

LBTQ Latina Sexual Health Knowledge, Attitudes and Values

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Abstract

Previous research on sexual minority and Latina women suggests that Latina LBTQ women may be at high-risk for sexually associated and transmitted infections. However, there has been limited research on the sexual health of women in this population. This exploratory qualitative study examined the knowledge, attitudes and values of Latina LBTQ women living in Seattle, Washington. Latina LBTQ women (N = 15) were recruited using purposive sampling to participate in in-depth 1-on-1 interviews about their sexual health. Data were analyzed in Atlas.ti. Results exposed four themes about Latina LBTQ women: 1) their sexual health is shaped by their social and cultural context, 2) they lack needed sexual health knowledge, 3) they value taking responsibility for their own sexual health, 4) their behaviors vary depending on relationship status and the gender of their partners. Our findings indicate that further research is needed to better understand this population's sexual health needs and ways in which strengths within contextual factors can be leveraged to contribute to positive sexual health outcomes for this population.

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Introduction, Motivation and Rationale

Both the Latino and the Lesbian, Gay, Bisexual, Transgender and Queer (See Table 1 – Terms and Definitions) populations in the United States are growing (Gates, 2012). In Seattle, Latinos currently account for 6.6% of the city's population, and gay and lesbian people account for 4.8% (Balk, 2015). Lesbian, bisexual, transgender and queer (LBTQ) Latinas lie at the intersection of both, and account for approximately 2.7% of the Washington State population (Kim & Fredriksen-Goldsen, 2012). Social theory and empirical data suggest that Latina LBTQ women are less likely to receive recommended sexual health screening and are at increased risk for adverse sexual health outcomes relative to white women, such as cervical cancer (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Bauer & Welles, 2001; Fahs, 2014; Gonzalez-Guarda, De Santis, & Vasquez, 2013; Hubbell, Chavez, Mishra, & Valdez, 1996; Power, McNair, & Carr, 2009; Wingood, 2000). Despite the growth in this vulnerable population, little research has focused on the sexual health knowledge, attitudes, values and intervention needs of Latina LBTQ women nationally or in smaller regional areas such as the Seattle/King County metro area in the Pacific Northwest.

The literature on sexual health and LBTQ women suggests that this population lacks information about sexual and reproductive health and STI transmission. In a study evaluating the transmission of sexually transmitted infections among 286 women who have sex with women (WSW), 13% of those with only female partners and 15% of lesbian-identified women in the study reported an STD history (Bauer & Welles, 2001). These findings indicate that WSW are at risk for infection (Bauer & Welles, 2001). The study also found that women who identify as lesbian were less likely to get tested than heterosexual

or bisexual women. A mixed-methods study of lesbian and bisexual women's knowledge and attitudes regarding cervical cancer screening, found that lesbians often ignore information about sexual health addressed at "all women" based on the assumption that it will not include information relevant to them (Power et al., 2009). A prospective cohort study examining risk of Bacterial Vaginosis (a sexually associated infection that puts cis women at greater risk for contracting sexually transmitted infections) among WSW found that participants were confused about how transmission of infections occurs, the harm-reduction benefits of barrier use, lack of access to information about safer sex toy use, and the increased risk of STIs associated with alcohol and/or drug use in sexual encounters (J. M. Marrazzo et al., 2010). When asked about how a person determines risk of infection when having sex with another woman, participants generally described risk evaluation through visual and nasal examination of their partner's genitals. Participants reported that lesbians do not talk to one another about sex, nor do they talk to their partners about sex, indicating that partner communication is likely a domain that impacts sexual health outcomes (J. M. Marrazzo et al., 2010).

Table 1 Terms and definitions

Term	Definitions
Lesbian	A woman who is sexually, emotionally and romantically attracted to women and seeks sexual, emotional and romantic relationships with women
Gay	A person who is sexually, emotionally and romantically attracted to persons of the same gender and seeks sexual, emotional and romantic relationships with persons of the same gender
Bisexual	A person who is sexually, emotionally and romantically attracted to women and men and seeks sexual, emotional and romantic relationships with women and/or men
Queer	An umbrella term used to describe persons who are not sexually, emotionally and romantically heterosexual
Trans*, transgender, trans gender	Umbrella terms used to describe a person whose gender identity and sex characteristics are incongruent
Dominant culture	Used here to describe White American culture
Latina	A woman who comes from or whose antecedents came from a Latin American country
Hispanic	A person who comes from or whose antecedents came from a Spanish language country
Biphobia	Intense and illogical fear of bisexual people
Sexual fetishization	Sexual desire based exclusively upon on a person's presumed race or ethnic identity
MSM	Men who have sex with men
WSW	Women who have sex with women

