Published in final edited form as:

J Racial Ethn Health Disparities. 2017 December ; 4(6): 1206–1213. doi:10.1007/s40615-016-0327-8.

Sexual Health in a Social and Cultural Context: A Qualitative Study of Young Latina Lesbian, Bisexual, and Queer Women

Christie A. Santos, MPH,

Department of Health Services, School of Public Health, University of Washington

Emily C. Williams, PhD, MPH,

Veterans Health Administration (VA) Health Services Research & Development Seattle-Denver Center of Innovation for Veteran-Centered and Value-Driven Care. Department of Health Services, School of Public Health, University of Washington

Julius Rodriguez, and

Department of Gender, Women and Sexuality Studies, University of Washington

India J. Ornelas, PhD, MPH*

Department of Health Services, School of Public Health, University of Washington

Abstract

Previous research on sexual minority and Latina women suggests that Latina lesbian, bisexual, and queer (LBQ) women may be at high risk for sexually associated and transmitted infections, but research on the sexual health and practices of this population is limited. This qualitative study explored the knowledge, attitudes, and values related to sexual health among a purposive sample of Latina LBQ women living in Seattle, WA. Latina LBQ women (N = 14) were recruited to participate in in-depth interviews about their sexual health through community organizations, flyers posted on college campuses, email and social media advertisements, and participant referrals. In-person semi-structured interviews were conducted and transcribed; transcripts were coded by two independent coders and reviewed for prominent themes. Four main themes emerged: 1) Latina sexual minorities' sexual health is shaped by their social and cultural context, 2) they lack needed sexual health knowledge, 3) their sexual health behaviors vary depending on the relationship status and gender of their partners, and 4) they value taking responsibility for their own sexual health. Further research is needed to better understand sexual health among Latina LBQ women and to identify ways in which their values can be leveraged to promote positive sexual health outcomes.

*Corresponding Author: India J. Ornelas, Health Services, Box 359455, University of Washington iornelas@uw.edu 206-685-8887.

Compliance with Ethical Standards:

Conflict of Interest: Christie A. Santos declares she has no conflict of interests. Emily C. Williams declares she has no conflict of interest. Julius Rodriguez declares he has no conflict of interest. India J. Ornelas declares she has no conflict of interest.

Ethical approval: All procedures performed in this study were in accordance with the ethical standards of the University of Washington Human Subjects Division and with the 1964 Helsinki declaration and its later amendments.

Informed consent: Informed consent was obtained from all participants included in the study.

Keywords

Latina; Sexual Minority; Sexual Health; Qualitative Methods

Background

Both the Latina and the Lesbian, Bisexual, and Queer (LBQ) populations are growing in the United States, yet little is known about sexual health of young Latina lesbian, bisexual and queer women¹ [1]. Research suggests that Latina sexual minority women are less likely to receive recommended sexual health screening and are at increased risk for adverse sexual health outcomes compared to both Latina heterosexual women and white women [2–5]. This may be in part due to limited knowledge about sexual health and sexually transmitted infections (STI), as well as structural barriers related to their identities as racial/ethnic and sexual minorities [6, 7].

While researchers and public health practitioners have developed sexual health education programs for young Latina women, most have been aimed at heterosexual women and therefore do not include information for sexual minority women, such as modes of STI transmission between women, barrier use, and safer sex toy use [8–11]. In addition, sexual minority women often ignore sexual health information addressed at “all women” assuming that it will not be relevant to them [12]. This limited access to health education when women are becoming sexually active may result in increased risk for adverse sexual health outcomes.

Because previous research on young Latina LBQ women’s perspectives on sexual health has been limited, our study sought to identify factors that may contribute to their sexual health to inform future policies and programs. Given the limited research on the specific needs of young Latina lesbian, bisexual and queer women, we relied on minority stress theory and intersectionality to inform our study [13, 14]. Minority stress theory helps explain how the stressors that sexual minorities experience impact health outcomes [15, 16]. This theory describes how health is shaped by both distal stressors, such as external objective experiences of discrimination or violence, and proximal stressors, such as expectations of rejection and internalized homophobia. Consistent with intersectionality theory, it also posits that multiple minority populations may have life experiences that are more stressful than those with only one minority identity, such as white sexual minority women or Latino heterosexuals, and that these stressful life experiences can be associated with increased sexual risk-taking behavior [13, 17–20].

