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“Is this normal? Is this not normal? There’s no set example”: Sexual Health Intervention Preferences of LGBT Youth in Romantic Relationships

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Abstract

Limited research has examined the romantic relationships of lesbian, gay, bisexual and transgender youth (LGBT) despite evidence of relationship-oriented risks, including STI/HIV infection, unplanned pregnancy, and interpersonal violence. In efforts to inform future dyadic sexual health interventions for LGBT youth, this couples-based study aimed to identify the most salient sexual and relationships concerns of young same-sex couples and to assess their preferences for intervention content and format. Participants were a subset 36 young, racially and ethnically diverse, same-sex couples ($N = 72$ individuals) recruited from two on-going longitudinal studies. Interviews were coded using a constant comparison method and a process of inductive and deductive thematic analysis was used to interpret the data. The analysis yielded the following intervention themes: addressing sexual risk and protective behaviors, improving communication, coping with family and relationship violence, and identifying role models and sources of support. The couples reported a clear preference for small group interventions and many recommended a mixed format approach for intervention delivery (i.e., including dyadic and online sessions). Additionally, recommendations for participant recruitment included a combination of Internet-based and social network referrals.

Keywords

Couples; Health Promotion; Health Status Disparities; HIV; Homosexuality; Qualitative Research; Sexual Health

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Peer and romantic relationships are critical developmental contexts for adolescents (Collins, Welsh, & Furman, 2009; Diamond & Savin-Williams, 2009) and most adolescents report being involved in dating relationships by their mid-teens (Carver, Joyner, & Udry, 2003; Diamond & Savin-Williams, 2009). Research indicates significant associations between adolescents' romantic experiences and several aspects of development, including development of a sexual identity, maintenance of peer relationships, and adjustments in prioritizing family relationships (Collins et al., 2009; Furman & Collins, 2009). The significance of romantic relationships in youth development has been hypothesized to depend on individual characteristics (e.g., age, gender, attachment style), relationship dynamics, and the settings in which they occur. In the long term, early romantic relationships may serve to establish patterns that influence the nature, quality, and course of subsequent relationships in adulthood, perhaps even marriages (Furman, Brown, & Feiring, 1999; Furman & Collins, 2009).

Emotional, psychological, and social benefits are derived from being in a romantic relationship (Collins et al., 2009; Pearce, Boergers, & Prinstein, 2002; Zimmer-Gembeck, Siebenbruner, & Collins, 2001) and it is not surprising that most youth, including lesbian, gay, bisexual, and transgender (LGBT) youth, desire to be in relationships (D'Augelli, Grossman, & Starks, 2008; DeHaan, Kuper, Magee, Bigelow, & Mustanski, 2013). Relationship involvement is associated with self-esteem, self-confidence, and social competence (Collins et al., 2009; Furman et al., 1999; Pearce et al., 2002; Samet & Kelly, 1987; Zimmer-Gembeck et al., 2001). For LGBT young adults, supportive peer relationships, particularly same-sex romantic relationships, may buffer against prejudice and discrimination (Peplau & Fingerhut, 2007). While romantic relationships have been associated with healthy, normative development in some youth, they also have been linked to negative mental health outcomes (e.g., anxiety, depression; Collins et al., 2009; Joyner & Udry, 2000), substance use (Zimmer-Gembeck et al., 2001), interpersonal violence (IPV) or dating violence (Kann et al., 2011; Rothman, Exner, & Baughman, 2011), STI infection (including HIV; Kelley, Borawski, Flocke, & Keen, 2003; Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011), and unplanned pregnancy (Saewyc, Bearinger, Blum, & Resnick, 1999). As such, romantic involvement during adolescence may present young people with both benefits and stressful circumstances that challenge their emotional, cognitive, and interpersonal resources (La Greca, Davila, & Siegel, 2008).

For those with compromised personal and family resources, especially LGBT youth, few resources exist to navigate romantic relationships as critical developmental contexts. One potential resource for youths' healthy development is relationship education. In a recent review, Markman and Rhoades (2012) defined relationship education as "efforts or programs that provide education, skills, and principles that help individuals and couples increase their chances of having healthy and stable relationships" (pp. 169–170). Several long-term, follow-up studies of adult heterosexual couples before marriage indicate that the origins of future marital problems often present themselves in early interactions (Markman, Rhoades, Stanley, Ragan, & Whitton, 2010). In one study of heterosexual adolescents participating in a relationship education program, effects included increases in relationship knowledge (e.g., identifying unhealthy relationships) and decreases in levels of verbal aggression compared to controls (Adler-Baeder, Kerpelman, Schramm, Higginbotham, &

Paulk, 2007). In addition, there is preliminary support for benefits of group-based relationship education program for male same-sex couples (Buzzella, Whitton, & Tompson, 2012; Whitton & Buzzella, 2012).

There are gaps in the relationship education research literature with regard to participant diversity (e.g., inclusion of female couples and ethnically/racially diverse populations) and it is not clear to what extent existing programs are developmentally appropriate for LGBT adolescents and young adults. There are also gaps in programmatic content regarding dating violence and sexual health. Assessing and addressing relationship aggression is considered a best practice in relationship education (Markman et al., 2010), however, there are only a handful of studies that have empirically investigated the effectiveness of programs to prevent dating violence or IPV among adolescents and young adults (e.g., Foshee et al., 2004; Wolfe et al., 2003). To the best of our knowledge, there are no published program effectiveness studies that focus on dating violence among LGBT adolescents. This is troubling given that these youth are a population at high risk for violence in their intimate relationships (Dank, Lachman, Zweig, & Yahner, 2014) and may face additional obstacles in navigating the formation of romantic relationships due to their minority status (Bauermeister, Ventuneac, Pingel, & Parsons, 2012; Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014; Whitton & Buzzella, 2012).

