Published in final edited form as:

J Obstet Gynecol Neonatal Nurs. 2014 July ; 43(4): 509–519. doi:10.1111/1552-6909.12461.

Sexual Safety and Sexual Security among Young Black Women Who Have Sex with Women and Men

Kamila Anise Alexander, PhD, MPH, RN and

A postdoctoral fellow in the School of Nursing, Johns Hopkins University, Baltimore, MD

Ehriel F. Fannin, MSN, RN, CNL

A predoctoral fellow at the Centers for Global Women's Health and Health Equity Research, University of Pennsylvania School of Nursing, Philadelphia, PA

Abstract

Objective—To examine sexuality narratives of Black women who have sex with women and men and explore factors that influence their sexual safety and sexual security.

Design—Secondary qualitative content analysis.

Setting—We recruited young self-identified Black women from beauty salons and community-based organizations.

Participants—Our sample included a subset of five sexually active, Black women age 19 to 25 who reported engaging in sexual relationships with women and men. Participants were selected from a larger parent study that included sexuality narratives from 25 women.

Methods—We analyzed interview transcripts in which participants described sexual relationships. We used constant comparative techniques and conventional content analysis methodology.

Results—We uncovered three themes illustrating influences on sexual safety and sexual security: institutional expectations, emotional connectedness, and sexual behaviors.

Conclusions—From this analysis, we derive valuable insights into decision-making processes within sexual relationships from the perspectives of young Black women who have sex with women and men. Clinicians and investigators can use these findings to inform programs designed to improve the sexual health of this often invisible group of women. Nurses are uniquely positioned to support young women as they navigate societal institutions and emotional experiences that inform future sexual decisions and behaviors.

Keywords

sexual health; women who have sex with women and men; bisexuality; sexually transmitted infections; HIV/AIDS; unintended pregnancy; sexual safety

Sexual minorities experience disparate sexual health challenges compared to heterosexual individuals (Ebin, 2012). Young Black women who have sex with women and men (WSWM) are especially vulnerable to unintended sexual health outcomes, such as sexually transmitted infections (STIs), mistimed or unwanted pregnancy, and HIV (Muzny, Harbison, Pembleton, & Austin, 2013; Muzny, Sunefara, Martin, & Mena, 2011). The term *WSWM* is used to describe women who engage in homosexual and heterosexual behaviors but may identify themselves as heterosexual, bisexual, gay or lesbian, or may choose to not self-identify (Bauer & Brennan, 2013). Current public health strategies are often framed around health risks in heterosexual relationships and are inadequate to address sexual health risks among WSWM. Furthermore, investigator and health practitioner assumptions about women's sexual identity and behaviors may inhibit opportunities for intervention (McNair, Hegarty, & Taft, 2012).

Sexual safety refers to the ways in which physical boundaries are maintained and respected. Individuals can promote their sexual safety by engaging in protective behaviors, assertive communication, and negotiating respectful relationships (Alexander, 2013). They can also negotiate condom or contraceptive use and ask about a sex partner's sexual history (Padgett, 2007).

At present, little is known about how WSWM maintain sexual safety, and even less is known about sexual security. *Sexual security* refers to individual emotional processes involving the use of past relationship experiences to influence future sexual decisions (Alexander, 2013; Davies & Cummings, 1994). Individuals often make decisions about sexual activity based on how they feel in that moment and over time. Emotional states are patterned and include feelings such as fear, love, and excitement. Therefore, these emotional drivers shape sexual security and inform safety behaviors (Alexander, 2013). In this study, we examined the sexual narratives of young Black WSWM and explored factors that influence sexual safety and sexual security.

Review of the Literature

Establishing sexual risk profiles during health care encounters can be a challenging prospect for nurses. In fact, among a sample of sexual minority women and mostly heterosexual general practitioners, rates of disclosure of sexual identity were correlated with how strongly women identified as a sexual minority (McNair, Hegarty, & Taft, 2012). Among the women that disclosed their sexual identities, almost all of the disclosures were initiated by participants rather than health care providers (McNair et al., 2012). Social institutions, such as family, religion, and peers impose expectations that inform feelings of perceived sexual discrimination. This discrimination is particularly prevalent within the Black community. For example, a study among 355 sexual minority young adults who frequented nonaffirming religious institutions revealed significantly higher levels of internalized homophobia among Black sexual minority adults than White sexual minority adults ($p = .03$) (Barnes & Meyer, 2012). Anticipation of discrimination may inhibit the willingness of a sexual minority to seek out appropriate and relevant sexual health information. This behavior is supported by findings from population-based and community-based studies in which young adult sexual minorities, particularly women, were less likely than heterosexuals to seek and receive

social support about sexual issues from their parents and friends ($p < .05$ in both studies) (Friedman & Morgan, 2009; Needham & Austin, 2010).

