BARRIERS TO SAFER SEX PRACTICES FOR LESBIAN AND BISEXUAL WOMEN

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ABSTRACT

DISSERTATION: Barriers to Safer Sex Practices for Lesbian and Bisexual Women

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Historically, literature on sexual health compared men vs. women, and gay men vs. heterosexual adults, while paying little to no attention to lesbian or bisexual women who have sex with women. Although researchers have continued to study sexual health risks among heterosexual adults, and gay and bisexual men, existing literature provides an inadequate understanding of sexual health risks for lesbian and bisexual women. This includes barriers to safer sex practices. The current study was designed to explore barriers to safer sex practices among lesbian and bisexual women who were college students. A total of 12 self-identified female, sexual minority students at a mid-sized mid-western university participated in one-on-one semi-structured interviews. Using Consensual Qualitative Research (Hill, 2012), domains that emerged included: limited resources; lack of education, knowledge, and awareness; belief of invulnerability; and stigma and shame. The most frequently cited barrier across all interviews was lack of education, knowledge, and awareness of risk related to STIs for lesbian and bisexual women. Limitations, implications for future research, and interventions are discussed.

Keywords: lesbian, bisexual woman, barriers to safe sex, STI
Barriers to Safer Sex Practices for Lesbians and Bisexual Women

In the United States (U.S.), population 318.9 million, the Centers for Disease Control (CDC; 2014) estimated there would be nearly 110 million individuals with sexually transmitted infections (STIs) in 2015. Of that total, roughly twenty thousand would be first time cases. The eight most common STIs are syphilis, gonorrhea, hepatitis B, human immunodeficiency virus (HIV), chlamydia, trichomoniasis, herpes simplex virus-2 (genital herpes or HVS-2), and human papilloma virus (HPV). The CDC has found nearly half of all new cases of STIs are present in young men and women (ages 15-24). Men and women bear the burden of STIs relatively equally—fifty million men and sixty million women are infected by one or more STIs each year.

In addition to the resulting health concerns STIs create, they also have severe financial implications for society as a whole. It is estimated the lifetime cost of treating the eight most common STIs contracted in a single year is $15.6 billion (CDC, 2014). The majority of costs go to treating and managing viral STIs, such as HIV and the cancers resulting from HPV, but the estimated costs of treating bacterial STIs is nearly $742 million. While little research has been done regarding the psychological distress of receiving a diagnosis of an STI, some studies have suggested individuals may experience shame, guilt, and embarrassment (Balfe, Brugha, O’Donova, O’Connell, & Vaughan, 2010), as well as mental health concerns such as major depressive disorder and generalized anxiety disorder (Workowski & Bolan, 2015).

In order to combat the rise in STIs, there have been consistent efforts across the United States to educate sexually active adolescents and young adults. Twenty-four states and the District of Columbia require developmentally appropriate sexuality education be taught to students from elementary school through high school (Guttmacher Institute, 2016). The level of sexuality education required varies from state to state, ranging from abstinence-only education.
with no discussion of contraceptives to comprehensive discussions of the biopsychosocial impacts of sexual behaviors. Consistently, it has been found that comprehensive sexuality education is the most effective strategy for decreasing risk factors that contribute to contracting an STI (CDC, 2011). Within comprehensive sexuality education, recommendations for safer sex practices include: abstinence (the only way to guarantee someone will not contract an STI), monogamy or limiting the number of sexual partners, avoiding sex with an infected partner, regular visits to health care providers, and exploration of ‘outercourse’ (genital contact without oral/vaginal/anal insertion) instead of ‘intercourse’ (Marr, 2007).

One area not covered in great detail in many sexuality education programs is safer sex practices for same-sex sexual behaviors. Many such programs focus on pregnancy protection, which is not a concern for same-sex couples. Fields (2008) suggested this might be the reason sexuality education programs have not given much guidance for same-sex sexual behaviors. The Guttmacher Institute (2016) found only thirteen states require discussions of sexual orientation be included in sexuality education in the classroom; nine are required to discuss it from an inclusive perspective while four others are mandated to provide negative information on non-heterosexual sexual orientations. Taking into account data that suggest adolescent females who are given information about safer sex practices still struggle with negotiating condom use (Black, Ping, & Sussman, 2011), how difficult must it be for sexual minority emerging adults to negotiate a range of safer sex practices when they have little to no foundation for it?

Research suggests 1.7 – 5.6% of the U.S. population self-identifies as lesbian, gay, bisexual, and/or transgender (LGBT; Gates, 2011). As a whole, the LGBT community consistently reports disparities and marginalized experiences with sexuality education (Gardner, 2015) and health care (Cahill & Makadon, 2013). Even further, when focusing on LGBT
healthcare, lesbian and bisexual women are often forgotten (Everett, 2013). For example, Lindley, Nicholson, Kerby, and Lu (2003) found the sexual behavior of gay and bisexual males received significant attention in conjunction with the HIV/AIDS epidemic around the late 1980’s. This has led to continued efforts from medical and psychological professionals alike to educate the gay male population on protection and prevention of contracting and spreading HIV/AIDS (Lindley et al., 2003). At the same time, lesbian and bisexual women’s sexual health receives almost no attention. What little information is available offers no specific exploration of barriers to safer sex practices, even though HIV/AIDS can also be spread from woman-to-woman (McNair, 2005).