Another gap in the relationship education literature is the limited focus on couples' sexual health. For both male and female youth who engage in same-sex behavior, their increased risk for STIs/HIV has not been met with a public health response appropriate to the magnitude of the problem. The vast majority of school-based sex education programs do not address the needs of many LGBT youth (Pingel, Thomas, Harmell, & Bauermeister, 2013; Santelli et al., 2006) and these youth are less likely to receive school-based sex education at all (Blake et al., 2001; Goodenow, Netherland, & Szalacha, 2002). Beyond the school setting, there are limited community STI/HIV prevention resources for LGBT youth (Lyles, Crepaz, Herbst, & Kay, 2006; Mustanski, Newcomb, Du Bois, et al., 2011). Given the paucity of STI/HIV prevention research on LGBT youth and young men who have sex with men (YMSM), specifically, there is an urgent need to establish scientifically sound prevention programs for these high-risk populations.

With the unique challenges faced by young same-sex couples (e.g., sexual minority stress, lack of socially prescribed relationship norms), interventions must address the challenges that may not be met by existing relationship education programs. Efforts to address the specific needs of LGBT youth must use a comprehensive approach to health that bridges relationship education, sex education, and dating violence prevention. Focusing on "sexual health" may be an effective strategy. As indicated by the World Health Organization (WHO, 2006), sexual health is more than just the presence or absence of disease; it is a holistic concept that includes how individuals approach their sexual behavior and relationships, how they feel about them, and how their health is affected by them (Robinson, Bockting, Rosser, Miner, & Coleman, 2002; Wolitski & Fenton, 2011).

Informed by the sexual health framework, this research fills a gap in the literature on romantic relationships among LGBT youth and lays the foundation for future culturally- and

developmentally-appropriate sexual health interventions. Prior intervention development has been precluded by fundamental deficits in our knowledge of young, same-sex couples, including an understanding of the specific logistical and ethical issues associated with implementing dyadic interventions. For example, what type of intervention formats (e.g., online, small groups) are most appealing to young couples? Are they willing to participate in HIV testing as part of a sexual health intervention? In this exploratory qualitative study, we conducted dyadic interviews with racially/ethnically diverse LGBT youth in serious relationships to: (a) understand sexual knowledge and behaviors of young same-sex couples; (b) explore intervention content preferences, including relationship education elements and support resources; and (c) determine intervention format preferences.

METHODS

Sample and Procedures

The university's Institutional Review Board approved all study procedures. We recruited participants from two ongoing, longitudinal cohort studies of LGBT youth, Project Q2 and Crew450 (for further description of these studies see Mustanski, Garofalo, & Emerson, 2010; Mustanski, Johnson, Garofalo, Ryan, & Birkett, 2013). Participants who indicated that they were in a serious romantic relationship at their last assessment were asked to invite their partner to participate. At least one member of the couple was required to identify as LGBT, and the couple was required to be sexually active with no history of intimate partner violence (for a detailed description of study recruitment procedures see Greene, Andrews, Kuper, & Mustanski, 2014). Participants were screened for inclusion until interview data reached saturation: 29 male-born couples and 21 female-born couples screened eligible with enrollments rates of 79.3% and 76.2%, respectively. Thirty-nine couples completed the dyadic interviews and three couples' interviews were excluded from analyses due to false reports of relationship status or sexual activity. The final analytic sample was comprised of 36 couples (14 male-born and 16 female-born couples from Project Q2 and six male-born couples from Crew 450)¹. Based on the longitudinal studies that served as recruitment sources, participants were 25 years and younger, but their partners could be of any age. The mean age of the sample was 22.21 years ($SD = 4.19$, range 18 to 46 years). As shown in Table 1, individuals from the 36 couples ($N = 72$) were racially/ethnically diverse, with the largest percentage of the sample identifying as African American (56.9%), followed by White (16.7%), and Hispanic (15.3%). In terms of relationship length, approximately 85% of the couples had been in their current relationship 3 years or less.

Each member of the couple completed self-report measures using computer-assisted self-interview technology. After completing their surveys, the couple participated in a dyadic qualitative interview that followed a semi-structured format. At the end of each interview, participants were compensated and provided with a list of local, LGBT-friendly, couples-based resources and services (e.g., couples-based HIV testing). The interview guide addressed three main areas: (1) relationship history; (2) relationship dynamics and sexual

¹Throughout the article, couples comprised of male-born individuals will be referred to as male couples; similarly, dyadic partnerships comprised of female-born individuals will be referred to as female couples. Transgender participants were included with their partners as "same-sex couples" and gender identity is noted in parentheses.

practices (e.g., monogamy); and (3) participation in previous HIV or couples-based interventions, as well as suggestions for intervention development. The interviews were audio-recorded, transcribed, and uploaded into Dedoose (2012), a qualitative and mixed methods analysis program. Utilizing procedures previously described (Greene et al., 2014), the coding team participated in two phases of inter-rater reliability testing; pooled kappas (De Vries, Elliott, Kanouse, & Teleki, 2008) ranged from 0.74 to 0.77 at the initial test and 0.80 to 0.87 at the follow-up to assess for coding drift, indicating substantial to excellent inter-coder reliability (Cicchetti, 1994). In the final phase of coding, codes relating to sexual health and intervention preferences were isolated and further analyzed using grounded theory (Glaser & Strauss, 1967). To improve readability of the results, only code application rates that differed by 20% or more between groups are reported, and for quotes, information not directly relevant to the theme was omitted.

RESULTS

Participant Recruitment Strategies

The couples offered a wide range of strategies to recruit participants into a potential intervention. Internet-based recruitment was mentioned most often. Nearly half ($n = 19$) of the couples recommended Facebook recruitment; other suggestions included Twitter, study websites, and geospatial partner-seeking mobile applications. Posting flyers in community areas (e.g., college campuses, LGBT-identified neighborhoods) was also commonly cited ($n = 11$), as well as recruitment by word of mouth and friend referral ($n = 9$). Posting flyers in bars/clubs was also recommended, but more so for males ($n = 7$) than females ($n = 1$).

When asked for input on how to advertise for a relationship or HIV prevention intervention, participants suggested that catch-phrases related to healthy relationships ($n = 10$) and the LGBT community ($n = 5$) should be used, in addition to using iconic LGBT symbols, such as the rainbow flag ($n = 6$). Some participants cautioned that program names and slogans should not explicitly mention the words “HIV” or “intervention.”