Sexual health of WSWM involves nuanced mental and emotional processes that require social and relational support from partners (Centers for Disease Control and Prevention, 2010; World Health Organization, 2006). Emotional connectedness is a key element in establishing gratifying, intimate relationships (Matson, Chung, Sander, Millstein, & Ellen, 2012). Additionally, emotions such as love, pleasure, shame, and trust, influence thoughts, behaviors, and the sexual well-being of individuals (Corbett, Dixon-Gomez, Hilario, & Weeks, 2009; Higgins & Hirsch, 2008). Individuals use emotional processes to make decisions about what type of sexual engagement and with whom and about contraceptive and condom use (Alexander, 2013; Higgins & Hirsch, 2008). Feelings of intimacy and love among women toward their partners have been associated with decreased perceptions of risk and nonuse of condoms (Corbett et al., 2009; Matson et al., 2012). In fact, participants in Corbett and colleague's (2009) research reported that their emotional needs superseded concerns about their health. In two other studies, investigators reported increased condom use when discussions of pleasure were incorporated into educational interventions (Ingham, 2005; Philpott, Knerr, & Boydell, 2006).

Sexual behaviors such as barrier use (including condoms and dental dams) and health screening for STIs, contribute to safer sexual health practices and decreased sexual risk (Everett, 2013). Women who have sex with women and men perceive lower sexual risks when engaging in sexual activities with women and are less likely to use barrier methods. In a study of 1,557 WSWM, more than 88% reported never using barriers when performing or receiving digital sex (use of a finger or toe as a stimulator during sex), more than 80% reported never using barriers when performing or receiving oral sex, and more than 60% reported never using barriers during genital stimulation with a sex toy (Rowen et al., 2012). The disparate sexual health outcomes experienced by WSWM compared to heterosexual women are affected by prior or current sexual activity with men. (Everett, 2013; Marrazzo & Gorgos, 2012; Singh, Fine, & Marrazzo, 2011).

In an analysis of the National Longitudinal Survey of Adolescent Health, which included 7,392 women age 24 to 32, WSWM were twice as likely to report STI histories as heterosexual women who had sex with only men (WSM)(64.19% vs. 43.62%; $p = .001$) (Everett, 2013). However, a larger proportion of WSWM had initiated STI screening compared with heterosexual women (34.6% vs. 26.83%; $p = .01$) (Everett, 2013). Singh and colleagues (2011) also found a higher prevalence of chlamydia among WSWM compared with WSM in a sample of 9,358 women attending family planning clinics (7.1% vs. 5.3%).

Methods

We conducted a secondary analysis of data collected from a parent study. The parent study sample included 25 self-identified Black young women who reported having sexual activity with a man at some point in their lifetimes. The primary aims of the parent study were to analyze meanings of sexual safety and sexual health among this group of young women. We used narrative methods to elicit in-depth stories from participants during the data collection

phase (Riessman, 2008). Results from the critical narrative analyses of the entire sample are reported elsewhere (Alexander, 2013).

During their interviews, 20% of participants ($n = 5$) identified specific relationships with women as important influences on their developing sexuality. Therefore, in this study, we used conventional content analysis (Hsieh & Shannon, 2005) to examine interview transcripts of this subsample. We selected interviews in which participants discussed sexual relationships with women and provided descriptive narratives about those experiences. This methodological approach was selected because existing literature about young Black WSWM is underdeveloped and requires description (Hsieh & Shannon, 2005). Institutional Review Board approval was obtained, and ethical protocols were followed to maintain the trustworthiness of the data.

Sample and Setting

The parent study's purposive sample included young Black women recruited from community venues (primarily beauty salons) through flyers and word-of-mouth advertising. Eligible women were age 18 to 25 years, reported at least one lifetime sexual experience with a man, and were able to read and write English. Sexual experience was defined as oral, vaginal, or anal intercourse. The subsample reported in this study included WSWM who ranged in age from 19 to 25 who had diverse sexual identities and varied types of sexual relationship with women. Participants identified their sexual orientations as bisexual, heterosexual, and lesbian. Two participants reported casual relationships with women, and three reported a primary relationship that lasted longer than one year.