Guided by an intersectionality perspective, we explored how young women’s gender, sexuality, and ethnicity intersect to shape their identities and perspectives on their sexual

¹In this paper we use the term lesbian to refer to women who self-identify as lesbians and/or report having sexual or romantic relationships with only women. We use the term bisexual to refer to women who self-identify as bisexuals and/or report having sexual or romantic relationships with both men and women. We use the term queer to refer to women who identify as queer and/or report sexual or romantic relationships that are not heterosexual. We use the term sexual minority to refer lesbian, bisexual and queer women as a group and more generally to people that are not exclusively heterosexual, including both men and women. We use the term transgender to refer to men and women that self-identify as transgender and/or report identifying with a gender that is different from the sex they were assigned at birth.

health [21, 22]. According to this perspective, life experiences of people with the same identities can take on different meanings depending on their context. Sexual minority and racial/ethnic statuses can also mutually influence one another and often reflect the social stratification of status and power in society. This perspective also encourages researchers to acknowledge the psychological benefits that come from different identities, such as social support, resilience, and identity based-pride [23, 24]. Therefore, we used both intersectionality theory and qualitative methods to describe how the sexual health of young Latina lesbian, bisexual and queer women's life experiences are shaped by both the unique stressors and benefits of their multiple minority identities.

Methods

Study Setting and Procedures

Our study sample was drawn from the Seattle/King County area in Washington State, in which Latinos represent 6.6% of the city's population, and sexual minorities are estimated to be 4.8% of the city's population [25]. Women were recruited using several techniques, including outreach to community organizations by research staff, posting flyers, email and social media advertisements, and personal referrals from recruited participants [26–29]. Women were eligible for participation if they: 1) identified as Latina and/or Hispanic; 2) identified as lesbian, gay, bisexual, transgender or queer identity; 3) identified as a woman or female; 4) were between the ages of 18–40 and 5) were English speaking. This resulted in contact via phone or email from 27 potential participants. Of these, 3 were ineligible due to gender identity, sexual orientation, and age; 9 failed to respond to requests for scheduling or did not keep appointments; and 15 were eligible and participated. Participants gave written and verbal informed consent to participate. The University of Washington's Human Subjects Division approved all study procedures.

In-depth interviews were conducted in English by the lead author (a Latina sexual minority woman) at private locations within Seattle, as selected by participants. The interview guide included open-ended questions and was developed based on the theoretical framework including topics on women's individual identities, interpersonal relationships, health care experiences, sexual health information, and health behaviors. Example questions included: "Tell me how your identities relate to your sexual health? Tell me about how you communicate about sexuality and sexual health with your partners? Where do you get your sexual health information?" In addition, we collected demographic information on women's age, country of origin, relationship status, household composition, level of education. They were also allowed to self-report their gender identity, sexual orientation and race/ethnic identity using their preferred terminology. Interviews lasted between 45 and 120 minutes, taking approximately 90 minutes on average. Interviews were conducted until the data reached saturation.

Data Analysis

Interviews were digitally recorded, transcribed verbatim and reviewed by team members to establish familiarity with the data. While 15 interviews were conducted, only one was conducted with a transgender women. Because it may have risked breaching confidentiality

to report on a single transgender participant and because during the interview the participant identified as heterosexual, we excluded this interview from data analysis. Data were analyzed using a deductive approach, developing an initial coding scheme based on our theoretical framework and the transcripts themselves. We also allowed for inductive analysis by adding additional codes during the coding process as needed. Two members of the research team (CS and JS) independently coded each transcript. Coders met several times to discuss their coding choices and to establish inter-coder agreement [28, 29]. Transcripts were coded in Atlas.ti for further analysis. We created queries of coded quotations based on the coding scheme, which were reviewed by the full investigative team in order to identify themes and exemplary quotes. We sought to identify patterns both within and between different identity groups.