Partner 1 (P1): I don't know about [using] HIV, a lot of people might, even within relationships, are not too comfortable with that... and then bringing it up to their partner... I want to speak of LGBTQ people of color, there's just a lot of things we don't talk about, and we're not comfortable with just putting it on the table like that. (Couple 19: males, ages 23 and 20, relationship length 1–3 years)

In this quote, the discomfort that some individuals may feel in discussing HIV in the context of their relationship is evident. For some couples this may be linked to cultural norms related to communication, as well as stigma associated with discussing HIV and same sex behaviors. It is evident that recruitment messages and strategies need to be tailored to be appropriate for racially diverse LGBTQ individuals. Messages that are not culturally-appropriate may deter individuals from participating in health interventions.

To assess potential motives for couples to participate in future interventions, the participants were asked to discuss reasons they took part in the research interviews. Across all couples, the most frequently cited reason for participating was curiosity ($n = 12$). They indicated that the interviews sounded interesting and were something they had never done before.

Following the novelty of the research, couples also highly cited the desire to give back to the community ($n = 11$) and to strengthen their relationships ($n = 11$). Relationship improvement was cited more frequently by the male couples ($n = 8$) and was the most common reason for their participation in the research. For the female couples, the reason most highly cited for taking part in the interviews was because one partner asked the other to participate ($n = 7$).

Intervention Format

As presented in Table 2, nearly two-thirds of couples ($n = 25$) stated that they would prefer to participate in a couples-based intervention formed around small groups. As illustrated in the following quote, some couples believed that small group formats would provide a degree of intimacy allowing participants to learn from each other's experiences.

P1: ...4, 5 couples at the most... just have like, an intimate discussion about it, but not like feel you're in a room full of strangers... just like a nice mix where you can get to know other couples and get different perspectives... (Couple 16: transgender male and female, ages 24 and 25, relationship length over 3 years)

In general, couples did not specify preferences for sex-exclusive groups (i.e., all male-couples, all female-couples, or mixed), however some noted their desire to participate in groups with couples similar to them. The following quote exemplifies this issue and articulates how small groups would be ideal settings to locate their own experiences as normative for LGBT youth.

Partner 2 (P2): I just think it would be interesting to see different lesbian couples because all I see is gay couples... "Is this normal? Is this not normal?" I kinda get confused sometimes because there's, like no set example or, something to at least go off of. (Couple 25: females, ages 22 and 18, relationship length 1–3 years)

As indicated by this quote, the lack of role models in the LGBT community represents a void for youth to learn about relationships and relationship norms. Further, perceived differences in the visibility of male versus female couples in the community prompted this female couple's preference for a setting that would facilitate meeting other lesbian couples. The small group format would provide young couples the opportunity to learn from couples similar to themselves in the absence of culturally-prescribed norms for LGBT relationships.

The next most common response for intervention modality was a dyadic-only intervention which was endorsed by one-third of the couples ($n = 12$). These couples-based sessions were particularly appealing to individuals who described themselves as shy or who would be uncomfortable disclosing personal information about their relationship in a group setting. Among the benefits of the dyadic sessions, participants stated that these sessions would offer greater flexibility in tailoring intervention content to couples' specific needs and concerns. In the following quote, the participant evaluates couple-specific intervention tailoring as more important than the potential fun and excitement of group-based formats. This is believed to result in enhanced engagement and commitment to the intervention.

P2: I could see group, um, being more exciting, but I think if you're not just a number among a group it makes it more specific to yourself, and I feel like that

would be more of a commitment. (Couple 3: males, ages 23 and 19, relationship length 1–3 years)

The couples also reported on their preferences for an online intervention format and one-quarter ($n = 9$; 7 male, 2 female) cited interest in this modality. These participants stated that youth may find an online format appealing due to their frequent use of the Internet for social and educational purposes. Other participants stated that an online intervention format would be effective for participants who may not have disclosed their sexual orientation to others. The following quote highlights how computer and information technology can be used to engage individuals who may not be out or may not choose to attend sessions in venues that may be identified as openly gay (e.g., LGBT community centers).

P1: A lot of people have video cam, where everybody can just be talking to each other... Because a lot of times, people don't want to come out, necessarily. (Couple 37: males, ages 19 and 38, relationship length under 1 year)

Over one-third of the couples ($n = 13$) indicated interest in a mixed format intervention. In this regard, most favored a small group and couples-based format ($n = 10$), highlighting the benefits of each, as illustrated in the following quote.

P2: They could choose theyself if they wanna be private like us right now or if they wanna be in a group and they wanna hear a little bit of feedback.

P1: I think it should be both ways like that, I think it should be like in a group setting, but the group setting is like where you don't tell – expose too much. (Couple 1: transgender female and male, ages 22 and 21, relationship length under 1 year)

This specific mixed format preference reflects participants' desire for privacy and opportunities for engaging with their peers as afforded by the dyadic and small groups sessions, respectively.

Intervention Content

Sexual Health among Male Couples—When asked about what safer sex means within the context of their relationship, the male couples frequently listed condom use ($n = 14$), STI/HIV testing (including knowledge of partner's status; $n = 6$), discussions of sexual history with their partner ($n = 3$), and monogamy ($n = 3$) as important sexual risk reduction strategies (see Table 2). The following description is a typical response given by the male couples which touched on the topics of HIV testing, sexual communication, and condom use.

P2: ... (laughs) Obviously being aware of where your partner is at. ...Getting tested and talking about that sort of thing, and being open about previous relationships, I guess...

P1: I think safe sex, being in that relationship, you need to have that conversation, that can't obviously be just assumed, um...I mean, a more technical definition would include using uh, condoms during oral and anal sex. (Couple 3: males, ages 23 and 19, relationship length 1–3 years)

When asked, “What do you think are the most important topics to talk about in a healthy relationship intervention?,” participants echoed the discussion topics addressed in the interview, including safer sex discussions, condom use, and monogamy agreements. While some thought it would be important to present standard sexual education information, such as statistics about HIV/AIDS, many of the male couples ($n = 8$) articulated the importance of contextualizing this information based on age, race/ethnicity, and relationship status.