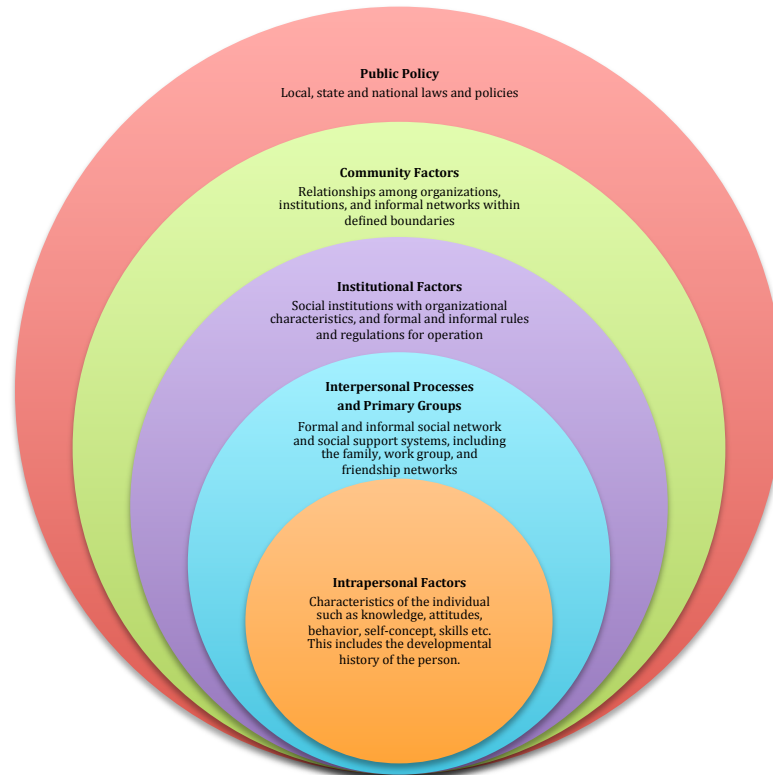
The lack of population-specific sexual health knowledge among sexual minority women may be even more complicated for Latina LBTQ women. Although there have been few studies on the health of this population, one study found that Hispanic bisexual women are at higher risk for mental distress compared to white Lesbian and bisexual women, and Hispanic heterosexual women (Kim & Fredriksen-Goldsen, 2012). In addition to these, both Mexican and US-born Mexican-American women have been found to engage in contraindicated sexual health behaviors (Arbour, Corwin, & Salsberry, 2009). Additionally,

marianismo, the idealized women's gender role in Latino culture, encourages women's passivity, lack of knowledge regarding sexual practices and safer sex, and general submissiveness, all identified risk factors for STIs (Hernandez, 2012; Marín, 1993; Moreno, 2007). These may contribute to Latina LBTQ's risk for negative health outcomes.

Conceptual Framework

Social theory asserts that social, political and environmental inequities that influence health contribute to the disproportionate distribution of disease among Latinos and sexual minorities (Krieger, 2005; Link & Phelan, 1995; Schulz & Northridge, 2004). Latina LBTQ women live their lives embedded within the context of inequitable social and ecological structures (Bronfenbrenner, 1989). These structures are interdependent, interacting to influence individual health information, behaviors and outcomes. Therefore, we drew upon the social ecological framework of public health (McLeroy, 1988) to identify the multiple contextual factors that influence Latina LBTQ's knowledge, attitudes and values, and contribute to the sexual health and well-being of this population. The model, illustrated in Figure 1 (below) includes five factors that contribute to health and behavior. These include public policy, community factors, institutional factors, interpersonal processes and intrapersonal factors (McLeroy, 1988).

Figure 1



Our study aimed to understand the factors influencing Latina LBTQ women's sexual health intrapersonal factors - knowledge, attitudes, values and behaviors - by conducting a qualitative study in the Seattle/King County metropolitan area. Specifically, we aimed to describe Latina LBTQ women's sexual health attitudes, knowledge and values about, and, to identify what Latina LBTQ women seek, want or need in a sexual and reproductive health intervention aimed at increasing protective behaviors to reduce potential negative sexual health outcomes.

Methods

This exploratory qualitative study utilized in-person in-depth interviews to collect information about Latina LBTQ women's sexual health. The University of Washington's Human Subjects Division approved study procedures.

Setting and Participants

The study was conducted in the Seattle/King County metro area in Washington State. Participant inclusion criteria were: Latina and/or Hispanic identity; lesbian, gay, bisexual, transgender or queer identity; woman or female identity; between the ages of 18-40; and English speaking. We recruited fifteen women to participate in the study who met eligibility criteria. All participants identified as either as Hispanic or Latina of any race; as female or woman; and as Lesbian, Bisexual, Gay, Transgender or Queer, and all were English speakers within the age range of 18-40. Women age 18-40 were selected because women within this age range are at highest risk for sexually transmitted infections; 90% of reported chlamydia and gonorrhea infections occur between the ages of 15-39 (Centers for Disease Control and Prevention, 2014). Racial and ethnic identities, education levels and monthly incomes varied. Some participants identified their race and ethnic identity as the same, and some differentiated between the two. Participants' incomes ranged from less than \$1250 per month to \$4170 per month or more. Three participants completed high school, three completed some college, six completed a Bachelor's degree and three had Master's degrees.

Recruitment

We used three qualitative sampling methods including Erikson's sequential sampling (Erikson, 1986), purposive sampling (Bernard, 2010; Miles, 2014; Patton, 1990), emergent sampling (Patton, 2002) to recruit women from this hard-to-reach population. First, participants were recruited through Women's Program contact lists maintained by Entre Hermanos, an organization serving the Latino LBTQ community. A general email with IRB approved language was sent giving women information about the study and asking them to email or call if interested. After the general email was sent, individual email

messages were sent to each of the women the principal investigator (PI) met personally through Entre Hermanos Women's Program events, including a queer women's mixer and health education workshops. Recruitment emails were also sent to LBTQ and Latino serving organizations; community partners at sexual health service providers; staff and students at women's centers, LGBTQ centers, ethnic groups at colleges and universities; faculty in the School of Public Health at the University of Washington; and Seattle and King County governments and institutions.