The literature on female sexual minorities’ safer sex practices is minimal and the existing literature fails to provide an in-depth understanding of college women’s perceived barriers to safer sex practices. Given those gaps, the current study aimed to explore sexual minority women’s experiences with sexuality education and perceptions of barriers to safer sex practices through interviews with 12 sexual minority college women.

**Definitions for the Lesbian, Gay, and Bisexual Community**

As mentioned above, between 1.7 and 5.6% of adults in the U.S. self-identify as lesbian, gay, or bisexual (Gates, 2011). Within this group, some 1.8% identify as bisexual and 1.7% identify as gay or lesbian. Gates and others (e.g., Herbenick et al., 2010) suggest the range in rate of self-reported sexual minority identity is due to significant stigma that endures for sexual minorities in the U.S. Perhaps related to this stigma, researchers have consistently found many people who have had same-sex sexual experiences do not identify as sexual minorities. In comparison to the percentages listed above, same-sex attraction and sexual behavior is reported
by roughly 20% of the U.S. population, with 11% of individuals reporting sexual behavior with both men and women and 8.2% reporting exclusive same-sex sexual activity (Gates, 2011).

**Clarification of Terminology**

It is important to note studies about female same-sex STI risk use different terminology to describe their participants. Much of the public health research uses the terms “women who have sex with women” (WSW) and “women who have sex with women and men” (WSWM) rather than “lesbian and bisexual women” (LB women). Subsequently, the literature presented will include studies that examined LB women as well as those that examined WSW/WSWM. While there is little evidence to support the preference for one descriptive term over another, it is possible the difference lies in the field in which information is being gathered. Researchers who are interested in the sexual health of participants (e.g., those whose articles are published in such medical journals as *American Journal of Public Health* or *Sexually Transmitted Diseases*) may be more interested in focusing on sexual behaviors regardless of how participants personally identified. This may occur as a result of medical professionals endeavoring to include those self-identified heterosexual people who engage in same-sex sexual behaviors.

Sexual orientation has multiple dimensions, including but not limited to, romantic attraction, emotional attraction, and physical attraction (Killerman, 2013). Within the research of STI for WSW/WSWM and LB women, the difference lies in the dimension of sexual orientation to be examined. “A lot of the WSW sexual health literature … focuses on the behavioral dimension of sexual orientation because [it is] interested in who the person is having sex with (i.e., female or male sexual partners) as this most closely influences that person’s risk for sexually transmitted infections” (Muzny, 2014, personal communication). At the same time, when targeting populations for care, the importance of targeting a specific cultural group
outweighs the importance of focusing on sexual behavior. Additionally, using the identifier LB women encompasses the broader social aspects of individuals’ self-identity rather than sexual behavior alone. Thus, for purposes of this work, LB women are the targeted population.

Literature on WSW/WSWM will be noted as such where appropriate.

**Sexually Transmitted Infections in the Lesbian, Gay, and Bisexual Community**

As indicated before, the groups within the LGBT community who have received the most attention regarding sexual health are gay and bisexual males, due to their increased risk for HIV/AIDS (CDC, 2014; Halkitis, Wolitski, & Millett, 2013). The CDC, which regularly samples the U.S. population for rates of HIV/AIDS transmission, consistently identifies the increased and continued risk of contagion for men who have sex with men (MSM). Because of this, the majority of HIV/AIDS (and by extension other STIs) prevention and intervention programs were developed to focus on men, including gay males, bisexual males, and MSM (Lindley et al., 2003). Although researchers have continued to study sexual health risks among heterosexual adults and male sexual minorities, existing literature provides an inadequate understanding of sexual health risks, including barriers to safer sex practices, for lesbian and bisexual women. The lack of attention to lesbian and bisexual women perpetuates the inaccurate assumptions, even within the LGBT community, that their sex activities are inherently safe (Marrazzo, Coffey, & Bingham, 2005).

By taking this approach, however, LB women’s experiences have been consistently neglected in research focusing on HIV/AIDS and STIs in general, thereby leaving their risk of contracting STIs unnoticed (Lindley et al., 2003). Though little research has been done, existing findings suggest some WSW may be at a higher risk for contracting and transmitting HIV/STIs than the general population (Marrazzo et al., 2001; McNair, 2005; Morrow & Allsworth, 2000).
Much of the safer sex practice interventions focus primarily on male condom use, limiting the amount of education presented to individuals who do not engage in sex acts using penises (Everett, 2013). Everett suggested this is due to the heteronormative assumption of what counts as sex—i.e., sex requires penile insertion. The aforementioned heightened risk for contracting STI/sexual transmitted diseases (STDs) in women and the lack of exploration of safer sex practices for these women guided the current study.