Data Collection

During the parent study, the primary author conducted all interviews in a private location (participants' homes, meeting rooms in public or university libraries, or unoccupied spaces in the beauty salons where recruitment took place). After participants provided written informed consent, semistructured interviews were audio-recorded. The interviews lasted between 60 to 90 minutes and were guided by open-ended questions with accompanying probes. The primary author designed the interview guide to elicit in-depth stories about positive and negative aspects of relationships and sexual experiences by including questions such as "Can you describe the most important intimate relationship in your lifetime? Tell me about a relationship that was good and/or not so good. What do the words (intimacy, desire, trust, and pleasure) mean to you when you think of your relationship with [insert partner name]? What does safety mean to you when you think about your sexual relationship with [insert partner name]?" Each participant selected a pseudonym to protect her identity. Following the interview, each participant completed a survey designed to elicit sociodemographic information and sexual behavior information.

Analytic Process

We approached analyses of the transcript texts using a four-step process (Hsieh & Shannon, 2005). During each step of the process, we integrated constant comparison techniques within and across interview transcripts (Glaser, 1965). All emerging data were coded, categorized,

and compared to previous data findings within each interview as well as between different interviews (Glaser, 1965). In the first step, each of the authors independently read all five interviews to immerse ourselves in the stories. In the next step, we coded the five interview transcripts with a focus on the participants' descriptions of same-sex relationships. Next, we discussed emerging categories and themes in an iterative fashion, linking findings between coders. Relevant data patterns were recorded and discussed to highlight across interview and within-interview analyses. Finally, using the emergent themes, interviews were then reanalyzed by each of the authors. During this step, we discussed incidents of contradiction and concurrence and identified cohering themes until we reached agreement (Glaser, 1965). To enhance trustworthiness of the findings, we created an audit trail by writing memos about our reactions to each participant's narrative throughout the analytic process (Lincoln & Guba, 1985).

Results

Participants described diverse experiences in sexual relationships with women and men. Three themes emerged describing influential factors to sexual safety and sexual security among this sample of young Black WSWM: institutional expectations, emotional connectedness, and sexual behaviors. These themes reflected a dynamic process that participants underwent to organize sexual relationships that affected decisions about sexual safety and feelings of security. Institutional expectations guided participants' understandings of appropriate sexual decisions through interactions with familial, religious, and peer norms. Processes for emotional connectedness integrated feelings of love, happiness, trust, and mistrust in relationships. Participant sexual behaviors included common practices such as regular testing for infection, hormonal contraceptive and barrier use, and growing sexual networks.

Institutional Expectations

Participants indicated that institutional expectations had profound influences on their sexual relationship experiences with men and women. Initiation of sexual activity during early teen years was common among participants. Angie, a 20-year-old hair stylist that identified as a lesbian described her first sexual experience at age 12 with a 14-year-old boy:

We was having a sleep over. You know how little kids is, wanna hop on each other We just knew we was gonna do something nasty.... I didn't like the whole idea of a boy doing that to me.... It felt disgusting to me.

She described her first sexual experience in the context of a cultural process that included expected behaviors of a sexually curious preteen. Chanel, a 21-year-old bisexual mother married to a man noted:

I lost my virginity young ... at 13 I mean you watch TV and you see the little fake sex scenes or whatever ... one day I just wanted to do it ... when I did it, it just happened. It wasn't nothing planned. It was like I did it and I felt bad and I think about it.... I mean once you do it you just keep doing it.... If my mom would've talked to me about how to choose a man, how and when to start dating and told me about sex, I think I wouldn't have had nowhere near as many sex

partners as I had ... I mean I've always been curious about females.... I don't think I probably would've acted on it.

Chanel described a lack of parental discussions about sex and influences from the media as institutional expectations that shaped her teen sexual experiences. This occurrence provided explanations for an emerging sexual life that moved on auto-pilot and eventually included relationships with women.

Family life also included institutional expectations that often became difficult for participants to manage. Jordynn, a 23-year-old heterosexual woman described responses she received from her family throughout a 3-year relationship with a woman: "It was very hard. My mom – I told my mom about it [the relationship]. She got mad, grandmother said I was gonna die from AIDS because I was gay." When Angie began having sexual experiences with girls, the importance of her family as an institution in her life also became apparent. She described her father's reactions to her developing sexual identity:

My father hated me for a long time ... I guess he don't like it. Like I have people in my family that's gay, but it's never been his child.... I guess he just felt like I'm his daughter, he didn't want me to be gay.... When he first found out, he would do mean stuff ... he would slam all the doors, he would fuss at me, like start arguments, do a lot of crazy stuff that was unnecessary.

Angie's father's reactions to her emerging sexual identity were also influenced by his position as a deacon in their church. Several participants discussed institutional expectations of religion. Chanel described the influence of religious doctrine on her developing sexuality, subsequent attraction to women, and consequential rebellious nature of being a teenager:

In our Bible, it says God views homosexuality as a dog eating his vomit—disgusting. That's how God views it.... I never went by the rules. I did what I wanted to do. I knew homosexuality was wrong, but I wanted to do it anyway. So you have consequences when you don't live by God's rules.