Second, email recipients were asked to share the recruitment documents and information with anyone else they knew and thought might have been interested in participating. Third, the research assistant and PI distributed over 250 flyers on college and university campuses (Colleges: South Seattle, Central Seattle, and North Seattle; Universities: University of Washington, Seattle University), bus stops near campuses and directly to Latino and LGBTQ student groups. Fourth the RA and PI recruited through one-on-one conversations at the Qolors Queer People of Color event at the University of Washington; Quinceañer@ Latino Drag Show at the University of Washington; and distributed 75 recruitment flyers at the May Day Workers and Immigrant Rights Rally at Judkins Park in South Seattle. Fifth, in addition to these direct personal recruitment strategies, the PI and RA advertised using social media in digital spaces where Latino and LBTQ people connect and network. These included 11 Seattle/King County Queer and Latino Facebook groups. Multiple tags were used to recruit on Tumblr, Instagram and Twitter. Finally, study participants were asked to share recruitment information with personal contacts that may have been interested in participating.

These sampling methods resulted in interest expressed via phone or email from 27 potential participants. Of these, 3 were ineligible due to gender identity, sexual orientation, and age; 9 failed to respond to requests for scheduling or to arrive at the set interview location; and 15 were eligible and participated in the study. All interviews were conducted in the City of Seattle at locations selected by participants. Participants gave written and verbal informed consent to participate. Participant demographics are found in Table 1.

Data Collection

Data were collected via one-on-one in-depth semi-structured interviews. The interview guide included open-ended questions on: sexual health information, sexual health care, identities, interpersonal relationships, safer sex and behaviors, partner communication, body image, sexual violence, sex under the influence and intervention needs. To reduce participant burden, Bernard and Ryan's "Long Question Probe" technique (Bernard, 2010) was used extensively. This technique, in which questions are framed within the context of the research question, orients participants to the rationale for asking potentially stigmatizing or disconcerting questions. Two five-minute breaks were structured into the interview so that participants could opt-out rather than opt-in. This strategy was utilized to eliminate the need for participants to request a break, which could be potentially challenging within the context of a research interview. We utilized participant-centered language to be inclusive of various identities and experiences of participants and their partners. For example, participants were asked about "toys, attachments or prosthetics." Adding "attachments or prosthetics" to a question about toys was inclusive of participants and/or partners who may have been trans* or gender non-conforming.

We used an iterative approach to our interview guide, making small adjustments based on preliminary findings in order to strengthen the framework and to collect richer data. For example, after 9 interviews it was clear that religion has a relationship with Latina LBTQ women's sexuality. To confirm whether or not religion was a key piece in the theoretical model, a question about current religious or spiritual affiliation was added. Probes were explicitly written into the guide (e.g. "tell me more" and "I heard you say ___. Can you tell me more about that"), and more were incorporated as needed over the course of data collection. Interviews lasted between 45 and 120 minutes, and took approximately 90 minutes on average.

Data Analysis

Interviews were digitally recorded, transcribed verbatim and analyzed using template analysis (King, 1988). Analytic memos were written describing key observations noted during the data collection process. Interview recordings were audio reviewed, and transcripts were read and reread to establish familiarity with the data. A coding scheme was developed based on the interview guide and transcripts. Two members of the research team independently coded each transcript and met iteratively to establish inter-coder agreement (Bernard, 2010; Carey, 1996; Miles, 2014; Patton, 2002). Coded data were iteratively reviewed with the full investigative team. Coded data were reviewed by the full investigative team in order to identify common and recurrent themes, as well as prototypical examples of each. These are presented below.

Results

Four themes were identified regarding the knowledge, attitudes and values of Latina LBTQ women's sexual health. These included: 1) LBTQ Latina women's sexual health is

shaped by their social and cultural context, 2) Latina LBTQ women lack needed sexual health knowledge, 3) Latina LBTQ women value taking responsibility for their own sexual health, 4) Latina LBTQ women's behaviors vary depending on relationship status and the gender of their partners. Each theme, its subthemes and representative quotes are presented in detail below.

Theme 1: LBTQ Latina women's sexual health is shaped by their social and cultural context

Participants shared experiences navigating complex social and ecological contextual structures, based on their identities as queer Latina women. Specifically, participants described their lived experiences as queer women of color living within a heteronormative and racist context (Feagin, 2014; Mink, 2014) and the ways in which this led to several experiences that appeared to shape the ways in which Latina LBTQ Latinas make decisions concerning their sexual health and safer sex practices.

Isolation

Participants identified feeling isolated and alone as queer Latinas in a predominately white city and county. Women shared that they desire friends who share their identities as well as opportunities to network and build community. They described their disappointment about the lack of women of color in attendance at queer women's events, the lack of Latina women who are in the queer community and the struggle to build relationships and connections with people who share all of their identities.

One said:

"It's unfortunate because here in Seattle, you've mentioned Entre Hermanos, but other than that, I don't think that there are spaces for the Latino community. There are

spaces where there's women's events, but usually those are white events. Then, there's also a language barrier, too. So, I just feel like it's not welcoming."

Participants identified a lack of opportunities to build friendships with other LBTQ Latina women who understand their identity struggles and can be trusted enough to ask for and share information about sexual health.