**Sexually transmitted infections among lesbian and bisexual women.** In general, WSW reported lifetime rates of between 10 and 20% for STDs (McNair, 2005). This was equivalent to the percentage of heterosexual women who reported contracting an STD over the course of their lifetime. Regarding the spread of STIs woman-to-woman, LB women reported contracting trichomoniasis, genital herpes, HPV, and HIV from female partners (Marrazzo et al., 2005). Research throughout the years has demonstrated consistent findings for bisexual women’s increased risk for contracting STDs when compared to their lesbian and heterosexual female counterparts (Everett, 2013; Koh, Gomez, Shade, & Rowley, 2005; Lindley, Barnett, Brandt, Hardin, & Burcin, 2008; Marrazzo et al., 2001; Reisner et al., 2010). Two of these studies—Everett (2013) and Lindley et al. (2008)—will be presented in detail.

Behavioral risks for contracting an STI in adulthood typically begin in adolescence. Everett (2013) utilized data from Waves III and IV of the National Longitudinal Study of Adolescent Health, which gathers longitudinal data from participants beginning in middle school. The age range of participants for each wave was 24 to 35 years old. Everett’s findings suggested self-identified heterosexual WSW and bisexual women’s STI risks were elevated, regardless of whether or not they reported same-sex sexual behavior; lesbian women were least
likely to report an STI. These findings echo results of Lindley et al.’s (2008) findings, which were based on a large national sample.

Lindley et al. (2008) explored the history of sexual behavior and STD status of nearly 30,000 female students aged 18-24 who completed the 2007 American College Health Association Survey. The results suggested, of the three sexual identity types studied (heterosexual, lesbian, and bisexual), bisexual students were the most likely to have had an STD (9%) while lesbians were least likely (2%). For students who had multiple partners, having sex with both men and women led to greater risk of STDs (16%), while having sex with only men or only women led to lower risk (9 and 6% respectively).

While Everett (2013) and Lindley et al.’s (2008) studies demonstrated a lower risk for lesbians who do not have sex with men, they highlight the increased risks bisexual women have with regard to contracting STIs. One infection that has an increased prevalence rate among lesbian and bisexual women is bacterial vaginosis. Due to the increased likelihood of one female partner having the infection if her female sexual partner also has the infection, some health professionals consider bacterial vaginosis an STI.

**Bacterial vaginosis among lesbian and bisexual women.** Bacterial vaginosis (BV) is highly prevalent among lesbian and bisexual women (Marrazzo, Thomas, Agnew, & Ringwood, 2010). BV is not a traditional STI such as one would consider HPV or chlamydia to be because there is no clear connection between sexual transmissions of the infection. BV is caused by an imbalance of good bacteria (lactobacilli) and bad bacteria (anaerobes) in the vagina’s microbial ecosystem (Eschenbach et al., 1988). An overabundance of anaerobes inflames the vaginal canal, which increases the likelihood of microtears when engaging in sexual activity. If a woman with BV engages in unprotected vaginal sex with a partner infected with a traditional
STI, such as gonorrhea or HIV, she is more likely to contract an STI. While the etiology of bacterial vaginosis is unknown, correlations have suggested it develops after having sex with a new male partner without using a condom. The question then becomes, with the absence of a male partner, how does BV spread between WSW?

Marrazzo et al. (2005) postulated that vaginal flora between female sexual partners is altered due to an exchange of infected cervicovaginal secretions and direct mucosal contact. This exchange of fluid can happen in multiple ways, including digital-vaginal sex, digital-anal sex, and shared penetrative sex toys. Marrazzo et al. (2002) found that 5-23% of heterosexual women reported being diagnosed with the disease in their lifetime, yet over 27% of the 392 lesbian and bisexual women participants had experienced the disease.

Taken together, these studies suggest sexual minority women are at the same or higher level of risk for contracting an STI as their heterosexual counterparts. Lesbian women and WSW are least likely to report contracting an STI, but have an increased risk of bacterial vaginosis compared with heterosexual and bisexual women. Bisexual women and WSW are at an increased risk for all types of STIs compared to other sexually active women. Much debate has occurred regarding why bisexual women/WSW experience an increased risk of STIs though little evidence has been presented. One belief among researchers is risk myths abound for LB women’s sexual health.

Myths about risk for lesbian and bisexual women. The greatest myth identified across multiple research studies about risk for lesbian and bisexual women is the myth of invulnerability (Marrazzo et al., 2005; McNair, 2005; Namaste et al., 2007; Power, McNair, & Carr, 2009); specifically, ‘women-with-women’ sexual contact precludes STI transmission. Rooted in heteronormativity, this myth prevails in society as a whole and is in some ways
perpetuated by the medical community (McNair, 2005). Research has suggested, aside from the fact health care providers have little contact with WSW in general, they are also poorly informed regarding risks for this population (Ard & Makadon, n.d.; Committee on Health Care for Underserved Women, 2012). While some acknowledgement does come from the medical community regarding the risks for STIs for WSW, the medical community presents the information as a blanket statement, without differentiating between sexual orientation and sexual behaviors, and without acknowledging the risks for this population, minimal for some though it may be.