Results

Participants included women that identified as lesbian ($n = 8$), bisexual ($n = 2$) and queer ($n = 4$). The average age was 27. All women had completed high school, and the majority had also attended some college or had a bachelor's or master's degree. Most were born in the United States ($n = 12$), but had grown up in other parts of the country (South and Southwest). Women identified as Chicana, Latina, Latino, Hispanic, Mexican, and Mexican-American. Most reported being in a married or committed monogamous relationship ($n = 9$), others were single or in married non-monogamous relationships. Four overarching themes were identified regarding the knowledge, attitudes and values of Latina LBQ women's sexual health. Themes, subthemes, and representative quotes are described and presented below.

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

Participants described how living within a heteronormative and racist context shaped the ways in which they make decisions concerning their sexual health and safer sex practices.

Discrimination

Participants reported experiencing discrimination based on both their racial/ethnic and sexual identity. Participants experienced sexual fetishization, or racially motivated objectification, from both women and men based on their perceived race or ethnicity. They described experiences of strangers approaching them with the assumption that they are "foreign." For example, one participant described,

"It becomes very apparent when the first thing someone asks is, 'Where are you from?' And you say, 'Seattle,' and they say, 'No, where are you from?' And then you pretty much know at that point that they aren't caring about anything about you. They're caring about this idea they have in their head. This person is foreign. They're from some exotic place, and I want to know all about them, and they're not listening to anything you say about yourself."

This contributed to a sense of isolation and a lack of belonging based on their racial/ethnic identity.

Bisexual and queer women who reported attraction to and/or experiences dating men described broader discrimination from both heterosexual and sexual minority communities. For example, women reported that heterosexual individuals view bisexual women as personally threatening to their relationships and heterosexuality, and that sexual minority individuals view bisexual women as a threat to the integrity of identity and community. Bisexual participants reported experiencing social ostracism from both heterosexual and sexual minority people. They reported that this caused them to question whether or not to be out about their bisexual identity, as they weighed the benefits of both authenticity and safety.

Family Acceptance

Some women noted that their family's acceptance (or lack of acceptance) influenced their sexual behaviors. Although there was some variation in the sample, most women reported experiencing some form of rejection from their family members. For example, women reported hiding their sexual identity or same-sex relationships from family members, receiving negative comments from family members, or having a break in contact with family members. Women noted that "traditional" marriage between a man and woman was a common cultural and religious value; therefore, they felt implicit pressure to conform to this standard. As one woman described her parents, "I would say they're more accepting now but I wouldn't say they are fully accepting. I would say that deep down they still have that hope that I'm just going to marry a man and have kids."

Navigating multiple minority identities

Many women reported feeling isolated as sexual minority Latinas living in a predominately white city and county. Many struggled to build relationships with women that shared their identity, in part because they perceived limited opportunities to network and build community. For example, one woman said, "There are spaces where there's women's events, but usually those are white events. Then, there's also a language barrier, too. So, I just feel like it's not welcoming."

As sexual minorities, they also described lacking a sense of belonging in the Latino and white American communities, given the heteronormative culture that permeate both, but that they also found it difficult to identify as both LBQ and Latina, because of heterosexual norms and expectations in Latino culture. Some participants shared that Latino cultural expectations contributed to internalized homophobia and difficulty coming to terms with their queer identity. Women described compartmentalizing their identities in order to navigate social situations, yet were unable to separate their identities. As one woman stated,

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

Additionally, Latina LBTQ's social and cultural contexts framed their experiences accessing health care. One participant shared:

"In my culture, going to the doctor is not something – you go to a doctor if you absolutely need to go to the doctor, like if you're dying, you have to go to the doctor. Even going for checkups and all this stuff, it's very foreign. I've had to start saying, 'No, I need to be taking care of this and this and this' because it's not something that I necessarily grew up with. So, it's different. But I feel like even every time that I do make that decision to go see someone, it's still threatening, I'd say."