Family Acceptance

Although there was variability in acceptance within their own families, all participants discussed the deep importance of family acceptance. Women identified that "traditional" marriage, rooted in Catholicism, is a cultural value, and felt implicit pressure to conform to this standard. Most participants expressed some experience or feeling of rejection from their family members, either through a break in contact, negative comments or the inability to talk to their families about their sexual identity. While some participants felt completely rejected or accepted, most described a slow increase in family acceptance over time after coming out to their family members.

One participant shared:

"I would say it's still difficult. I wouldn't go as far to say that my parents are – I would say they're more accepting now but I wouldn't say they are fully accepting. I would say that deep down they still have that hope that I'm just going to marry a man and have kids. But things have gotten better I would say."

Discrimination

Participants shared experiences of discrimination perpetrated by individuals within the queer community and from the dominant culture. These include sexual fetishization and biphobia (See Table 1 – Definitions).

Participants experienced sexual fetishization, or racially motivated objectification, from both women and men based on their perceived race or ethnicity. They described experiences of strangers approaching them with the assumption that they are “foreign.” For example, one participant described the experience of being desired for her perceived mixed race identity:

“Two or three weeks ago, I had an experience where this woman came up to me, and I was in a bar setting and she was talking very friendly. Then, she was like, ‘Oh my gosh, you’re so beautiful. Where are you from? Are you mixed?’ I was just like, ‘No, I’m Mexican.’ She was like, ‘Oh, you’re full Mexican?’ I was like, ‘Yeah.’ She’s like, ‘Oh,’ and then walks away... I was not mixed or I was not exotic enough for her. Clearly the whole beautiful thing didn’t resonate any more.”

Both bisexual and queer women who are attracted to or date men described experiencing both external biphobia from the straight and queer communities and the accompanying internalized biphobia stemming from this contextual factor. Participants shared that straight individuals view bisexual women as personally threatening to their relationships and heterosexuality, and that queer individuals view bisexual women as a threat to the integrity of a queer identity and the queer community. Thus, bisexual participants experience social ostracism from both queer and straight people, and are hypersexualized, or perceived as overly sexual and unethical in their sexual behavior, in the process.

One participant shared:

“So there’s always this fear [from] women that they say well, ‘I don’t date bisexuals because every bisexual woman I’ve ever dated leaves me for a man.’ And so there’s this

fear that we're just here to figure things out, and then we're gonna go back and date men again."

Bisexual participants discussed navigating whether or not to be out about their bisexual identity. Based on heterosexist assumptions of their straight sexual orientation, participants described feeling conflicted between authenticity and safety. One participant said:

"I'm out as bisexual to my friends. I'm – I guess you could say technically I'm out at work, but I – with people I don't know well or people that I work with, I feel really nervous about divulging the fact that I'm not straight, and that's where I think a lot of my shame issues and stuff come up, where I – not only do I feel like awkward mentioning my romantic life whenever it's relevant to the conversation, but I also feel awkward if my coworkers assume that I'm straight because then our conversations have this weird kind of heterosexist undertone, I would say."

Bisexual participants additionally discussed a delay in understanding their queer identity because of their attraction to men. They live within a world that favors heterosexual people and structurally assumes heterosexuality. As a result, bisexual participants were able to find partial belonging in straight communities, which seemed to have delayed their realization that they also identified with queer communities. They described profound feelings of isolation and loneliness that accompanied accepting their bisexuality, and feeling invisible both in the queer community and among straight people.

Navigating multiple identities

Participants spoke about navigating multiple identities while interacting within social and ecological contextual factors. They shared a lack of belonging in both the Latino

and white American communities based on their multiple identities. Participants consistently shared the challenges in navigating expectations and contexts, and the heteronormative structures that permeate both. Participants talked about struggling to identify as queer and Latina, because of heterosexual cultural norms and expectations. They described the cultural value of “traditional” marriage and heterosexual reproduction and child rearing, and their subsequent feelings of inadequacy, disinterest or resentment to meet those expectations.

One participant said:

“I think they’re very different because it’s a minority within a minority group. So yeah, I think they’re just very different. They’re more Latinas stay at home, lesbian you shouldn’t have any kids. So it’s like okay, I’m supposed to stay home without any kids. What am I supposed to do?”

Some participants shared that Latino cultural expectations contributed to internalized homophobia and a struggle to come to terms with their queer identity. Participants described both compartmentalizing their identities in order to navigate social situations, and the inability to separate their identities. One shared: *“Amongst heterosexuals I probably say bisexual because I feel that is more easy for them to understand and comprehend.”*

Another said:

“I cannot say lesbian if I’m in a social gathering and it’s all Mexicans, like my family. That would just cause an uproar... Like I said, it’s very complex, being Mexican. And more, a Mexican woman. And even more, a Mexican lesbian woman.”

Another said:

“It's not like there's an opportunity to do that, but just today, someone said, oh – I think they saw my ring. And they're like, ‘So what does your husband do?’ And I was like, ‘Well I have a wife, you know’... so that continual kind of coming out stuff is – can be exhausting in a new environment.”

History of sexual trauma

Many participants shared histories of sexual coercion, assault, rape or molestation, and some described repeated molestation, sexual assault and rape over many years by multiple perpetrators. Participants reported their experiences of sexual violence occurred as children, teens or young adults. Some participants associated these experiences with lower self-esteem, unhealthy substance use and high-risk sexual behaviors. Participants who had not experienced sexual violence shared that their previous partners had.