P1: I would say the downfall is a lot of the programs do more, um, trying to instill uh, use condoms, do this, do that... I think they need to have more conversations on um, what is...a healthy relationship and all that other stuff, cuz not many... programs talk about um, healthy relationships, and how to keep a healthy relationship, or how to get a healthy relationship or anything around that. (Couple 34: males, ages 23 and 19, relationship length 1–3 years)

This quote suggests that the ineffectiveness of many HIV interventions may be their narrow focus on sexual risk behaviors and simplistic approaches to HIV prevention. Instead, a more effective approach would be comprehensive and consider the importance of healthy relationship formation and maintenance as key to sexual health. On this note, some male couples described a preference for combining HIV prevention and relationship content in a unified program, such as “safe sex in a relationship” (Couple 40) and “I would say HIV prevention could be a part of it, but it would focus more on maybe the healthy relationship” (Couple 24).

Nearly two-thirds of male couples ($n = 13$) indicated that they would be interested in testing for HIV with their partner as part of a couples-based intervention. Testing was generally viewed as a way to strengthen sexual agreements and to create a sense of trust.

P2: I mean, it’s good for the couple to know right away if, or if anything together know that they’re both negative, know that they’re not infected with anything.

P1: The sense of unity’s really important, too, ‘cause I mean, if you can’t get tested together, what other stuff can’t you do together, you know? It’s more of like a display of your relationship, like we’re so confident and we trust each other enough that if something... were to come along, we know, we’re comfortable. (Couple 35: males, ages 21 and 21, relationship length over 3 years)

As discussed by both partners in this quote, HIV testing is important to ensure appropriate sexual health, particularly in the early stages of the relationship. They added that testing as a couple represents a sense of trust and togetherness, and suggested that these qualities would help them to manage difficult test results. However, not all couples agreed on the inclusion of HIV testing in couples-based interventions. In the following quote, one participant cautioned that the emotionally sensitive nature of HIV testing could put undue stress on a couple.

P1: Oh, I think that it’s just a lot mentally on a young person, anybody at all... They go over a lot of different issues like depression and hurting yourself, and “What are you gonna do if you come back positive,” and I think that’s just a lot to put on a couple in case you don’t know what their actual issues are, cause

sometimes they might not even tell the real issue. (Couple 7: males, ages 23 and 25, relationship length 1–3 years)

In addition to the anxiety associated with the testing process, there may be additional discomfort for couples who are unprepared for what testing positive might mean within the context of their relationship, and for couples who may be dealing with other significant relationship issues. For these reasons, participants stressed that HIV testing should not be mandatory for participation in a couples-based intervention. Additionally, some participants stressed the importance of being sensitive to the needs of newly diagnosed individuals and serodiscordant couples.

Sexual Health among Female Couples—When asked about what safer sex means within the context of their relationship, female couples listed condom use with sex toys ($n = 7$), STI/HIV testing (including knowledge of partner's status; $n = 7$), dental dam use ($n = 4$), monogamy ($n = 3$), and other sex toy safety precautions (e.g., cleaning after use; $n = 3$) as important sexual risk reduction strategies (see Table 2). The following description is a typical response shared by the female couples.

P2: To me, getting checked on a regular, I mean, I know that between me and her, we're in "just a me and her type of sexual relationship" but other female relationships, it's an open thing and I just think that...a lot of people are afraid to go to the doctor because they're afraid of the answer that they might receive...

P1: Well, immediately what comes to mind to me is just monogamy, I feel like that's...um, the biggest thing as far as, practicing safe sex, and like what [P2] was saying with... getting tested... just to make sure that you're good is always important (laughs). (Couple 15: females, ages 22 and 27, relationship length 1–3 years)

For this couple, the practice of monogamy was central to their definition of safe sex. They suggested that women in open relationships may be more at risk for STIs. Both members of the couple also listed getting tested and having regular check-ups as safer sex strategies, but acknowledged that fear associated with STI testing may be a barrier for some women. In only a few cases were the couples specific about the STIs they would be testing for in relation to their sexual behaviors and risk for infection.

Although three-quarters of the female couples ($n = 12$) were able to identify specific safer sex practices, some had difficulty understanding the concept of safe sex for lesbians and identifying sexual risks in female same-sex relationships.

I: What does safe sex mean for women who have sex with women?

P1: I have no idea. That's complicated for lesbians. But um, I think we tried the whole thing once and it was really stupid...dental dams. Things like that.

P2: ...I would guess it would have to do with like, hygiene and I'm sure not sure... it's kind of difficult, I see how people can contract different STDs, but I think it would be a little more difficult, as far as lesbians, but I'm not sure if that's

completely accurate, so... (Couple 25: females, ages 22 and 18, relationship length 1–3 years)

This couple underscored the complexity of defining safe sex for young women in relationships. With the perception that lesbians are at low risk for STIs, women who have sex with women may not seek sexual health knowledge and skill development to reduce their risk for STIs. Despite a clear understanding of their risk for infection, this couple and others were able to describe perfunctory prevention strategies, such as using dental dams. Some couples noted the knowledge gap in women's sexual health may be due to the lack of relevant information available on safer sex practices for women who have sex with women. A perceived bias towards the promotion of male sexual health in the public health arena is illustrated in the following quote.

P1: ...Like promoting safer sex, like I don't see that for us... Like, they promote, like men should use condoms when they're having sex, like I never see anything, like with us, telling women to use, like dental dams, and like I don't know, that's the only first immediate thing that I can think of when practicing safe sex. (Couple 15: females, ages 22 and 27, relationship length 1–3 years)

Relationship Dynamics as Targets for Intervention Activities

Communication—Over half of all couples ($n = 20$) described communication as an integral component of a couples-based intervention and this topic was more frequently suggested by female couples ($n = 12$). Basic communication skills, as well as discussions focused on sexual history, were perceived as important for improving relationship quality. The following quote illustrates that effective communication is the key to building a healthy relationship. In addition, for this couple, establishing communication and problem solving skills would potentially serve to alleviate conflict in the relationship.