The myth of invulnerability is problematic for many reasons, including the assumption a woman who discloses her current sexual partner is female is not also having sexual contact with men. Koh et al. (2005) found women who self-identify as lesbians and bisexuals are more likely than heterosexual women to engage in unprotected sex acts with gay and bisexual men. When compared to heterosexual women (of whom only 3% reported engaging in sexual activities with MSM), 36% and 22% of lesbian and bisexual participants respectively reported engaging in sexual activity with MSM. This type of sexual behavior inherently places this group of women at a greater risk for contracting an STI because they are engaging in sexual activities with men who consistently have the highest rates of STIs, such as HIV and syphilis. Additionally, Koh et al. (2005) found lesbian and bisexual women were more likely than heterosexual women to report more risk-taking behaviors during sex. Specifically, compared to heterosexual women, lesbian and bisexual women reported higher rates of drug and alcohol use during sexual activity, which can result in dysfunction of higher executive decision-making and decrease the likelihood of engaging in safer sex behaviors.
Safer sex practices for lesbian and bisexual women. Studies also provide suggestions for safer sex practices for lesbian and bisexual women. These safer sex practices include using gloves (latex or non-latex examination) when engaging in any sort of digital penetration (Marrazzo et al., 2005), utilizing dental dams when engaging in cunnilingus or anilingus (Namaste et al., 2007), and washing sex-toys, having multiple sex toys, or using condoms with sex toys to ensure no fluids are exchanged (Lindley et al., 2003). Along with these practical safer sex behaviors, researchers recognize knowledge barriers to safer sex. Lack of knowledge related to symptoms of STIs has led many women to assume a female partner is clean because she has no visible symptoms, such as lesions or open sores (Namaste et al., 2007). Furthermore, there remains an overall lack of sexual script for safer sex practices for women because the predominant information focuses on heterosexual women (Power et al., 2008).

Barriers to Safer Sex Practices

While limited research is available regarding barriers to safer sex practices for female sexual minorities, many of the extant literature currently available may provide evidence for psychosocial barriers. The first possible barrier to safer sex practices is lack of preparation and foresight. Studies have shown past behavior can influence the intention of future safer sex practices. One example by Carter, McNair, Corbin, and Williams (1999) found retrospectively, when men and women intended to use condoms prior to a sexual encounter, it was highly likely they would use condoms. In other words, when individuals are preparing for a sexual encounter and tells themselves “I am going to use a condom” it is likely they will, in fact, use a condom.

This lack of preparation by sexually active people could be a direct result of a lack of education at key developmentally appropriate times (Stanger-Hall & Hall, 2011). Adolescents report safer sex practice information tends to come from school, family, and friends but such
information is sporadic and subtle or indirect (Jones, Biddlecom, Hebert, & Mellow, 2011). In many ways, this can perpetuate the stigma around sex, sexuality, and STIs and can further inhibit a potential user from seeking out condoms or dental dams. For LB women, this may be an even greater concern, as sexual education about non-heterosexual relationships is almost non-existent.

Stigma and shame about being tested for an STI is also a barrier for safer sex practices because it implies that the individual has done something wrong by having sex (Fortenberry et al., 2002). Being tested can also place someone diagnosed with an STI in an awkward position, as it is essential to contact current and former partners to ensure they remain healthy. Consequently, many people do not get tested for STIs for fear of social repercussions as a result of an STI diagnosis (Fortenberry et al., 2002).

Gender role expectations regarding sexual behavior can also present a barrier for safer sex practices, especially when negotiating prophylactic use. Condom negotiation is an active process in which both partners should be involved. Yet due to a power imbalance, many women reported a lack of control when negotiating condom use in heterosexual sexual encounters (Serewicz & Gale, 2008). Ultimately, men tend to report a greater role in the condom-use decision-making process (Carter et al., 1999). When power imbalances due to gender are not present, such as in male same-sex relationships, barriers such as cost of condoms are often reported (Hubach et al., 2014). Though embarrassment is certainly not unique to gay or bisexual men, it was cited as a barrier to purchasing condoms (Mustanski, DuBois, Prescott, & Ybarra, 2014). While no literature was found that surveyed LB women’s use of condoms, it is possible many LB women do not consider the use of condoms necessary in WSW encounters because conception is not a consideration.
Both psychosocial and biological developmental processes, such as adolescents’ assumption of vulnerability with optimism bias, also act as a barrier to safer sex practices, and may also provide an explanation for the disproportionate number of new STI cases in people aged 18-25. When considering risky behaviors, many adolescents are likely to assume negative consequences will happen to someone else, while they will personally experience positive outcomes (Lapsley, Aalsma, & Halpern-Felsher, 2005). When an individual assumes he or she is at a decreased risk for contracting an STI, it is likely that person will not engage in routine safer sex practices.