Furthermore, Angie acknowledged that her family's devotion to religion continued to be a point of contradiction in her life. She stated, "I go to church.... It's really nobody's business who I date. But of course, you know they preach about not dating women."

Institutional expectations for sexual behavior among the participants began early in their lives and were informed by peers, family, and religion. These expectations influenced participant sexual safety by influencing the timing of sexual initiation. Individual sexual security was affected as they processed emotions such as anger and shame through the lens of the institution.

Emotional Connectedness

During relationship experiences with women, participants described emotional connectedness as an important characteristic of their sexual security. Participants universally described experiencing extreme emotional highs and lows. Connectedness was described as negative or positive with varied consequences. It was often determined by the type (casual versus primary) and length of a relationship and the participants' current emotional

experiences. For example, Natasha, a 25-year-old heterosexual woman described the most important relationship in her life:

I loved real hard once. I was young ... oh I was so in love. I was dating a girl for five years. I loved her. I thought we were gonna get married and everything.... I feel like with her I learned how to love, what it felt like to love someone totally.

Emotional drivers such as seeking love and negotiating mistrust undergirded Chanel's feelings of sexual security. Chanel discussed feeling constrained from establishing emotional connectedness with a specific girl in her past. She emphasized the fragility of relationships and a need to develop protective mechanisms for herself:

I do miss it. I do still think about all the girls I had sex with, which I don't even know their number or all the girlfriends I had. I loved one girl and I said I would never go that road again, because if you get too tied up ... but I still do care about her, but I had to cut her completely off ... she gave me the security I needed emotionally and I loved her.

Likewise, Angie's relationship with her previous girlfriend began as happy and mutually satisfying:

I just was happy. She treated me nice, she made me feel real nice about myself. I was happy with her Anything, anything I needed, anything I wanted, even if I was mean to her ... she always told me I was pretty ... she would hold me when I cried, she was there for me. She would do stuff that she didn't have to do.

Infidelity and accompanying feelings of mistrust, however, often shattered feelings of emotional connectedness among all participants. These experiences resulted in an initiation of distant relationships by several participants as a mechanism for emotional protection. For example, in response to the feeling that her partner was being unfaithful, Angie coped with the pain by initiating sex with a girl outside her primary relationship:

I did. I did. I cheated on her one time. She found out but she really don't know.... She knows that I talked to the person. But she don't know for sure if I had sex with her. But I did.

Angie's relationship experiences informed strategies for emotional protection and maintaining distance from deep connections. She said, "I'm still bitter because of her ... I won't give nobody a chance. I don't want nobody hurting my feelings."

Likewise, mistrust, deceit, and guilt shaped Chanel's feelings of sexual security during her marriage. She struggled to understand the meaning of infidelity in that relationship.

He didn't physically cheat. He called her his girlfriend. They may have kissed or touched, but it wasn't like they saw each other naked But he did admit that they were kissing. He did admit that it was his girlfriend. He did admit that he did hide it from me.

In response to these feelings of insecurity, Chanel stated, "I cheated on him with three women."

On the other hand, Kim, 19 and bisexual, used targeted strategies to compartmentalize her emotional connectedness depending on the gender of her partners. She developed these strategies after suffering several physical and emotional consequences while in a sexual relationship with a man she cared about deeply. Physical costs to her sexual health included a gonorrhea diagnosis, pelvic inflammatory disease, and an unintended pregnancy that ended in miscarriage.

Like with males, I'm more sensitive. With females, I act like a boy. When it comes to females ... I don't have time for the emotions and stuff like that ... if we do something, we do what we do and that's it, I don't want you as a girlfriend or anything, it's just for fun.

Emotional connectedness represented part of a process for initiating and maintaining participant sexual safety and sexual security. Emotional processes of sexual security were influenced by decisions to establish close bonds or to distance oneself from a relationship. Furthermore, the variability of emotional connectedness as experienced by participants affected sexual safety because these feelings underpinned decisions about sexual behaviors.

Sexual Behaviors

Participants described ways sexual behaviors were integral to their sexual safety and sexual security. Behaviors integrated practices that affected participant physical and emotional health and included dynamic sexual networks. Health testing rituals, hormonal contraception, and condom use, as well as decisions about sexual partnerships influenced sexual safety and sexual security.

Testing and screening for STIs were common practices discussed by all participants. Many of the practices were dependent on the type of relationship. For example, Angie described how she remained knowledgeable about her health status throughout a long-term relationship with a previous girlfriend:

We both went and got checked out. We did this with each other on the regular ... we would do this all the time. We was together four years. So every time I would get checked out she would get checked out.