P1: We could be from two different worlds, but if we can find some common ground to communicate, we always talk about this, if we can find some way to communicate without becoming physical, without raising our voices, without letting too much emotion get behind us... communication is the key to the door that leads to a really healthy relationship. (Couple 31: males, ages 25 and 23, relationship length under 1 year)

Building upon the acquisition of basic communication skills, the couples identified specific conversation topics in which these skills would be beneficial. A few of the couples reported that it may be valuable to learn how to openly communicate sexual history in a relationship given the difficulty that some individuals may have sharing this information with their partner. Similarly, some couples described the importance of being able to negotiate relationship agreements and have conversations about monogamy.

P1: I mean I guess it could be kind of chaotic having a lot of partners without the right communication, so teaching people if they're not gonna be monogamous like how to...

P2: How to negotiate that...

P1: Mhmm. And how for everyone to be safe, and still happy in the relationship.
(Couple 16: transgender male and female, ages 24 and 25, relationship length over 3 years)

This couple described how effective communication on difficult topics, such as non-monogamy in a relationship, is vital for relationship safety and happiness.

Family and Relationship Violence—Nearly half of all couples ($n = 17$) commented on violence (both partner and familial) as a target for prevention efforts. Female participants ($n = 14$) more frequently discussed intimate partner violence than males, partially due to more questions about this topic in the interview guide for female couples. Five female participants discussed significant histories of interpersonal violence which extended beyond experiences with previous partners and involved abusive or neglectful family members. In the following quote, a female participant described a life-long history of abuse in her family and referred to a history of abuse experienced by her partner. Through this relationship, she was adamant in her desire to end the cycle of violence for herself and her partner, and to help them both experience a healthy and loving relationship.

P1: Well, it happened with me like, I got physically abused, like all my life. Like even with my family... it's just not a good feelin'. So if I don't like the way it feel, you know, why would I turn around and do it to her? Especially, knowin' what she been through, I'm not gonna take her back down that path and abuse her like that. And I just wanna show her what, like, true love is, 'cause gettin' beat on a everyday basis – that's just not it. (Couple 22: females, ages 21 and 22, relationship length 1–3 years)

In discussing how to address relationship violence in an intervention context, participants discussed the importance of learning how to identify potentially abusive behaviors, de-escalate conflict, and obtain appropriate health and social services. In the following exchange, a female couple described the importance of establishing healthy relationship norms and expectations for young same-sex couples. Included in these norms would be the absence of abuse.

P2: I know what would work for me is if you highlighted how people deserve to be, to feel safe with their partner, to feel happy with their partner and...just, you know, make it known that it's not okay to have those kind of abuses happening in a relationship.

P1: I think a lot of emphasis is always being put on the person that's getting abused or was abused...the tables need to turn and, you know, educate the people who might be violent or, um, have a history of violence...which I know might be tricky but um, 'cause no one wants to admit that they're the bad guy. (Couple 30: females, ages 24 and 21, relationship length under 1 year)

In addition to providing appropriate resources to victims of relationship violence, this couple suggested the need to address perpetrators of violence in relationships.

Relationship Role Models and Sources of Support—Participants were asked to identify LGBT role models for their relationships to inform a future relationship education

program for LGBT young people. Across all couples, only three were able to identify such role models. These couples listed their friends, a celebrity couple (Ellen DeGeneres and Portia de Rossi), and fictional characters on a television series (*Noah's Arc*) as role models. Both male and female couples noted that difficulty of finding healthy and enduring relationships in the LGBT community.

P1: I don't know many gay relationships that are as positive for us to go off of, you have to go from the little bits that you know about relationships that are positive. And I, that's all I can say because I don't see too many long-lasting relationships as it is, that stand as of right now...

P2: Especially in the gay community. (Couple 34: males, ages 23 and 19, relationship length 1–3 years)

Moreover, another participant described the invisibility of male couples of color in the gay community.

P1: I was 18, I was expecting to find some you know... like not even within my own comm-, like maybe like some older White guys, but I never saw like, any Latinos or any like, happy, same-sex Black guys or anything like that, or Asian guys, it wasn't happening. I was like "What the hell is going on, like, does it not exist?" (Couple 35: males, ages 21 and 21, relationship length over 3 years)

When asked more broadly about couples that they hoped to emulate or aspire to be like, many couples turned to their parents and families as examples. One-quarter of the couples ($n = 9$; 7 male, 2 female) cited their mother, father, or parents, and six couples cited other family members. These couples tended to cite the roles family members can play in establishing relationship norms and modeling healthy behaviors, particularly with coping strategies as relationships evolve over time. Some couples ($n = 3$) who were not able to identify role models in their family and peer networks turned to cultural icons (e.g., Beyonce and Jay Z) and fictional television characters for their relationships aspirations. The following quote highlights one couple's hopes to model their relationship after Clair and Cliff Huxtable on *The Cosby Show*.

P2: It's just like, [how] they are with each other...the way they communicate, you know, keep their relationship healthy. That's how I see like, that's how I want my relationship to be. That's anytime you know, I think about our relationship, I think about well, how I want it to be better or how I want it to last.

P1: And how you want it to be different than other people's. Like, it seems like in the lesbian community relationships fall apart so quick. And we don't want that. (Couple 4: females, ages 21 and 19, relationship length under 1 year)

In addition to reporting on relationship role models, the participants were asked, "Who do you go to for relationship advice and support?" As reported in Table 2, friends were the most commonly reported source of support ($n = 15$; 9 male, 6 female), followed by non-parental family members ($n = 13$), romantic partners ($n = 7$), and parents ($n = 5$). Across the couples, relationships with families varied greatly. Many participants identified non-parental relatives as important sources of support and a few reported situations where parental

support was not an option. These participants described situations where parents may have respected their sexual orientation identity, but were perceived to be unaccepting of their same-sex relationship. Often underlying support deficits from family and friends were discussions of heterosexism and homophobia, underscoring a lack of acceptance of LGBT individuals.