Finally, communication, or rather a lack thereof, can act as a barrier to safer sex. Keeping in mind the social stigma and general awkwardness surrounding frank discussions of sexual history, the discussion of safer sex may also be inhibited. Additional barriers include the perception condoms (or other barrier methods) will decrease sexual pleasure (Crosby et al., 2004), substance use prior to a sexual encounter, which increases risk taking behavior and decreases planning behaviors (Parkes, Wight, Henderson, & Hart, 2007), and the implication condom use (or other barrier methods) means lack of trust in a relationship (Martson & King, 2006). An additional barrier to safer sex exists if LB women perceive that safer sex practices are designed to avoid pregnancy instead of avoiding STIs.

To conclude, a clear need exists for studies that explicitly investigate safer sex practices among lesbian and bisexual women. Studies have demonstrated the lesbian and bisexual women’s risks for STIs and have highlighted the myths and consequences of the lack of attention to this phenomenon. Thus, women in the current study were asked about their experiences with and perceptions of safer sex education for sexual minority women and barriers to safer sex practices.
The Current Study

The literature suggests that, as a whole, lesbian and bisexual women’s sexual health is significantly less valued than both their heterosexual female and gay male counterparts. Achieving a better, more nuanced understanding of barriers to safer sex practices among LB women is crucial to this vulnerable population’s health. The purpose of this study is to address existing gaps in the extant research by exploring U.S. college female sexual minorities’ experiences with and perceptions of safer sex practices in depth and from their personal perspectives. To achieve this purpose, the qualitative research approach Consensual Qualitative Research (CQR; Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) was employed. CQR helps elicit and maintain the unique experiences of participants by using small samples, relying on words over numbers, acknowledging the context, integrating multiple viewpoints, and consensus of the research team (Hill, 2012). The interview questions were designed to allow a broad conceptualization of these women’s personal experiences and perceptions within their cultural context to increase understanding of psychosocial barriers to safer sex practices for LB women.

Methodology

Participants

Recruitment. Participants were recruited through an email sent out at a mid-sized, Midwest public university through the campus-wide Communication Center and the Counseling Psychology and Guidance Services Department (Appendix A). Each participant who responded to the recruitment email with contact information was sent the informed consent document (Appendix B) and scheduled, via email, a time to talk via telephone to complete the Telephone Screening Questionnaire (Appendix C). Participants who met inclusion criteria for the study and
agreed to participate in the full, audio-recorded, semi-structured qualitative interview scheduled a time to complete the one-on-one interview.

In total, 14 college women who self-identify as sexual minorities were screened to ensure they met criteria for the study (identify as a cisgender, sexual minority woman, over the age of 18, who is willing to participate in a study) via telephone. Twelve of the 14 women participated in a face-to-face interview, which was an appropriate number for CQR’s data analysis as the recommended minimum number of interviews is eight (Hill, 2012). All participants were between the ages of 19 and 25 years old, were fluent in English, and were current students at a public university. The mean age of women interviewed was 20.6 years old. The women were asked to self-identify their biological sex, gender identity, sexual orientation, and race. All 12 women reported their biological sex as female; ten reported ‘female’ for gender identity while one reported ‘gender non-conforming’ and one reported ‘feminine.’ Five women identified as lesbian, four as bisexual, two as pansexual, and one as homoflexible. Briefly, pansexual is a sexual orientation used to describe someone’s attraction to another person that is not limited by biological sex, gender, or gender identity (Killerman, 2013). The participant who described her sexual orientation as homoflexible detailed her attraction to others as “Usually women, but every now and again there’s a guy and it’s like ‘Damn, I’d hit that.’” Racially, two women identified as Caucasian, two identified as African-American, two identified as Black, one identified as Hispanic, and five identified as White. The mean year in school of the participants was 14.5 (Junior). Each of the 12 participants completed the Telephone Screening Questionnaire and the Semi-Structured Qualitative Interview. All participants were given the opportunity to receive course credit for participation or be entered into a drawing to receive a $20 gift card for their participation. All participants completed the full qualitative interview.
Research Team

The primary researcher and interviewer is a 29-year-old White female doctoral candidate in Counseling Psychology. She has clinical and research experience focused on college students, sexual orientation and gender identity development, qualitative methods, and prevention and outreach. Personal motivations to do this project included a passion for social justice and sexuality health education, her identity as a female sexual minority, and an interest in improving the lives and sexual health of female sexual minorities.