For instance, one said:

“A lot of my female partners have been sexually violated in the past, raped of some sort, so that certainly kind of – I find that might be more unique for women to women or women trans relationships because in terms of rape, more women are raped than men... It certainly impacts – for me, it certainly had impacted my sexual behavior with them in terms of words that they told me they didn't want to hear and situations that they didn't want to be in, and kind of like power dynamics. You know, there's certainly trigger points that you have to be very sensitive to.”

Theme 2: Latina LBTQ women lack needed sexual health knowledge

Participants discussed their exposure to sexual health information across the lifespan. Participants associated their childhood sexual health education with Catholic

teachings, and many included fear- and shame-based tactics. Participants reported receiving their sexual health knowledge from the Internet, friends and health care providers, and trust their doctors above other sources.

Family- and school-based sexual health education

Participants shared that the sexual health education they received during childhood came from their families and schools. Family teaching tended to frame sex and sexuality in the context of puberty, reproduction or love between two people. One participant shared:

“My mom was always very open about sexuality. And so I had information since I was little about how babies were born and where they came from and how they were made. And so there was a lot of information when it came to that about safe sex practices, like using condoms or contraceptives but definitely abstinence.”

Participants shared the importance and lasting impact of family-based sex education. One participant identified that the information she received from her family protected her from internalizing shame-based education:

“I got a lot of information from them. They gave me a lot of like books to read and then we had Family Life, I think it was called, in fifth grade at school, and then we had some real weird sex-ed in Catholic school when I was a freshman. Most of what I remember is like watching videos of men screaming at young girls about how if they got pregnant no one would ever want to marry them.”

Misinformation and lack of queer safer sex information and education

Most participants shared that they talk to peers and sometimes use the internet for

sexual health information, but ultimately trust doctors exclusively for sexual health information. One participant shared: *“As I said, I get all of my sexual health information from my doctors. That’s the only person I’m gonna trust with that kind of information.”*

However, these participants shared that doctors either do not give any information about how to protect themselves against sexually transmitted and associated infections, or definitively state that women cannot contract infections from their female partners.

One participant shared:

“I had my annual Pap smear, it’s going on two years now. She said that because I don’t partake in intercourse with males and my age and my health that I didn’t have to do it again for four years.”

Variation in sexual health education

Participants experienced variation in knowledge based on region of origin and sexual orientation. Women who grew up in the Southwest and Southern United States received little sexuality education at home, limited puberty education in school and abstinence-only sexual health education.

One participant shared:

“Oh, I didn’t. [laughs] I mean there - I guess the most info I got - I remember a Seventeen magazine that had a two-page layout around birth control, and that was like my guide to figuring out how to engage in sex - or how to protect myself. And so through that I was like, okay, there’s a sponge thing. And so if I’m gonna have sex with a guy I’m gonna have to like get a condom, have a sponge because I want to have - be doubly safe, and so I mean there was no talk about sex and family. And I don’t really

remember any sex education growing up in high school quite frankly either. So probably Seventeen magazine was the most info I had in high school and growing up. "

Another shared:

"As far as sexual health it was the typical sex ed class in elementary school more middle school. 'This is what happens when you grow up. You go through puberty... 'You'll be interested in guys,' when they were talking to females. Or when they were talking to guys they'd be like, 'You'll be interested in girls,' so that was it as far as sexuality was talked about. "

Participants that identified as queer stated that within the queer community there is an understood accountability between sexual partners, and that there is an expectation between sexual partners to protect each other. One participant shared proudly that the queer community has empowered her to take steps to protect herself and her partners:

"I feel that my queer identity – I think – well, I think it's related to kind of queer culture and the queer community which I feel is probably a little more informed and a little more active than the heterosexual culture. I don't know if that's a gross generalization, but that's how I feel. So I feel because of that it kind of motivates me to be more informed and more educated and more proactive just to kind of like keep up with the community around me."

However, for others lack of behavior- and identity-specific information may make queer safer sex expectations impossible to fulfill. One participant shared: *"Safe sex. Yeah.*

We all know what that means, and then you realize that maybe we don't know what that means."

Uncertainty regarding how to practice safer sex with women

Participants reported uncertainty of how to negotiate and practice safer sex with women. Participants shared that the sexual health education they did receive was limited to safer sex in the context of heterosexual behaviors. Participants largely practiced safer sex with men, and were firm in their decisions to use barriers with men for fear of pregnancy and sexually transmitted infections. Many participants stated that they did not know what safer sex methods were available to them, and some attributed their high-risk sexual behaviors to their lack of knowledge.

One participant shared earnestly that in order to practice safer sex with women she would have to make a concerted individual effort. She said: *"To make that change, I would have to go out of my way to do things differently — be more prepared, be more assertive in that moment."*

Bisexual participants reported having little information regarding safer sex behaviors with women. In response to a question regarding safer sex practices with women, one shared: *"No 'cause I don't have any information on that, so I wouldn't [do it]."*

Provider responsibility

As above (misinformation), participants identified doctors as their desired and trusted source of sexual health information, and were generally satisfied with their most recent sexual healthcare interaction. However, participants shared that providers often assume they are heterosexual and offer them heterosexually oriented safer sex advice.

A participant shared her experience of obtaining sexual health information from her doctor:

"I would say that most of the time, it's my doctor. And the only time I really go over things is when I have my annual checkup and they usually ask how many partners do you have, are you on birth control, those types of things. I think the only time that I've been thrown off is I think I have been asked are you sexually active and I say yes and then they say something or and then they follow up with are you on birth control? And I say no and then they say well, do you want to be on birth control? And then I feel like I have to say well no, I don't need birth control because I have a female partner...And so then that's the end of the conversation."