Theme 2: LBTQ women's knowledge regarding safer sex is shaped by social and cultural influences, which are largely reflective of heterosexual safer sex practices

Most participants reported receiving sexual health education from their families and schools during their childhoods. Families tended to frame sex and sexuality in the context of puberty, reproduction or love between two heterosexual people. One participant shared:

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

For some women, family and school-based sexual health education was rooted in Catholic ideology, including fear- and shame-based messages to discourage women from having premarital sex. These women reported that they did not receive any information related to sexual minority health in these settings.

As they became sexually active, participants described mostly seeking sexual health information from their peers and the Internet, but ultimately trusted the information they received from their doctors the most. Despite this, they shared that their doctors often did not give them any information about how to protect themselves against sexually transmitted infections when having sex with women and/or assumed they were heterosexual and offered them advice according to this assumption. One participant shared:

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

Another participant shared that a doctor led her to believe that she did not need regular cervical cancer screening because she had only had sex with women.

The result of receiving information from these sources was that women felt unsure of how to negotiate and practice safer sex with women. Participants largely knew how to have safer sex with men, and were firm in their decisions to use barriers with men to reduce risk of pregnancy and sexually transmitted infections. However, many participants stated that they did not know what safer sex methods were available to them when having sex with women, and some attributed their high-risk sexual behaviors to their lack of knowledge. For example, when a bisexual participant was asked about practicing safer sex with female partners, she responded, “No, because I don’t have any information on that, so I wouldn’t.”

Theme 3: Latina LBTQ women’s sexual health behaviors vary depending on their relationship status and the gender of their partners

Variations on “safer sex”

Women that reported having sex with men generally reported consistent barrier use with their male partners. One participant shared her condom use history with a transgender female partner, expressing that she uses condoms with any of her partners who have a penis. However, most women reported not regularly using barriers when they have sex with women, with only one woman explicitly stating that she used female condoms with all of her female partners. After describing practicing barrier methods with men, one participant shared:

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

Participants in polyamorous or non-monogamous relationships reported engaging in consistent testing regimens to protect their partners without the use of barriers. As one participant shared, “If we have a closed circle where people aren’t having sex with other people outside of it, then it can be unprotected and everybody’s been tested.”

Trust as a proxy for safer sex

Participants identified trust as important in their sexual decision-making processes and behaviors. Women described having higher levels of trust in their female partners, due to being less afraid of infection risk. This greater trust led to engagement in unprotected oral and digital penetrative sex. Many felt confident that their female partners would not intentionally expose them to infections or harm; yet, this trust did not extend to their male partners. They cited specific reasons for consistently using barriers with men, including fear of pregnancy, a history of sexual violence, fear of men’s dishonesty in reporting sexual history, and men not taking responsibility for their or their partner’s sexual health.

Sex toy use

Use of barrier protection methods with sex toys varied across participants. Most participants indicated knowledge regarding safer toy use by explaining that they use toys made of silicone, rather than porous materials that may harbor bacteria or viruses, however this was less common among bisexual participants. Some women reported limiting their toy use to serious rather than casual partners. They also explained that toys are generally purchased with a specific partner for their exclusive use, and that toys are disposed of or left with said partner at the end of the relationship. As one participant explained, “Toys are always exclusively when I’m monogamous with somebody. I will not use them if it’s somebody I’m not exclusive or monogamous with. That’s always exclusively with them... If that’s over, it goes in the trash.”

Theme 4: Latina LBQ women value taking responsibility for their sexual health

Women reported placing a high value on taking responsibility for their own health. When asked about accessing sexual health care, participants described prioritizing their sexual health exams as directed by their doctors despite the physical discomfort of exams and previous negative experiences. One participant shared: “It’s not necessarily the most comfortable experience [but] I just go check in and do my thing.” Participants identified sexual health care as a way to take care of themselves. Some also saw it as a way of taking care of their partners. For example, one participant shared that she requires her partner to get her Pap test regularly: “Being with me means that you have to go to the doctor and be healthy.”