P1: ...I think that that stuff needs to really be talked about 'cause it fucks with you. Me being Mexican, the machismo, and like the manliness of the culture just, it's really hard to identify with any other Mexican guy. Like, I want to be able to identify with other males my age, but it's really difficult with the mindset that they have because of the culture that we have collectively. So, I think it's really important to talk about where we came from, and how that affects who we are as gay men 'cause sometimes it, that reinforcement we were given as younger people isn't necessarily good for the life that we wanna live. (Couple 35: males, ages 21 and 21, relationship length over 3 years)

As articulated in this quote, deeply engrained cultural values need to be addressed in intervention sessions. Specifically, perceptions and experiences of stigma and discrimination, as well as the internalization of homonegativity, may be associated with feelings of isolation and rejection. In addition to having harmful mental health effects, these experiences may also negatively affect individuals' abilities to relate to others, including engagement in healthy relationships.

DISCUSSION

Given the significance of romantic relationships during adolescence and emerging adulthood, the unique challenges faced by young same-sex couples (e.g., sexual minority stress, absence of LGBT relationship norms) may pose a threat to their long-term social, emotional, and physical health. Inequities exist in the availability of evidence-based school- and community-based services and programs for LGBT youth and the limited existing health resources may not adequately serve the unique cultural and developmental needs of these youth. Among potential resources, relationship education programs are promising (Whitton & Buzzella, 2012), but they do not fully address the range of relationship and sexual health challenges faced by young same-sex couples (e.g., elevated IPV and STI risks). The adoption of a sexual health framework that bridges relationship education, sex education, and dating violence prevention may be an effective approach to improve health among LGBT youth in romantic relationships. In efforts to inform future interventions, this study identified the most salient relationship and sexual concerns of young same-sex couples and assessed their preferences for intervention content and format.

The couples in this study were interested in a broad range of intervention topics pertaining to their relationship and sexual health. Primary intervention content areas gleaned from the interview data included assessing sexual risk and protective behaviors, improving communication, coping with family and relationship violence, and identifying role models and sources of support. Many couples, both male and female, discussed sexual health in terms of healthy relationships and described programs focused exclusively on HIV as less enticing. Although sex differences were evident, the couples were knowledgeable about

sexual risk behaviors and attendant STI/HIV prevention activities. For example, all couples readily described the importance of barrier methods for prevention (e.g., using condoms). In addition, many couples discussed the influence of relationship agreements (e.g., monogamy) on their sexual behaviors, such that monogamy was equated with safe sex in the dyad.

While LGBT youth may be knowledgeable about sexual risks and safer sex practices, there are shortfalls in motivations for, and enactment of, protective sexual behaviors. Our previous research on couples has documented the presence of HIV risk behaviors among young male couples (Greene et al., 2014). Specifically, couples reported behavioral risks for infection based on individual-level (i.e., unknown HIV status of partner and/or self) and relationship-level factors (i.e., disagreements about monogamy). Other research with YMSM, has shown that engagement in HIV protective behaviors varies by type of partner and relationship. That is, in sexual encounters with casual partners, young gay and bisexual men tend to be more conservative in their sexual risk taking (e.g., no anal sex or condom use with anal sex). Additionally, the longer the length of the relationship, the more likely young men are to engage sexual behaviors without condoms (Mustanski, Newcomb, & Clerkin, 2011; Newcomb, Ryan, Garofalo, & Mustanski, 2014). The sexual risk implications for male couples are clear, but for female couples, the risks are more nuanced. While women who exclusively have sex with other women are at low risk for HIV, they may maintain risk for other STIs. Additionally, women who have sex with both women and men show a relatively high epidemiological risk (e.g., Muzny, Sunesara, Martin, & Mena, 2011). Our interviews uncovered wide-ranging confusion by the female couples regarding safe sex needs within their relationships and the dissemination of basic safer sex practices may be warranted for these couples.

These findings highlight the need for young same-sex couples to learn about the meanings of safe sex in their romantic relationships and to understand the risks they are exposed to when engaging in unprotected behaviors. In consideration of safety in relationships, both male and female couples made specific connections between the importance of sexual health practices and relationship agreements. In particular, monogamy was frequently cited as a safe sex practice. Based on these interview data, it is logical that development of relationship agreements would be a core element for future intervention work with male and female couples. The agreements that couples make about sexual behavior inside and outside of their partnership has almost exclusively focused on male couples with regard to HIV risk (Hoff et al., 2009; Parsons, Starks, DuBois, Grov, & Golub, 2013). However, the female couples in this study frequently talked about monogamy as a key aspect of their safer sex practices, and some couples discussed breaks in monogamy, or infidelity, as sources of distrust and conflict in their relationships. For young male and female couples, relationship agreements may serve to prevent STI/HIV infection, as well as potential relationship stress and violence. The development of such agreements is consistent with relationship education programs which aim to create a sense of shared goals and expectations among couples (Markman & Rhoades, 2012; Whitton & Buzzella, 2012).

Issues related to relationship history, emerging adulthood, and sexual minority status must be considered prior to developing sexual agreements with young same sex couples. Within newly formed partnerships, couples may be in the process of discerning their agreements. As

such, partners may be unsure of what their agreement is or ought to be in early relationship stages. This uncertainty may be further complicated by nuanced definitions of monogamy espoused by each member of the couple (Hoff & Beougher, 2010). From a developmental perspective, researchers and interventionists must gauge where each member of the couple is in terms of relationship seriousness and commitment in light of the documented prevalence of a “hook-up culture” among some youth (Heldman & Wade, 2010). Young couples may also present with rudimentary communication skills with difficulties expressing relationship needs surrounding sexual exclusivity and sexual health (Hays, Kegeles, & Coates, 1997; Trussler, Perchal, & Barker, 2000). In consideration of sexual minority status, LGBT youth have reported challenges in finding dating partners because of their sexual orientation (Elze, 2002), and some may be more likely to enter a relationship with a friend and encounter blurred distinctions between friend and dating roles (Rose & Zand, 2002), which may ultimately extend to disagreements about relationships norms and expectations, including monogamy.