Participants shared that upon sharing their sexual orientation or behaviors, providers perceived them to have negligible risk and did not recommend safer sex practices, dismissed concerns regarding desired testing or provided them with incorrect information regarding the need to be tested in the future.

One participant shared:

"I had had a female partner who told me that she tested positive for HPV in spite of having had the vaccine and that she had contracted it from another female partner that she had. And I had a male partner as well at the time, and I was concerned about transmitting it to him because we were not monogamous and just – so I went to the doctor because I wanted to be tested, and she basically told me that it was impossible for women to transmit HPV to each other and that I didn't need to be tested and I wasn't within my three-year window for, you know, recommended screenings and that

I didn't need one. And I was insistent and I told her that my female partner had gotten it from her female partner, so I didn't think that that was accurate information and [laughs] I think she said, 'You know, I mean to that I would just respond, really?' The implication was very clear that my female partner had been with a man if she had contracted HPV, which I knew not to be the case. So it was a frustrating experience."

Theme 3: Latina LBTQ women value taking responsibility for their sexual health

Participants reported valuing taking responsibility for their own health and described how this value influences their sexual decision making and behaviors. Participants identified the value they place on sexual responsibility and its importance to them as women. Women identified that their sexual health is connected to their gender identity and that maintaining their sexual health is a way in which they protect themselves and their partners from harm.

A participant shared: *"Obviously being a woman, there's things that I have to get checked on a regular basis. I have to go to a gyno and all that kind of stuff."*

When asked about their recent experiences accessing sexual health care, participants identified that they prioritize their sexual health exams as directed by their doctors, even though these are uncomfortable. One participant shared that contextual factors—Latino culture and heterosexism—frame her experiences accessing sexual healthcare. She said:

"In my culture, going to the doctor is not something – you go to a doctor if you absolutely need to go to the doctor, like if you're dying, you have to go to the doctor. Even going for checkups and all this stuff, it's very foreign. I've had to start saying, 'No,

I need to be taking care of this and this and this' because it's not something that I necessarily grew up with. So, it's different. But I feel like even every time that I do make that decision to go see someone, it's still threatening, I'd say."

All but one participant reported having health insurance at the time of the study, with some specifically identifying obtaining healthcare through the Washington State Health Exchange. Several participants mentioned obtaining healthcare at Planned Parenthood and named this provider as a common source of sexual health information in adolescence.

Theme 4: Latina LBTQ women's sexual health behaviors vary by relationship status and the gender of their sexual partners

While the reported sexual behaviors varied among participants to some extent, participants reported differences in their own sexual behavior that was dependent on the gender of their partners, as well as the status of their relationships.

Differences in practices based on sex with women or men

Participants identified differences in safer sex practices based on the gender identities and sexes of their partners. Participants expressed that they were generally consistent about barrier use with their male partners. One participant shared her a history condom use history with a trans* female partner, expressing that she uses condoms with any of her partners who have a penis. Many of the participants in our study did not regularly use barriers when they have sex with women, with only one woman explicitly stating that she used female condoms with all of her female partners.

After describing practicing barrier methods with men, one participant shared:

“But like I’ve never been with a female partner and offered to use a dental dam or something like that. I feel like that would just – I don’t know, I don’t know why it would be weird and maybe the reason why is because with men, I think it’s like well, we use a condom because I don’t want to get pregnant or something whereas with women, that wouldn’t be the excuse. The excuse would be I don’t want to get an STI. And so then that’s almost like assuming but it gives that person the impression that you think that maybe they would have an STI or something.”

Trust as proxy for safer sex

Participants identified trust as important in their sexual decision-making processes and behaviors. Women identified that when trust is established between them and their female partners, they are less afraid of risking infection and engage in unprotected oral and digital penetrative sex. Participants shared that they were confident that their female partners would not intentionally expose them to infections or harm.

One shared: *“And I trust women more than men to not jeopardize my health which is not necessarily like a safe choice... I guess it really comes down to trusting them more than men, I guess.”*

Participants identified that their use of trust does not apply to their sexual behaviors with male partners. Participants consistently identified that they do not trust men or use trust as a proxy for safer sex with men. All participants cited specific reasons for consistently using barriers with men, and these included fear of pregnancy, a history of sexual violence, fear of men’s dishonesty in reporting sexual history, history of men dismissing potential consequences of unprotected sex such as unintended pregnancy or

contraction of infection and men not taking responsibility for their or their partner's sexual health.

One participant shared:

“And I remember at one point, I was in this situation and I think I mentioned the condom part and I got some sort of answer of like ‘oh, well it’s not like there aren’t options if something happens’ or something like that which I was like okay, no thank you... I’m assuming what he was meaning is it’s not like you couldn’t have an abortion if you got pregnant or something like that.”

Sex toy use

Use of barrier protection methods with sex toys varied across participants. Most participants indicated knowledge regarding safer toy use by explaining that they use toys made of silicone, rather than porous materials that may harbor bacteria or viruses. One participant shared: *“You know, using silicone versus, you know, other kind of material, porous materials.”*

Participants shared that they limit their toy use to serious rather than casual partners. Participants explained that toys are generally purchased with a specific partner for their exclusive use, and that toys are disposed of or left with said partner at the end of the relationship. Another shared:

“Toys are always exclusively when I’m monogamous with somebody. I will not use them if it’s somebody I’m not exclusive or monogamous with. That’s always exclusively with them. I will only use that one with them. If that’s over, it goes in the trash.”