Discussion

This qualitative study was the first to our knowledge to describe young Latina LBQ women’s perspectives on sexual health. We found that women’s sexual health was shaped by their social and cultural context, including experiences of discrimination, family rejection, and navigating multiple minority identities. In addition, many had not received relevant sexual health education as children and adolescents, and some continued to receive inadequate information from their health care providers as young adults. Despite this, many were practicing forms of safer sex and valued taking responsibility for their sexual health.

Consistent with intersectionality theory, the social and cultural context of Latina LBQ women in this study shaped their sexual health in several ways. Women identified feelings of both belonging to and feeling distanced from sexual minority and Latino communities. Within the queer community they at times felt alienated because their Latina identity was not concordant with the largely white community in Seattle. While they also felt excluded by Latinos because their sexual orientation does not meet cultural expectations of being a Latina woman. Our findings are consistent with previous studies of African-American lesbians and sexual minority Latinos and support the importance of understanding young lesbian, bisexual and queer Latinas sexual health needs from an intersectional perspective [20, 22, 23, 30]. Though Latina LBQ women suppress parts of themselves depending upon

the context, they need social spaces where they can feel complete. Social networks can provide emotional support to Latina LBQ women and promote self-worth, which may decrease risky sexual behaviors [31, 32].

Women in this study reported experiences of discrimination based on their gender, sexual orientation, and racial/ethnic minority identities. Experiences of discrimination appeared to be related to distress in their interactions with potential partners, as well as fear of being “out” in certain contexts. Stress related to discrimination has been associated with poor mental health among sexual minority men and women [33, 34]. Research has also shown that sexual minorities of color experience excess stress exposure as they face discrimination in multiple contexts from both majority and minority groups [16, 33, 35]. For example, in a study of Latino men who have sex with men, discrimination was associated with increased risk of HIV infection due to increased sexual risk taking [36]. Discrimination has also been associated with increased substance use among Latinas and Latino men who have sex with men [37–39], which can increase risk for STIs. Future research should explore whether discrimination is associated sexual health behaviors and utilization of health care among Latina sexual minority women.

In addition to navigating their multiple social identities, Latina LBQ women described receiving information about their sexual health from their families, schools, and health care providers, which was inadequate and/or irrelevant to practicing safer sex in same sex relationships. Specifically, sexual health information they received in adolescence and misinformation from health care providers throughout their young adulthood lacked information that was specific to sexual minorities. This finding was consistent with previous studies that have also noted limited sexual health knowledge among sexual minority women [12, 40–42], and lack of population specific safer sex information delivered by providers [43, 44].

The lack of accurate and appropriate sexual health information, may serve as a barrier to safer sex behaviors, such as a communicating with sexual partners. Women in our study reported that they relied on feelings of trust to determine whether to practice safer sex with women, rather than explicitly communicating with their partners about risk. While relying on trust to determine the extent to which safer sex is practiced is not specific to sexual minority women, women in this study reported that their women partners were seen as safer partners because they trusted them to take care their own health, protect them from risk, and to disclose histories of prior or current infections [45]. Previous studies of sexual minority women have also noted that women generally trust their women partners and as such do not perceive the need to practice safer sex [40, 46, 47]. Together, these studies suggest the need for sexual minority relevant health education that focuses specifically on safer sex practices with women partners, including partner communication.

Despite the many social and contextual factors increasing Latina LBQ women’s sexual health risk, the women in this study placed a high value on their sexual health and prioritized taking responsibility for their own health. Many reported safe use of sex toys, had been tested for sexually transmitted infections and cervical cancer, and were open about sharing their sexual histories (e.g. sexual behavior with female partners) with their providers and

partners. Women were interested in protecting their sexual health despite potential barriers to care, including discrimination from providers and other barriers to care. Many also reported consistent safe sex behavior with their partners that were men. Future research should focus on ways to encourage better patient-provider communication for sexual minority women. Health care providers should receive education and training on how to conduct sexual histories and provide appropriate sexual health information to this population. Latina LBQ women should also be encouraged to communicate with their partners about sexual health and maintain health-promoting behaviors.