The majority of couples described communication as an integral component for future interventions to improve relationship and sexual health. The couples described the need to learn basic communications skills which could later be applied to difficult conversations in their relationships. For example, a few couples reported that it may be beneficial to learn how to communicate about sexual history in a relationship given the difficulty that some people may have sharing this information with their partner. Similarly, couples described the importance of applying effective communication skills to negotiate relationship agreements and to have conversations about monogamy (or non-monogamy). This emphasis on communication as a core element for future couples interventions is consistent with foundational aspects of relationship education programs (Markman & Rhoades, 2012). Based on social learning and behavioral exchange theories, the quality of communication and conflict management early in a relationship is associated with the quality and the health of the relationship over time (Markman et al., 2010).

Coping with histories of interpersonal violence perpetrated by previous romantic partners and family members was another topic discussed by the couples who participated in this study. Previous research has established that victimization among adolescents, in general, increases risk for negative health consequences including re-victimization, risky sexual behaviors, teen pregnancy, and poor health and mental health outcomes, including eating disorders, attempting suicide, and substance abuse (Ackard, Eisenberg, & Neumark-Sztainer, 2007; Banyard & Cross, 2008; Eaton, Davis, Barrios, Brener, & Noonan, 2007; Howard, Qiu, & Boekeloo, 2003; Resnick, Acierno, & Kilpatrick, 1997). Unfortunately, LGBT youth who experience violence often lack the protective resources, such as acceptance and support from families, schools, and communities (Eisenberg & Resnick, 2006; Safren & Heimberg, 1999), that can buffer them from the adverse health and mental health consequences of violence (Beeble, Bybee, Sullivan, & Adams, 2009; Hammack, Richards, Luo, Edlynn, & Roy, 2004). Addressing and treating the myriad of negative individual health outcomes associated with interpersonal violence may be beyond the scope of a relationship intervention and may require individual treatment before couples engage in intervention activities. Nonetheless, the couples did emphasize the value in learning what healthy relationships look like and in being able to recognize that abuse is not a part of such

relationships, despite witnessing or experiencing violence in previous family or romantic contexts. These findings are consistent with relationship education effort with young adults which are increasingly giving attention to issues such as how to end unhealthy relationships (Antle, Sullivan, Dryden, Karam, & Barbee, 2011). For LGBT couples, intervention skills development could focus on identifying abusive behaviors in relationships (e.g., isolation from family, threats of outing, violence) and applying effective communication skills to de-escalate conflict and increase help-seeking behaviors.

The relationship education literature suggests that developing community and social support networks for the relationship may be particularly important for same-sex couples (Whitton & Buzzella, 2012). The couples in this study cited friends as their most common sources support or advice, and some highlighted the presence of supportive family members. It is important for LGBT couples to assess the varied sources of support in their social networks and the types of support that they may enlist from their network members. Further, given that some couples exclusively turn to each other for support, it is vital for individuals to identify community resources outside of the relationship to turn to in cases of crisis. Related to relationship supports, only three of the 36 couples were able to identify LGBT relationship role models. It is not known what the long-term effects are for not having such role models and the research findings on the relationship between having LGBT role models and individual health outcomes are mixed. In one study, 60% of participants (16 to 24 years old) reported the presence of a role model, but role model presence and accessibility were not significantly related to substance use and sexual health outcomes (Bird, Kuhns, & Garofalo, 2012). Instead, those with inaccessible role models evidenced increased psychological distress. The researchers recommended that formal mechanisms to link LGBT youth with caring adults are critical for improving health outcomes. For young same-sex couples, a core element for intervention development would be the identification of relationship supports and role models to serve as resources to protect them against internal and external relationship stressors.

The couples who participated in this study had definite preferences for intervention format and delivery. Nearly two-thirds of the participants indicated that they favored participation in a relationship intervention formed around small groups. Peer group socialization was the primary reason for opting for this modality as couples described their hopes to learn from the experiences of their peers (e.g., how to handle conflict). They added that social events would provide couples with an opportunity to meet and interact with new people, thus providing them with an important sense of belonging and community. Acknowledging the strengths of other intervention format modalities, many couples recommended a mixed format approach for intervention delivery. Sessions with just the couple and a facilitator were viewed as important for tailoring content and activities to couples' specific needs and concerns. These smaller, private sessions would be appealing for individuals who would not be at ease in a group setting or with disclosing private relationship information (e.g., sexual histories) to other intervention participants. Additionally, some couples suggested online intervention delivery as a method to reach younger participants. Taken together, a combination of group, dyadic, and online formats could address specific concerns related to intervention tailoring and privacy.

The couples also made insightful and timely recommendations for how to recruit potential participants into an intervention. Internet-based recruitment, and specifically Facebook, was suggested by nearly half of all couples. Related, many participants noted that word of mouth would be an effective way to recruit peers into the study and one way to recruit their friends would be through Facebook, Twitter, and geospatial partner-seeking mobile applications. In combination, Internet recruitment and chain referral sampling, or respondent-driven sampling (RDS; Heckathorn, 1997), may be an effective approach to recruit young LGBT couples into intervention research. A recent study found that web-based RDS was an effective strategy to recruit 18 to 24 year olds using Facebook (Bauermeister, Zimmerman, et al., 2012) and included recommendations for oversampling technologically disadvantaged youth, expanding recruitment to smart phone platforms, and identifying appropriate incentive amounts for peer recruitment in future studies.

Drawing from the couples' motivations to take part in the study interviews, potential recruitment messaging for a prospective relationship-oriented intervention would focus on three key areas. First, many couples indicated that there are not many opportunities for them to participate in activities together. Highlighting the novelty of the couples program would likely stir curiosity among LGBT youth who desire formal settings for shared experiences with their partners. Second, many couples expressed a strong desire to strengthen their relationship. For couples without networks to support their relationship, and with limited resources that address the development and maintenance of healthy relationships, promoting a healthy relationship skills program would be critical for recruiting intervention participants. And third, across the interviews, the notion of community was significant for the participants. Perhaps reflecting lifelong experiences of stigma and disenfranchisement, many expressed desire to build community and a sense of belonging with their peers. In addition, participation in research was often viewed as a way to give back to the community and to improve life for the next generation of LGBT youth. In these regards, highlighting opportunities for community building would be a promising strategy for intervention recruitment messaging.