Bisexual participants were not as familiar with safer toy materials, or barriers with which to use with them. Toys that are safe to use without barriers are made of non-porous materials such as silicone; porous materials may hold bacteria and viruses that can be transmitted to sexual partners via unprotected toy use. One participant shared that the sex toys she used with partners were made of plastic, a porous material.

Non-monogamous communities and safer sex

Participants in polyamorous or non-monogamous communities reported engaging in consistent testing regimens to protect their partners without the use of barriers.

One participant shared: *“And then if we have a closed circle where people aren't having sex with other people outside of it, then it can be unprotected and everybody's been tested, so that's kind of our setup right now, but it's always changing.”*

Discussion

This small qualitative study explored the sexual health knowledge, attitudes and values of Latina LBTQ women in the Seattle/King-County area and found that although Latina LBTQ women value taking care of their sexual health, many lack needed sexual health information needed to make informed and healthy decisions. This is the first study to our knowledge to describe sexual health knowledge, attitudes, and values of Latina LBTQ women. While further research is needed in this marginalized population with multiple identities and related vulnerabilities to poor health outcomes, findings from this study can be considered hypothesis-generating regarding areas for improving sexual health within this population.

Latina LBTQ women reported a lack of sexual health education specific to them across their lifespan. Participants reported limited knowledge regarding practices to reduce their risk of sexually associated and transmitted infections. Lack of queer-specific sexual health information in adolescence and young adulthood, and provider's omission of queer safer sex advice leaves this population without essential information to reduce their risk of infections when participating in sexual behaviors with women. This finding is consistent with previous studies that have identified a lack of sexual health information relevant to WSW (J. M. Marrazzo, Coffey, & Bingham, 2005; Power et al., 2009) and provider's failure to provide lesbian and bisexual women with queer safer sex information (Bauer & Welles, 2001; Muzny, Harbison, Pembleton, Hook, & Austin, 2013), despite evidence that WSW are at risk for sexually transmitted and associated infections (J. M. Marrazzo et al., 2005; J. M. Marrazzo, Koutsky, L.A., Kiviat, N.B., Kuypers, J.M., & Stine, K., 2001; J. M. Marrazzo et al., 2010). Conversely, participants generally reported using condoms consistently with male partners, which is indicative of their desire to protect themselves. This finding suggests that LBTQ Latinas would utilize queer safer sex information if it were available to them, specifically because they value their own health.

Latina LBTQ women in this study reported placing a high value on their sexual health and prioritizing sexual responsibility. Many had been tested for sexually transmitted infections and cervical cancer, and were open about sharing their sexual histories (e.g. sexual behavior with female partners) with their providers. Women were interested in protecting their sexual health despite potential barriers to care, including fear of discrimination from providers, limited income and a lack of employer-provided healthcare. These findings are supported by findings from a recent study exploring

disparities in pap testing by sex of sexual partner among women of various ethnicities and sexual orientations (branAgenor, Krieger, Austin, Haneuse, & Gottlieb, 2014). The study found no difference in pap testing between behaviorally heterosexual and homosexual Latinas, suggesting that Latina women's culture, rather than sexual orientation, may play a role in valuing their sexual health.

Despite identifying as both Latina and LBTQ, Latina LBTQ women in this study identified feelings of both belonging to and feeling distanced from the LBTQ and Latino communities. They shared that within the queer community they feel somewhat alienated because their ethnic and racial identities are not concordant with the largely white LBTQ community in Seattle. They also shared that among Latinos they feel somewhat out of place because their sexual orientation does not meet cultural expectations of being a Latina woman. Their feelings of isolation while interacting with either community ultimately result in feelings of isolation in both. This is consistent with findings of a study of English-speaking Latino gay men examining community connectedness in which participants felt both connected to and disconnected from the queer and Latino communities (Gray, Mendelsohn, & Omoto, 2015). Bisexual participants in this study shared feelings of discomfort associated with concealing their bisexual identity for fear of discrimination. Other studies have also identified stress associated with biphobia among Brazilian lesbian women (Mora & Monteiro, 2010) and stress from bisexual concealment among Latino bisexual men (Holloway, 2013). Our findings support the importance of addressing public health concerns with an intersectional framework (Bowleg, 2012); though Latina LBTQ women suppress parts of themselves depending upon the context of a particular moment, they bring their entire selves with them in each. An intervention that addresses the

intersecting identities of queer Latina women has the potential to contribute to reducing negative and promoting positive health outcomes.

We found that Latina LBTQ women experienced prejudice and discrimination based on their sexual orientation, racial/ethnic minority status and gender. Stress related to discrimination has been associated with a higher prevalence of psychiatric disorders among lesbians, gays and bisexuals of various ethnicities (Meyer, 2003). Additionally, research has shown that the double minority status of queer people of color is likely to confer excess stress exposure (Meyer, Schwartz, & Frost, 2008) as they face prejudice and discrimination from both majority and minority groups (Herek & Garnets, 2007) in various contexts of their lives (Balsam et al., 2011). As such, these women's experience of discrimination is likely to result in chronic stress that impacts their health. Latina LBTQ women in this study expressed unsettling experiences of sexual fetishization based on their perceived racial identity, and some directly associated these with feelings of discomfort and lowered self-esteem. This finding is consistent with a study of gay men of color in which participants reported similar experiences of being sexually desired for their physical appearance or to fulfill sexual fantasies based on racial stereotypes (Ro, Ayala, Paul, & Choi, 2013). Reported discrimination and racism may contribute to sexual risk taking behaviors among Latina LBTQ women, as discrimination has been associated with increased risk of HIV infection among Latino men who have sex with men (MSM) due to sexual risk taking behaviors (Mizuno et al., 2012).