Chanel coped with her husband's infidelity by enacting secret plans for maintaining sexual safety through regular testing:

I just got tested a couple weeks ago. I'm fine. I got the rapid HIV and blood work done, urine ... I tested for everything ... I would say every three to six months ... I don't tell him that I get tested.

Natasha described requirements to preserve her sexual safety, "Well I want to see your papers I make my partners go take tests. For the most part we usually wait."

Participants also described a process for making decisions about use of hormonal contraceptive and condoms based on their partners' genders. For example, Angie stated, "You can get stuff from women as well. But we didn't have no safety when I cheated on her [with another woman], there was no safety." During sexual encounters involving men,

however, she recounted, “Those times were safe sex, used a condom. I mean I told him, do you have a condom?”

Kim reiterated this process when discussing barrier methods for disease prevention:

Like, the first girl I ever did any ... mouth action down there with, she was so clean, it was so nice that she was clean, because that was the first time I ever did that, and that would have scarred me for life if she wasn't ... I use protection [condoms] with guys.

Hormonal contraceptive decisions were also influenced by the gender of Kim's partners: “I get on and off the pill according to whether or not I'm having sex with a guy ... like since that happened [hospitalization due to PID] three or four months ago, I've only been with females. I can't get pregnant.”

Participants described their sexual networks (the ways individuals are sexually linked) as dynamic and overlapping. Networks included both genders and often involved risky sexual behaviors. Numbers of sexual partners, relationship duration, and timing of sexual relations influenced the size of an individual's sexual network. All of the participants described casual sexual encounters. For example, Natasha, a heterosexual woman, recalled her approach to noncommittal sexual partnerships:

Yeah. I've had moments of ... randomness, kind of like men do. I've had my guys and girls where it's like, I don't need to know your name or where you come from I don't think we'll talk about it anymore. I've done that. I'm not ashamed.

Angie expressed a desire to learn more about her sexual desires after experiencing a relationship breakup with a girlfriend:

I was talking to a guy over the Internet ... I hated girls at the time. Just to see if that's what I wanted, I decided to do it. One day I called him over ... I told him what it was about ... I just wanted to do it and we did. I didn't like that neither.

Chanel described how one's sexual health can be influenced by engaging in sexual behaviors that expand one's sexual network and increased the probability of becoming exposed to a STI:

The last girl I cheated on him with was his best friend's ex-girlfriend. So she had a boyfriend and her boyfriend was still having sex with the mother of his child, so the mother of his child gave it [Chlamydia] to him, the boyfriend gave it to the girl I had sex with, the girl I had sex with had sex with her ex-boyfriend which is my husband's best friend, so everybody has it. Then he gave it to the other girl he was having sex with and I gave it to [my husband]. So like seven people had this and we all knew each other and it was just nasty and weird.

Decisions about engaging in casual sexual partnerships expanded participants' sexual partner networks.

Discussion

Unintended health consequences of sexual activity among heterosexual Black young women and men result in tremendous social and public health burdens. Although an abundant body of literature about the sexual practices of this population is available, nursing and public health investigators often overlook risks for unintended sexual health outcomes of WSWM such as HIV/AIDS, STIs, and unwanted or mistimed pregnancies. In this study, we probed the sexuality narratives of Black young WSWM to explore ways sexual activities with other women can inform our understanding of this population's sexual safety and sexual security. As evidenced by these findings, this group is navigating institutional expectations, experiencing emotional connectedness, and making decisions about sexual behavior in unique ways.

Common institutional expectations guided participant feelings of sexual security in their sexual relationships and influenced decisions about sexual behavior. Familial institutions were instrumental in the sexual socialization of participants. Participants reported introductions to sexual activity during their early teen years and recounted learning about sex through peers and experiences. These findings are similar to those of other researchers who found that bisexual women reported early sexual debut (Timm, Reed, Miller, & Valenti, 2013).

Participants described the challenges of navigating the institutional expectations of religious doctrine that influenced the development of sexual identity and decisions about same-sex sexual activity. Although religion provided a framework for promoting the expectations of appropriate heterosexual behavior, cultural influences from peers and families also confirmed that sexual relations between women fell outside the community's norm. Aligned with current research around stigma and minority stress, navigating same-sex relationships in many religious and ethnic communities presented unique obstacles to development of healthy sexual relationships and positive coping mechanisms among the WSWM in this study (Barnes & Meyer, 2012).