Due to the qualitative study design and sampling procedures, our findings may have limited generalizability. For example, all the participants in our study spoke English and had completed high school and most at least some college education. Therefore, while our findings suggest that Latina LBTQ women may have experiences that put them at risk for poor sexual health, these risks may be even greater for women who were ineligible for our study; those with limited English proficiency, lower levels of acculturation, lower levels of education, and undocumented immigration status. Future studies should include be conducted in other areas of the United States, and among younger, older and Spanish-speaking LBQ Latinas who have limited access to healthcare.

Conclusion

Latina LBQ women have intersecting identities with unique perspectives on sexual health. Future research should further explore how their social and cultural context impacts their sexual health behaviors, and what can be done to create a more positive social environment for these women. In addition, future studies should examine whether Latina LBQ women are receiving adequate sexual health education and health care and how this contributes to their sexual behaviors. Our findings suggest that existing sources of sexual health information programs may not adequately address the needs of young sexual minority Latina women. Future sexual health education programs should focus on providing this population with information about safer sex practices with women, safer sex toy use and routine STI and cervical cancer screenings. Health care providers may also need additional training on how to provide quality care for Latina LBQ women, including building trust with patients and accurately communicating sexual health risks. Providers should also be aware of women's history with discrimination, and consider ways to make their practice more inclusive. Given the high priority Latina LBQ women place on their sexual health, these strengths should be leveraged to promote more positive sexual health outcomes.

Acknowledgments

We would like to extend our appreciation to the women that participated in this study. Dr. Ornelas is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health (KL2TR000421). Dr. Williams is supported by a Career Development Award from the Veterans Health Administration (VA) Health Services Research & Development (CDA 12-276) and was a fellow with the Implementation Research Institute (IRI) at the George Warren Brown School of Social Work at Washington University at the time this research was conducted. IRI is supported through an award from the National Institute of Mental Health (R25 MH080916-01A2) and the Department of Veterans Affairs, Health Services Research & Development Service, Quality Enhancement Research Initiative (QUERI). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health, the University of Washington, or the VA.

Funding: India J. Ornelas is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health (KL2TR000421). Emily C. Williams is supported by a Career Development Award from the Veterans Health Administration (VA) Health Services Research & Development (CDA 12-276) and was a fellow with the Implementation Research Institute (IRI) at the George Warren Brown School of Social Work at Washington University at the time this research was conducted. IRI is supported through an award from the National Institute of Mental Health (R25 MH080916-01A2) and the Department of Veterans Affairs, Health Services Research & Development Service, Quality Enhancement Research Initiative (QUERI). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health, the University of Washington, or the VA.