Demographic characteristics are the most common sources for bias in qualitative research (Hill et al., 2005); therefore, it was important the research team for the proposed study be as heterogeneous as possible. The primary researcher recruited three additional researchers as part of the research team, and one outside auditor (see Appendix D for detailed description of the research team members). All team members were White, which is representative of the department from which they were recruited. They varied in education level; one member was a doctoral student in Counseling Psychology and two members were master’s students in Clinical Mental Health. Counseling research interests were similar and included diversity and multiculturalism, interests in LGBT issues, African-Americans’ experiences, religion and spirituality, and intersectionality. Team members also varied by age (24 to 32 years old), sex (one male, three female), sexual orientation (with one person identifying with each of the following: bisexual, gay, pansexual, and heterosexual), religion/faith, SES background, and year in training (second year master’s students, third year doctoral student, doctoral candidate).

The auditor was a Caucasian, female, heterosexual faculty member in School Psychology from the same university. She has several previous experiences with analyzing data from
qualitative studies, and has research interests in juvenile offenders, school discipline policies and their impact on students, and evidence-based psychosocial and academic interventions.

**Research team training.** The primary researcher trained research team members on the CQR method and included discussion of the purpose of domains, categories, and core ideas. The training lasted approximately 90 minutes. To ensure team members’ readiness to code the data, the research team worked together on one interview to completion. Once each team member demonstrated competence with the method, team members worked independently and then came together to compare ideas and check biases. Prior to data analysis, team members documented their personal biases.

**Team members’ initial biases.** Team members’ biases surrounding barriers to safer sex practices for sexual minority women were discussed during the initial training meeting. Biases discussed included team members’ identities as sexual minorities, positive bias for sexual minorities, history of heteronormative sex education experiences, belief women who have sex with women do not need to engage in safer sex practices, and assumption that sexual minorities are more likely to engage in unsafe sex.

**Procedure**

**Measures.** *Telephone Screening Questionnaire.* Developed by the principal investigator, the Telephone Screening Questionnaire was used to gather demographic information to ensure participants met inclusion criteria. Participants who self-identified as cisgender, sexual minorities were invited to participate in the interview.

*Semi-Structured Qualitative Interview.* The 11-item, Semi-Structured Interview Questionnaire (Appendix E) was developed by the principal investigator after review of salient literature regarding safer sex practices of sexual minority women and barriers to safer sex
practices for emerging adults, and her personal experiences with sexual health education. Practice interviews using the semi-structured questionnaire were conducted with two women who identified as sexual minorities to assess length and clarity of questions, and to allow the principal investigator to practice the semi-structured interview.

Prior to conducting the interview, the research team and auditor reviewed the questionnaire and appropriate revisions were made (i.e., ordering of questions, rewording double-barreled questions). The final script focused on the following for sexual minority women: the female sexual minority community as a whole, messages about safer sex practices, methods of safer sex practices, and barriers to safer sex practices. During interviews, questions were modified and added depending on the previous responses of participants. For example, for participants who identified as women of color, the intersection of their racial identity and their sexual orientation were briefly explored. For participants who identified as bisexual, the experience of bisexual erasure was briefly explored. Bisexual erasure is the phenomenon in which the legitimacy of bisexuality is questioned or denied (GLAAD, 2016). In essence, bisexual erasure is the assumption that everyone is only either gay (lesbian) or heterosexual, which precludes people from being attracted to both sexes/genders.

**Interview procedures.** The principal investigator conducted each of the audio recorded, face-to-face interviews; at the beginning of the interview she shared she identified as a sexual minority woman. The participants were told the purpose of the study was to develop a better understanding of female sexual behavior and safer sex practices and the goal of the study was to advance the understanding of the lived experiences of women who identify as sexual minorities. Interviews ranged from 23 to 67 minutes with a mean interview time of 48 minutes (SD=11 minutes). The principal investigator transcribed all audiotaped interviews and reviewed all
Each participant was invited to review the transcript of her interview to provide feedback, elaboration, or redaction before the research team analyzed the transcripts. Each participant’s transcription was sent to her for review and approval. Five of the 12 participants responded with affirmation of the content, which meant there was no elaboration, or redaction; the other seven participants did not respond to the request to review.

**Data analysis.** The qualitative interviews were analyzed using consensual qualitative research (CQR) methodology (Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997). Data analysis in CQR consists of three distinct parts: development of domains, identification of core ideas, and application of cross analysis. When the research team identifies domains, they are identifying topic areas that emerge from the interviews (Hill, 2012). Typically, entire paragraphs from participants are condensed into a few words or a sentence known as core ideas. With core ideas, researchers further condense the responses and identify abstracts or brief summaries from the domains identified with each participant’s responses (Hill, 2012).

Throughout this process the research team checks in as a group to ensure consensus is met for the domains and core ideas. After the domains and core ideas are identified for each interview reviewed, cross analysis occurs (Hill et al., 1997). Cross analysis is used to construct common themes across participants. Frequency labels are used during cross analysis to provide a quantitative representation of the data.