Stories about loving relationships as well as those destroyed by infidelity were common in this group of participants. These occurrences affected participant sexual safety and sexual security positively and negatively. Incidents of infidelity lead to concurrency of sexual partners, emotional withdrawal, or changing the preferred gender of the participants' partners. Participants responded to a series of physical and emotional consequences by incorporating sexual behaviors designed to protect their emotions. All of the participants relayed stories of burgeoning sexual networks that influenced their ability to maintain sexual safety. Emerging research about bisexual women confirms they tend to have more lifetime partners (Lindley, Walsemann, & Carter, 2013; Xu, Sternberg, & Markowitz, 2010). Therefore, having male and female partners may be evidence of increased sexual risk.

Our current narrow focus on presumed sexual orientation, genders of partners, and types of sexual activities omits the influence of romantic love, intimacy, and physical pleasure on developing WSWM sexual identities and behaviors (Higgins & Hirsch, 2008). Participants in this study confirmed that sexual orientation is not necessarily in concordance with sexual

behavior (Lindley et al., 2013). Diamond (2008) argued that love and relational attachment can form outside the boundaries of sexual orientation. Examinations of Black women's sexualities should attend to the fluidity of sexual relationships that may include person-based rather than gender-based attractions and may provide insights into ways WSWM construct sexual identities (Diamond, 2008).

Gender-specific interpretations of risk were evident in all participant stories. Many participants insisted on condom use with male partners but were less likely to incorporate barrier methods into sexual activity with female partners. Perceptions of risk for STI and pregnancy were heightened with male partners. In fact, one participant specifically altered her contraceptive regimen according to the sex of her current partner, starting and stopping oral contraceptives as necessary. Despite evidence that STIs are transmitted between same-sex women partners (Marrazzo & Gorgos, 2012; Rowen et al., 2012), participants appeared to have little more than experiential knowledge about these risks.

Future Directions for Research

Research about the sexual health of WSWM is sparse and requires greater attention. To develop further knowledge about the needs of this population, investigators should develop more inclusive ways of measuring sexual orientation. For example, definitions should attend to the fluidity of sexuality and provide options for self-identification based on a continuum of behaviors and desires over time. Additionally, assessments of samegender sexual activities should no longer be the sole basis on which to categorize the orientations of WSWM or develop risk profiles. Investigators should strive to provide a comprehensive picture that includes behavior, orientation, and desire as components for understanding the sexual lives and subsequent health outcome disparities of young WSWM. Furthermore, to design effective interventions that target this group of women, we need to better understand sexual health outcomes that include the relational as well as physiological consequences to sexual activity.

Knowledge about Black WSWM age 18 to 25 is even more limited. In turn, researchers should focus on the unique cultural constraints these young women face as they develop sexually and navigate familial, partner, and religious expectations that are largely outside of their control and dictated by societal norms. This group may be especially vulnerable because they are transitioning from adolescence to adulthood and no longer benefit from health messaging that targets adolescents. Additionally, they do not have sufficient relationship experiences to inform healthy decisions about sexual activity. Studies are needed to uncover the processes young Black WSWM undergo for sexual relationship development as well as sexual initiation.

Implications for Nursing Practice

Results from this study provide several implications for nursing clinical practice (see Table 1). Our current approaches to young women's sexual health may silence experiences of WSWM. Thus, our ability to identify and support sexual minority women is limited. Clinicians should consider broadening assessment and history taking tools to include measures of sexual orientation that incorporate identity, behaviors, and desires as requisites

for developing risk profiles. Broadening identity categories from heterosexual/bisexual/gay models to include mostly straight/heterosexual may offer an opportunity for women who consider themselves primarily straight/heterosexual to disclose same-sex behaviors.

Clinicians should also consider the roles culture and unspoken traditions may play in the disclosure process. Specifically, same-sex attractions and behaviors in many Black communities are stigmatized within families and religious doctrine. Eliciting information about cultural influences on sexual development may open conversations between health care providers and patients about sexual relationships.

Gender-neutral information about healthy relationship development and opportunities for positive sexual partnerships are largely unavailable. Sexual health information is often focused on heterosexual relationships and omits the health concerns of women who engage in same-sex sexual behaviors. Limited access to this specific information affects how WSWM make decisions about maintaining their sexual safety.

Emotions guided sexual decisions made by the participants in this study. Therefore, to obtain the most comprehensive information possible about a patient, clinicians should broaden assessments to include sexual security. For example, history taking could include assessments for loneliness, sexual relationship options, and partner concurrency. Furthermore, clinicians should incorporate knowledge that management of sexual relationships is a process. Thus, when a woman presents for pregnancy or STI testing, clinical assessment for sexual health should be completed in the context of her sexual relationship experiences.

