from emerging adult women’s perspectives. It is important to understand findings as framed by college women’s experiences, which might not hold true for non-academic emerging adults. Finally, the study may conflate participants responses related to sexual comfort, intimacy and trust, which might be more nuanced constructs that need further independent investigation.

This research and future projects of a similar nature have an important role to play in developing more relevant campaigns and curricula by providing insight into emerging adult women’s views on their sexual lives and needs (Gammeltoft 2002). The findings make explicit an articulation of experiences of trust that are often tacit, taken for granted and unexamined in research. This articulation of women’s rational and personal experiences that create sexual priorities problematises the current discourse on risk assessment and the role of trust in negating condom use. Public health frameworks currently often view trust within relationships as a barrier to condom use. However, the current findings suggest that the

discourse on risk assessment and trust need to be merged as there may be ways to use trust to promote sexual health aims. These insights must now be translated into future actions by public health practitioners to promote healthy sexual relationship and communication about sexual health topics as a form of trust building.

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Table 1

Participant sociodemographic characteristics and relationship context.

Name	Age	Race	School	First-generation student	Relationship status
Amy	19	Black	Community	No	Single
Bridget	19	Black	Community	No	Single
Cathy	21	Mixed	Community	No	New
Diana	22	White	University	No	New
Erin	23	White	University	No	Long
Francis	22	White	Community	Yes	Long/married
Georgia	21	White	Not in school	–	Long/kid
Heidi	20	White	Community	Yes	Single
Isabel	18	White	University	No	Long
Jill	19	White	University	Yes	New
Kristen	19	White	University	No	Single
Lisa	18	White	University	No	Single
Mary	24	White	Community	No	New
Nancy	21	White	University	No	New
Olive	21	White	Community	No	Single
Pearl	23	Mixed	University	No	Long
Quinn	21	Mixed	University	No	Long
Rachael	22	White	University	No	Long
Sarah	22	White	University	No	Long
Tina	20	Asian	University	No	Single
Ursula	22	White	Community	No	Long
Victoria	19	White	Community	No	New
Wendy	19	White	Community	Yes	Single
Yolanda	20	Black	Community	No	New
Zelda	21	White	University	Yes	New