Interpretation of the results must be considered in the context of study limitations. Data from this convenience sample of LGBT youth in serious relationships ($N = 36$ couples) from the Midwest may not be generalizable to all same sex couples. Also, the results may have been affected by selection bias. Participants were recruited from two longitudinal cohort studies of LGBT youth. The couples who were willing to participate in the interviews may have been more interested in and knowledgeable about issues related to sexual health compared to the general population of young LGBT couples due to their involvement in our prior research. In addition, given the few transgender participants in this study, as well as the small subset of serodiscordant couples who participated, further research is necessary with larger samples to examine the unique sexual health needs for diverse populations. In light of these limitations, the study has many strengths. This study may be one of the first that has focused on young LGBT couples to gather their perspectives for developing a sexual health intervention tailored for their specific interests and needs. The sample was racially and ethnically diverse, and included male and female same-sex couples. Additionally, the use of qualitative data facilitated a rich understanding of the relationships of these young couples.

And related, the coding team achieved excellent inter-rater reliability across the 36 dyadic interviews.

CONCLUSIONS

Comprehensive sexual health education is an adolescent public health priority with implications for future research, practice, and policy. From a public health standpoint, LGBT youth are disproportionately burdened by the paucity of research and evidence-based prevention programming that address the compounding risk factors that lead to this population's poor sexual health outcomes. Interventions for young same-sex couples should not be simple modifications of those developed for adult LGBT populations, as the intervention material may not generalize to the developmental context of emerging adulthood (Arnett, 2000). Similarly, interventions designed for heterosexual youth may not be appropriate for LGBT youth given the distinct cultural and contextual factors that impact sexual minority youth (Garofalo & Harper, 2003; Mustanski, Newcomb, Du Bois, et al., 2011; Rosario, Schrimshaw, & Hunter, 2006). To develop future developmentally- and culturally-appropriate sexual health interventions for young same-sex couples, this study offers clear recommendations. The recommendations address many of the unique challenges faced by these couples by bridging relationship education, sex education, and dating violence prevention. Policy-makers are encouraged to promote cross-disciplinary exchanges in these areas to enhance youth development and promote healthy outcomes across multiple ecological settings. For example, interventions that incorporate core elements of the sexual health paradigm (e.g., identity development, healthy relationships and sexuality) with emerging issues identified by LGBT youth (e.g., intersectionality of race and sexuality, role model identification, community connectedness) may be achieved through policy initiatives promoting comprehensive sexual health programming. As the experts in their own lives, the young couples that participated in this study openly and directly provided their perspectives on healthy relationships to improve their own partnerships, as well as the overall health of the LGBT community. This level of engagement and commitment demonstrates the need for active youth participation in the development and dissemination of local, national, and international sexual health promotion efforts.

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Table 1

Demographic Characteristics of Study Participants (N = 72)

Variable	n (%)
<i>Birth Sex</i>	
Male	40 (55.6%)
Female	32 (44.4%)
<i>Race/Ethnicity</i>	
African American	41 (56.9%)
Hispanic/Latino	11 (15.3%)
Caucasian	12 (16.7%)
Other/Multi-racial	8 (11.1%)
<i>Sexual Orientation^a</i>	
Gay/Lesbian	57 (79.2%)
Bisexual	10 (13.9%)
Heterosexual/Other	2 (2.8%)
<i>Gender Identity</i>	
Male	39 (54.2%)
Female	29 (40.3%)
Transgender	4 (5.6%)
<i>Living Situation^b</i>	
With parents	28 (38.9%)
With romantic partner	22 (30.6%)
Other stable housing	18 (25.0%)
Unstable housing/Other	3 (4.2%)
<i>Relationship Length</i>	
Less than 1 year	29 (40.3%)
1 to 3 years	32 (44.4%)
Greater than 3 years	11 (15.3%)

Note. Participants were able to select “I don’t want to answer” for all demographic questions; sample sizes reported above vary as a result of that response option.

^aThree participants did not report their sexual orientation.

^bOne participant did not report their living situation.

Table 2

Code Application by Couples' Birth Sex

Codes	Birth Sex		
	Total (N = 36)	Male (n = 20)	Female (n = 16)
Intervention Format			
Small Group	64.1%	56.5%	75.0%
Dyadic	33.3%	30.4%	31.3%
Online	25.0%	35.0%	12.5%
Mixed	36.1%	35.0%	37.5%
Intervention Content: Sexual Risk Reduction			
Condom Use	58.3%	70.0%	43.8%
STI/HIV Testing	55.6%	65.0%	43.8%
Monogamy	16.7%	15.0%	18.8%
Dental Dam Use	11.1%	-	25.0%
Sex Toy Safety	8.3%	-	18.8%
Intervention Content: Relationship Dynamics			
Communication	55.6%	40.0%	75.0%
Relationship/Familial Violence ^a	47.2%	15.0%	87.5%
LGBT Relationship Role Models	8.3%	10.0%	6.3%
Other Relationship Role Models			
Parents	25.0%	35.0%	12.5%
Other Family Members	16.7%	20.0%	12.5%
Celebrities	8.3%	10.0%	6.3%
Relationship Sources of Support			
Friends	41.7%	45.0%	37.5%
Parents	13.9%	20.0%	6.3%
Other Family Members	36.1%	30.0%	43.8%
Partner	19.4%	15.0%	25.0%

Note.

^aThe semi-structured interview guide for female-born participants specifically probed for relationship violence. This section of the interview began with the following statement, "Now we're going to ask you a few questions about relationships between women. You can answer these questions based on your own experiences, or you can comment on how you think female couples act, in general." A sample question read, "Some people feel that when there are two females in a relationship, it is more acceptable for partners to physically fight with each other than in heterosexual, male-female relationships. Is this something you've heard?"