Ladany, Thompson, and Hill’s (2012) recommended labels were used to describe how representative each category was for the sample. General described categories that applied to 10-12 participants, typical applied to 6-9 participants, and variant applied to 2-4 participants.
**Coding by research team.** Each member of the research team was trained by the principal investigator in the use of CQR and read the relevant works of Hill and colleagues. As previously indicated, a training meeting was held where initial biases were recorded and discussed. The principal investigator provided a discussion-based presentation to outline CQR and address research team members’ questions. Research team members all agreed to discuss their opinions freely, minimize power differentials, and discuss problems openly throughout the research project given that consensus and equality of power are essential components of the CQR process (Hill et al., 2012).

Initially, the research team met to code the same interview (Interview 1) for domains and core ideas, and to discuss the coding process, difficulties, and suggestions. From there, team members independently coded Interviews 2, 3, and 4, then team meetings were held to compare domains and core ideas for consistency and consensus. Once a consensus was met for Interviews 2-4, the remaining interviews were divided between members and were coded for domains and core ideas, and then presented to the entire research team for discussion and to consensually reach an agreement on final coding. All domains were developed from the semi-structured interview questions and participants’ responses. Domains and subcategories were then created across cases. The frequency with which the domains and subcategories applied to the whole sample was reported using Hill et al.’s (2012) modified labels. An external auditor was used to provide feedback for the domains, core ideas, and cross-analysis.

**Validation strategies.** Consistent with Hill et al.’s (1997) recommendations, the data obtained from using CQR were evaluated according to coherence, representativeness to the sample, and trustworthiness. Coherence of the results refers to the idea that the results make logical sense to a reader and are presented so that a reader could understand how the research
team came to their conclusions. Coherence is shown through answering the research questions in a logical way that accounts for all the data along with supporting findings with direct quotes from participants to further illustrate categories within each domain (Hill et al., 1997). The representativeness of the results to the sample is also evaluated. Representativeness is used to determine whether and if the domains and subcategories identified by the research team are consistently represented across cases. This is done through the labels of *general, typical, or variant*, as discussed earlier. If a result only applied to one case, it was dropped because it was considered not representative of the sample (Hill et al., 1997). Trustworthiness is similar to the concept of validity in quantitative studies. Trustworthiness refers to “the researchers’ claim to have used appropriate, adequate, and replicable methods and to have correctly reported the findings” (Williams & Hill, 2012, pp. 175). In this study, trustworthiness was achieved by providing details about the methods (e.g., the research team’s biases and expectations, the interview protocol), achieving saturation of data in which no new domains and categories emerged by using a relatively large sample, and transferability in which details of the study are provided so the reader can judge whether the findings could transfer to another setting.

**Results**

In the following section, the domains and corresponding subcategories that emerged from responses by the participants addressing messages about safer sex practices, methods of safer sex practices, and barriers to safer sex practices are briefly defined. A description of participants is presented in Table 1 along with their interview number for ease of reference throughout the text. A conceptual framework is provided in Table 2 to assist the reader’s understanding of participants’ psychosocial experiences with safer sex. Table 2 includes the list of domains and subcategories, frequency of each core idea within the domain and subcategory based on Ladany
et al. (2012), and the coding criteria created by the research team for development of the domains. Quotes are provided in the body of the text.

Results are structured and presented based on frequency in order to outline common experiences of participants. Within each domain, those findings presented first are those that emerged as general, which are those present in 10-12 of the interviews. Findings that emerged as typical (6-9 interviews) and variant (2-4 interviews) will be presented.

Frequency: General

Practices. All 12 participants described various methods and forms of safer sex practices they were aware of. Participants often reported methods that were comprehensive in nature and included open communication with sexual partners, prophylactics, and sexual history, as illustrated in the following examples:

Participant #2: I think of practices such as dental dams. I think of screening, making sure you’re tested. Being active and letting your partner know what you’ve done in the past … that you’ve been tested kind of thing. Letting them know that either you’ve been sexually active in the past, that you have been tested. Not exactly who, you don’t need to tell them like who, as in “Let me just go through the list here before we do anything.”

Participant #3: Of course the material things that you can do to prevent infections, but more conversation. You need to talk about, maybe not how many partners you’ve had but how, risky you’ve been when it comes to sex with other people. How risky you’ve been when it comes to tattoos. How risky you’ve been when it comes to drugs. Or have you done anything that puts me at risk? Because then you really don’t care about me, if you have and choose not to protect yourself and me.
Messages. All 12 participants described the messages they received throughout their lives regarding safer sex practices. Many participants reported the information they received about sex was abstinence-only in nature, as illustrated by the following responses:

Participant #1: Don’t have sex. ‘Cause if I do, I die! (laughing) Definitely like in schools all we’re taught is just don’t have sex and then if you do have sex wear a condom, but that was an afterthought. All I know about is condoms and birth control.