References

1. Gates, GJ., Newport, F. Special Report: 3.4% of U.S. Adults Identify as LGBT. 2012. [cited 2014; Available from: <http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx>]
2. Benard VB, et al. Vital signs: cervical cancer incidence, mortality, and screening - United States 2007–2012. *MMWR Morb Mortal Wkly Rep.* 2014; 63(44):1004–9. [PubMed: 25375072]
3. Centers for Disease, C. and Prevention. Cervical cancer screening among women aged 18–30 years - United States 2000–2010. *MMWR Morb Mortal Wkly Rep.* 2013; 61(51–52):1038–42. [PubMed: 23282861]
4. Champion JD, et al. Risk and protective behaviours of bisexual minority women: a qualitative analysis. *Int Nurs Rev.* 2005; 52(2):115–22. [PubMed: 15842324]
5. Mays VM, et al. Heterogeneity of health disparities among African American, Hispanic, and Asian American women: unrecognized influences of sexual orientation. *Am J Public Health.* 2002; 92(4): 632–9. [PubMed: 11919064]
6. Flores K, Bencomo, Christopher. Preventing Cervical Cancer in the Latina Population. *Journal of Women's Health.* 2009; 18(12)
7. Mann L, et al. Listening to the voices of Latina women: Sexual and reproductive health intervention needs and priorities in a new settlement state in the United States. *Health Care Women Int.* 2016:1–16.
8. Fiddian-Green A, Gubrium AC, Peterson JC. Puerto Rican Latina Youth Coming Out to Talk About Sexuality and Identity. *Health Commun.* 2016:1–11.
9. Wang H, Singhal A. East Los High: Transmedia Edutainment to Promote the Sexual and Reproductive Health of Young Latina/o Americans. *Am J Public Health.* 2016; 106(6):1002–10. [PubMed: 27077336]
10. Logie CH, et al. A Pilot Study of a Group-Based HIV and STI Prevention Intervention for Lesbian, Bisexual, Queer, and Other Women Who Have Sex with Women in Canada. *AIDS Patient Care STDs.* 2015; 29(6):321–8. [PubMed: 25867642]
11. Marrazzo JM, et al. Bacterial vaginosis: identifying research gaps proceedings of a workshop sponsored by DHHS/NIH/NIAID. *Sex Transm Dis.* 2010; 37(12):732–44. [PubMed: 21068695]
12. Power J, McNair R, Carr S. Absent sexual scripts: lesbian and bisexual women's knowledge, attitudes and action regarding safer sex and sexual health information. *Cult Health Sex.* 2009; 11(1):67–81. [PubMed: 19234951]
13. Kim HJ, Fredriksen-Goldsen KI. Hispanic lesbians and bisexual women at heightened risk for [corrected] health disparities. *Am J Public Health.* 2012; 102(1):e9–15.
14. Loue S, Méndez N. I Don't Know Who I Am: Severely Mentally Ill Latina WSW Navigating Differentness. *Journal of Lesbian Studies.* 2008; 10(1–2):249–266.
15. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull.* 2003; 129(5):674–97. [PubMed: 12956539]
16. Meyer IH, Schwartz S, Frost DM. Social patterning of stress and coping: does disadvantaged social statuses confer more stress and fewer coping resources? *Soc Sci Med.* 2008; 67(3):368–79. [PubMed: 18433961]
17. Han CS, et al. Stress and coping with racism and their role in sexual risk for HIV among African American, Asian/Pacific Islander, and Latino men who have sex with men. *Arch Sex Behav.* 2015; 44(2):411–20. [PubMed: 25060122]