Plans of care that follow the clinical assessment should include physiologic interventions and address psychosocial implications. For example, we learned from the participant stories that testing behaviors affect sexual security because testing may signify trust in one's partner. On the other hand, some behaviors that are considered risky could be clinically interpreted as responses to perceived emotional connectedness. Each of the participants discussed rationales for engaging in multiple sexual partnerships. These decisions were often informed by emotional setbacks including sadness, loneliness, or mistrust. This information may provide a platform for developing an individualized plan of care to address the patients' sexual security.

Limitations

This study has several limitations. First, the research question was developed after the data were collected and not incorporated into the primary aim of the study. Second, all participants identified themselves as Black or African American, were from working-class backgrounds, and were living in one of two large urban environments. Therefore, their descriptions and interpretations of sexual relationship experiences and institutional expectations may not represent those of women from other races, ethnicities, social classes, or geographic environments. Third, in this study, we did not have access to the perspectives of the participants' sexual partners. Examining the experiences of partners could shed light on the relationship process because decisions about sex are most often made between two people.

Conclusions

We described processes for managing sexual relationships and provided evidence that further research is needed to fully understand the often hidden sexual decisions of WSWM. We can draw several conclusions from the case narratives of these young WSWM. First, sexual relationships are developed and maintained within specific contexts influenced by broad societal expectations for sexual behavior, individualized feelings of sexual security, and targeted strategies for sexual safety. Second, WSWM encounter unique challenges to managing healthy sexual relationships compared to women engaged in sexual behaviors exclusively with men or women. Third, findings highlight the interactive nature of coping and sexual behaviors on healthy outcomes. Fourth, WSWM, particularly emerging adults, are engaged in a period of sexual discovery that includes uncovering personal affinities for identity, behaviors, and desires. Scientists developing interventions to meet the sexual health needs of young, Black women and clinicians who serve them can use this information to appropriately identify WSWM and promote development of safe, meaningful sexual partnerships.

References

- Alexander, KA. Sexual safety and sexual security: Broadening the sexual health discourse. University of Pennsylvania; Philadelphia: 2013. (Unpublished doctoral dissertation)
- Barnes DM, Meyer IH. Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry*. 2012; 82(4):505–515. [PubMed: 23039348]
- Bauer G, Brennan D. The problem with “behavioral bisexuality”: assessing sexual orientation in survey research. *Journal of Bisexuality*. 2013; 13(2):148–165.
- Centers for Disease Control and Prevention. A public health approach for advancing sexual health in the United States: Rationale and options for implementation, meeting report of an external consultation. Atlanta, GA: Author; 2010.
- Corbett AM, Dickson-Gómez J, Hilario H, Weeks MR. A little thing called love: Condom use in high-risk primary heterosexual relationships. *Perspectives on Sexual and Reproductive Health*. 2009; 41(4):218–224. [PubMed: 20444176]
- Davies PT, Cummings EM. Marital conflict and child adjustment: An emotional security hypothesis. *Psychological Bulletin*. 1994; 116(3):387–411. [PubMed: 7809306]
- Diamond, LM. *Sexual fluidity: Understanding women's love and desire*. Cambridge, MA: Harvard University Press; 2008.
- Ebin J. Why bisexual health? *Journal of Bisexuality*. 2012; 12(2):168–177.
- Everett BG. Sexual orientation disparities in sexually transmitted infections: Examining the intersection between sexual identity and sexual behavior. *Archives of Sexual Behavior*. 2013; 42(2): 225–236. [PubMed: 22350122]
- Friedman CK, Morgan EM. Comparing sexual-minority and heterosexual young women's friends and parents as sources of support for sexual issues. *Journal of Youth and Adolescence*. 2009; 38(7): 920–936. [PubMed: 19636736]
- Glaser BG. The constant comparative method of qualitative analysis. *Social Problems*. 1965; 12(4): 436–445.
- Higgins JA, Hirsch JS. Pleasure, power, and inequality: incorporating sexuality into research on contraceptive use. *American Journal of Public Health*. 2008; 98(10):1803–1813. [PubMed: 18703457]
- Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Quality Health Research*. 2005; 15(9):1277–1288.