Latina LBTQ in this study reported relying on feelings of trust to determine whether to use safer sex behaviors, rather than explicitly communicating with their partners about

risk. Latina LBTQ women identified that they choose to engage in sex without barriers with women because they generally trust women to safeguard their health, to protect them from risk and to disclose histories of prior or current infections. This finding is similar to that of a study examining sexual health attitudes among WSW that found that participants generally trust women and as such do not need to use barriers during sexual contact (Dolan & Davis, 2003). One participant in our study mentioned that asking to use barriers with women would imply a lack of trust, because she could not leverage fear of pregnancy as a reason for barrier use. Other studies have identified that affective aspects of sexual behaviors (e.g. love, trust) can reduce the utilization of barriers (Rosenberger, Herbenick, Novak, & Reece, 2014) and can dissuade individuals from using them (Canin, 1999), putting themselves at risk for infection. This finding is consistent with previous studies of Australian women (Richters, Prestage, Schneider, & Clayton, 2010) and African American WSW (Muzny et al., 2013), which found that women generally did not use dental dams with their female partners. These findings suggest that Latina LBTQ women may not use safer sex methods when engaging in sex with women, which may increase their risk of contracting sexually associated and transmitted infections.

Many participants in this study experienced sexual abuse, assault and rape, in childhood, adolescence and young adulthood, with some reporting revictimization throughout their lives. These participants' experiences are not unique; studies with other marginalized sexual and racial/ethnic minority populations have found similar histories (Arreola, 2012; Balsam, Lehavot, Beadnell, & Circo, 2010; Loue, 2008). Childhood sexual abuse has been associated with various adverse sexual health outcomes, including greater number of sexual partners, trading sex for money, and risky sexual behaviors (Dilorio,

Hartwell, Hansen, & Group, 2002; Senn, Carey, & Coury-Doniger, 2012; Testa, VanZile-Tamsen, & Livingston, 2005). Past sexual victimization is also associated with high-risk sexual behaviors (Lang et al., 2011; Maman, Campbell, Sweat, & Gielen, 2000; Smith & Ford, 2010). Our findings suggests that Latina LBTQ women may be at increased risk for high-risk sexual behaviors due to a history of sexual victimization.

Latina LBTQ women in this study did not consistently make connections between their Latina identity and their sexual health or safer sex decision-making. Rather, they connected their sexual health and sexual decision making more with their sexual orientation and behaviors. For example, Latina LBTQ women in this study had limited information regarding safer sex with their female partners and associated this with lack of queer safer sex information during sexual health education. This finding suggests that sexual health practices may have less to do with Latino culture and more to do with sexual orientation.

This study has both strengths and limitations. Due to the qualitative design of our study, findings are not generalizable to Latina LBTQ women as a population. Our eligibility criteria were determined based upon the participation of Entre Hermanos' Women's Program at the time of recruitment. This limited our study to participants who were English-speaking, and between the ages of 18-40. These reduced our ability to understand the sexual health knowledge, attitudes and values of Latina LBTQ women who primarily speak Spanish. Additionally, we excluded adolescent (15-17) and mid-life LBTQ Latinas (40-50), who may be at greater risk for sexually transmitted infections (CDC, 2011) and cervical cancer (CDC, 2012), respectively. While our findings suggest that Latina LBTQ

women may be at higher risk for engaging in high-risk sexual behaviors and infections through unprotected sex, these risks may be heightened for women who were ineligible for our study; those with limited English proficiency, lower levels of acculturation, lower levels of education, undocumented immigration status and inability to qualify for free or reduced cost health insurance through the Washington State Health Exchange. Additionally, all participants had completed high school and most at least some college education. Despite challenges related to recruitment and feasibility, we were able to recruit and interview a sample of 15 Latina LBTQ women of various sexual orientations and regions of origin, thus being the first study of this kind to shed light on the sexual health knowledge, attitudes and values of Latina LBTQ women. Further studies should include younger, older and Spanish-speaking LBTQ Latinas who have limited access to healthcare to examine whether findings from this study persist.

Conclusion

Latina LBTQ women are a population with intersecting marginalized identities and unique sexual health knowledge, attitudes and values. Participants in this study reported strongly valuing and prioritizing their sexual health, while simultaneously lacking much needed sexual health knowledge, potentially as a result of navigating multiple identities in the context of a heterosexist and racist culture. Findings also suggest that, as a result of this lack of knowledge and related practices, Latina LBTQ may be at increased risk for sexual risk-taking behaviors and sexually transmitted infections. While more research is needed on this population, findings suggest the possibility that it may be possible to leverage the value Latina LBTQ women have in their sexual health to ultimately reduce their risk of negative sexual health outcomes. Further research should be conducted to

learn more about this population's sexual health and apply it to interventions aimed at reducing Latina LBTQ women's risk of infection and increasing positive sexual health outcomes.

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