18. Holloway IWPMB, Willner L, Ramos-Guilamo V. Effects of Minority Stress Processes on the Mental Health of Latino Men Who Have Sex with Men and Women: A Qualitative Study. *Arch Sex Behav*. 2013
19. Rhodes SD, et al. Depressive symptoms among immigrant Latino sexual minorities. *Am J Health Behav*. 2013; 37(3):404–13. [PubMed: 23985187]
20. Mays VM, Cochran SD, Rhue S. The impact of perceived discrimination on the intimate relationships of black lesbians. *J Homosex*. 1993; 25(4):1–14.
21. Hankivsky O. Women's health, men's health, and gender and health: implications of intersectionality. *Soc Sci Med*. 2012; 74(11):1712–20. [PubMed: 22361090]
22. Brooks, KD., Bowleg, L., Quina, K. Minority Sexual Status Among Minorities. In: Loue, S., editor. *Sexualities and Identities of Minority Women*. Springer; Cleveland, OH: 2009. p. 41-64.
23. Gray NN, Mendelsohn DM, Omoto AM. Community connectedness, challenges, and resilience among gay Latino immigrants. *Am J Community Psychol*. 2015; 55(1–2):202–14. [PubMed: 25576015]
24. Morales A, Corbin-Gutierrez EE, Wang SC. Latino, immigrant, and gay: A qualitative study of their adaptation and transition. *Journal of LGBT Issues in Counseling*. 2013; 7:172–184.
25. Balk G. Survey ranks Seattle area 5th for LGBT population - so how many people is that? *The Seattle Times*. 2015
26. Erikson, F. Qualitative Methods in Research on Teaching. In: Wittrock, MC., editor. *Handbook of Research on Teaching*. MacMillan Reference Books; 1986.
27. Patton, MQ. *Qualitative Evaluation and Research Methods*. Sage; Beverly Hills, California: 1990. Purposeful Sampling.
28. Bernard, RH., Ryan, GW. *Analyzing Qualitative Data Systematic Approaches*. Thousand Oaks, California: Sage; 2010.
29. Miles, MB., Huberman, AM., Saldaña, J. *Qualitative Data Analysis A Methods Sourcebook*. Third. Thousand Oaks, California: Sage; 2014.
30. Craig SL, et al. Minority Stress and HEROic Coping Among Ethnoracial Sexual Minority Girls. *Journal of Adolescent Research*. 2016
31. Mansergh G, et al. Internalised homophobia is differentially associated with sexual risk behaviour by race/ethnicity and HIV serostatus among substance-using men who have sex with men in the United States. *Sex Transm Infect*. 2015; 91(5):324–8. [PubMed: 25512667]
32. Arnold EA, Rebchook GM, Kegeles SM. 'Triply cursed': racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Cult Health Sex*. 2014; 16(6):710–22. [PubMed: 24784224]
33. Lee JH, et al. Discrimination, Mental Health, and Substance Use Disorders Among Sexual Minority Populations. *LGBT Health*. 2016; 3(4):258–65. [PubMed: 27383512]
34. Newcomb ME, Mustanski B. Internalized homophobia and internalizing mental health problems: a meta-analytic review. *Clin Psychol Rev*. 2010; 30(8):1019–29. [PubMed: 20708315]
35. Balsam KF, et al. Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultur Divers Ethnic Minor Psychol*. 2011; 17(2):163–74. [PubMed: 21604840]
36. Mizuno Y, et al. Homophobia and racism experienced by Latino men who have sex with men in the United States: correlates of exposure and associations with HIV risk behaviors. *AIDS Behav*. 2012; 16(3):724–35. [PubMed: 21630014]
37. Verissimo ADO, et al. Discrimination, drugs, and alcohol among Latina/os in Brooklyn, New York: Differences by gender. *International Journal of Drug Policy*. 2013; 24(4):367–373. [PubMed: 23481289]
38. Verissimo ADO, et al. Racial Discrimination, Gender Discrimination, and Substance Abuse Among Latina/os Nationwide. *Cultural Diversity & Ethnic Minority Psychology*. 2014; 20(1):43–51. [PubMed: 24491127]
39. Gilbert PA, et al. Social stressors and alcohol use among immigrant sexual and gender minority Latinos in a nontraditional settlement state. *Subst Use Misuse*. 2014; 49(11):1365–75. [PubMed: 24708429]

40. Muzny CA, et al. Misperceptions regarding protective barrier method use for safer sex among African-American women who have sex with women. *Sex Health*. 2013; 10(2):138–41. [PubMed: 23369280]
41. Bauer GR, Welles SL. Beyond assumptions of negligible risk: sexually transmitted diseases and women who have sex with women. *Am J Public Health*. 2001; 91(8):1282–6. [PubMed: 11499119]
42. Greene G, Fisher K, Kuper L, Andrews R, Mustanski B. “Is This Normal? Is This Not Normal? There Is No Set Example”: Sexual Health Intervention Preferences of LGBT Youth in Romantic Relationships. *Sexuality Research and Social Policy*. 2015; 12(1):1–14. [PubMed: 25678895]
43. Marrazzo JM, Coffey P, Bingham A. Sexual practices, risk perception and knowledge of sexually transmitted disease risk among lesbian and bisexual women. *Perspect Sex Reprod Health*. 2005; 37(1):6–12. [PubMed: 15888397]
44. Formby E. Sex and relationships education, sexual health, and lesbian, gay and bisexual sexual cultures: views from young people. *Sex Education*. 2011; 11(3):255–266.
45. Paranjape A, et al. Effect of relationship factors on safer sex decisions in older inner-city women. *J Womens Health (Larchmt)*. 2006; 15(1):90–7. [PubMed: 16417423]
46. Dolan KA, Davis PW. Nuances and shifts in lesbian women’s constructions of STI and HIV vulnerability. *Soc Sci Med*. 2003; 57(1):25–38. [PubMed: 12753814]
47. Richters J, et al. Do women use dental dams? Safer sex practices of lesbians and other women who have sex with women. *Sex Health*. 2010; 7(2):165–9. [PubMed: 20465981]