- Ingham R. 'We didn't cover that at school': Education against pleasure or education for pleasure? *Sex Education*. 2005; 5(4):375–388.
- Lincoln, YS.; Guba, EG. *Naturalistic inquiry*. Beverly Hills, CA: Sage; 1985.
- Lindley LL, Walsemann KM, Carter JW. Invisible and at risk: STDs among young adult sexual minority women in the United States. *Perspectives on Sexual and Reproductive Health*. 2013; 45(2):66–73. [PubMed: 23750620]
- Marrazzo JM, Gorgos LM. Emerging sexual health issues among women who have sex with women. *Current Infectious Disease Reports*. 2012; 14(2):204–211.
- Matson PA, Chung S, Sander P, Millstein SG, Ellen JM. The role of feelings of intimacy on perceptions of risk for a sexually transmitted disease and condom use in the sexual relationships of adolescent African-American females. *Sexually Transmitted Infections*. 2012; 88:617–621. [PubMed: 22707479]
- McNair RP, Hegarty K, Taft A. From silence to sensitivity: A new identity disclosure model to facilitate disclosure for same-sex attracted women in general practice consultations. *Social Science & Medicine*. 2012; 75(1):208–216. [PubMed: 22503834]
- Muzny CA, Harbison HS, Pembleton ES, Austin EL. Sexual behaviors, perception of sexually transmitted infection risk, and practice of safe sex among southern African American women who have sex with women. *Sexually Transmitted Diseases*. 2013; 40(5):395–400. [PubMed: 23588129]
- Muzny CA, Sunesara IR, Martin DH, Mena LA. Sexually transmitted infections and risk behaviors among African American women who have sex with women: Does sex with men make a difference? *Sexually Transmitted Diseases*. 2011; 38(12):1118–1125. [PubMed: 22082722]
- Needham BL, Austin EL. Sexual orientation, parental support, and health during the transition to young adulthood. *Journal of Youth and Adolescence*. 2010; 39(10):1189–1198. [PubMed: 20383570]
- Padgett PM. Personal safety and personal safety of women using online personal ads. *Sexuality Research and Social Policy*. 2007; 4(2):27–37.
- Philpott A, Knerr W, Boydell V. Pleasure and prevention: when is good sex safer sex? *Reproductive Health Matters*. 2006; 14(28):23–31. [PubMed: 17101419]
- Riessman, CK. *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage; 2008.
- Rowen TS, Breyer BN, Lin T, Li C, Robertson PA, Shindel AW. Use of barrier protection for sexual activity among women who have sex with women. *International Journal of Gynecology & Obstetrics*. 2012; 120(1):42–45. [PubMed: 23106842]
- Singh D, Fine DN, Marrazzo JM. Chlamydia trachomatis infection among women reporting sexual activity with women screened in Family Planning Clinics in the Pacific Northwest, 1997 to 2005. *American Journal of Public Health*. 2011; 101:1284–90. [PubMed: 20724697]
- Timm TM, Reed SJ, Miller RL, Valenti MT. Sexual debut of young black women who have sex with women implications for STI/HIV risk. *Youth & Society*. 2013; 45(2):167–183.
- World Health Organization. *Defining sexual health: Report of a technical consultation on sexual health*. Geneva, Switzerland: Author; 2006.
- Xu F, Sternberg MR, Markowitz LE. Women who have sex with women in the United States: Prevalence, sexual behavior and prevalence of herpes simplex virus type 2 infection—results from national health and nutrition examination survey 2001–2006. *Sexually Transmitted Diseases*. 2010; 37(7):407–413. [PubMed: 20531032]

Young women who have sex with women and men have unique sexual health needs often overlooked by investigators and clinicians.

These findings support the assessment and development of individualized plans of care for women who have sex with men and women.

Participants described a process for managing sexual safety and sexual security that included negotiating institutional expectations, emotional connectedness, and sexual behaviors.

Table 1
Findings and clinical implications

Theme		Findings	Clinical Recommendations
<i>Institutional expectations</i>			
Familial, religious, and peer norms	Sexual Safety	Influenced timing of sexual debut and understandings of acceptable sexual behaviors.	Focus on the unique cultural constraints young women face as they develop sexually and navigate familial, partner, and religious expectations.
	Sexual Security	Family and peer reactions to an evolving sexual identity invoked emotions of anger and shame.	
<i>Emotional connectedness</i>			
Feelings of love, happiness, trust and mistrust	Sexual Safety	Influenced behaviors such as casual sex and infidelity. Provided ways to cope with feelings of physical and emotional vulnerability, mistrust, and unintended health outcomes, including sexually transmitted infection (STI) and unintended pregnancy.	Include relational as well as physiological consequences to sexual activity.
	Sexual Security	Underpinned decisions to establish close bonds or maintaining emotional distance during sexual encounters.	
<i>Sexual behaviors</i>			
Practices such as STI screening, contraceptive use, and sex with multiple partners within sexual networks	Sexual Safety	Behaviors such as hormonal contraceptive and condom use, health testing, and sex with multiple sexual partners, increased or mitigated the risk of unintended sexual health outcomes.	Reframe sexual health messaging so that it is gender inclusive, developmentally appropriate, and individualized for sexually active young adults who are transitioning from adolescence to adulthood.
	Sexual Security	The type (primary vs. casual) and duration of the relationship, feelings of commitment, and sex partner gender differentially informed sexual risk perceptions.	