Participant #10: Oh my parents were very much like “No sex before marriage!” kind of thing. It’s hard for me to like remember, but I want to say that my school was an abstinence only school as well. Probably coming from the Midwest so growing up it was always a very “Don’t have sex, like ever, but here’s how sex organs work separately. But we’re not going to show you how they work together!” And then they would show you the horror pictures of STDs and that kind of stuff.

Even more than abstinence-only messages about sex, these participants noted information was heterosexually skewed. In many cases, there was little to no discussion of safer sex practices for sexual minorities as a whole and no information specifically about female sexual minorities. Again, a consistent theme emerged of experiencing a lack of information with regard to safer sex practices that are applicable to their experiences.
Table 1

Participants’ Interview Alias and Demographics

<table>
<thead>
<tr>
<th>Interview alias</th>
<th>Demographics (age, biological sex, gender identity, sexual orientation, race, and year in school)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>19 yo, female, woman, lesbian, Caucasian, and Sophomore</td>
</tr>
<tr>
<td>Participant 2</td>
<td>21 yo, female, gender-nonconforming, lesbian, White, and Junior</td>
</tr>
<tr>
<td>Participant 3</td>
<td>21 yo, female, woman, pan-sexual, African-American, and Junior</td>
</tr>
<tr>
<td>Participant 4</td>
<td>19 yo, female, woman, bisexual, African-American, and Sophomore</td>
</tr>
<tr>
<td>Participant 5</td>
<td>19 yo, female, woman, lesbian, Black, and Sophomore</td>
</tr>
<tr>
<td>Participant 6</td>
<td>19 yo, female, woman, lesbian, Caucasian, and Freshman</td>
</tr>
<tr>
<td>Participant 7</td>
<td>25 yo, female, feminine, pan/bisexual, White, and Junior</td>
</tr>
<tr>
<td>Participant 8</td>
<td>20 yo, female, woman, lesbian, Black, and Junior</td>
</tr>
<tr>
<td>Participant 9</td>
<td>21 yo, female, woman, bisexual, Hispanic, and Senior</td>
</tr>
<tr>
<td>Participant 10</td>
<td>24 yo, female, woman, bisexual, White, and Graduate student</td>
</tr>
<tr>
<td>Participant 11</td>
<td>21 yo, female, woman, homoflexible, White, and Junior</td>
</tr>
<tr>
<td>Participant 12</td>
<td>19 yo, female, woman, bisexual, White, and Freshman</td>
</tr>
</tbody>
</table>
Table 2

Participants’ Psychosocial Experiences with Safer Sex: Domains, Subcategories, Frequencies, and Coding Criteria

<table>
<thead>
<tr>
<th>Domains and Subcategories</th>
<th>No. of Cases</th>
<th>Definition or Coding Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Safer sex practices</td>
<td>12 (General)</td>
<td>Ways to engage in safer sex</td>
</tr>
<tr>
<td>• Messages about safer sex</td>
<td>12 (General)</td>
<td>Messages received regarding safer sex practices</td>
</tr>
<tr>
<td>• Biological risk factors for contracting an STI</td>
<td>8 (Typical)</td>
<td>Acknowledgement of increased risk factors for contracting an STI</td>
</tr>
<tr>
<td>• Barriers to safer sex practices</td>
<td>12 (General)</td>
<td>Barriers to safer sex practices</td>
</tr>
<tr>
<td>o Limited resources for safer sex practices</td>
<td>5 (Variant)</td>
<td>Lack of access to and money to pay for safer sex practices (e.g., STI testing, prophylactics, etc.)</td>
</tr>
<tr>
<td>o Lack of education, knowledge, and awareness</td>
<td>12 (General)</td>
<td>Report of never having received information on risk about and protection against STIs for sexual minority women</td>
</tr>
<tr>
<td>o Belief of invulnerability</td>
<td>6 (Typical)</td>
<td>Belief that female sexual minorities, especially lesbians, are not at risk for contracting an STI</td>
</tr>
<tr>
<td>o Stigma and shame</td>
<td>7 (Typical)</td>
<td>Fear of social repercussion when negotiating safer sex practices with a female partner.</td>
</tr>
</tbody>
</table>
Participant #7: I went to a high school that was a lot more liberal than schools here so in high school we did get the education with pictures of the STDs and we did watch the teacher put a condom on a, like a fake penis. And we watched them put in a diaphragm in a little clear uterus thing, and it was pretty cool. Yea but those were all very heterosexual messages so … mixed messages I guess ‘cause it’s like we [female sexual minorities] don’t use condoms.

Participant #6: [Safer sex for sexual minorities] is definitely not something being taught in school and definitely not something being offered as an alternative. It’s hard enough, I think, especially for schools to talk about safer sex when it comes to straight couples. Because a lot of them are very hell-bent on the abstinence and so it’s definitely something that’s not talked about and I really don’t know much about it and I don’t think society knows much about it either.

Other participants shared that the information they were told was limited to abstinence, so they sought out information on their own as a way to educate and support themselves and people around them:

Participant #2: Yea, I definitely learned a lot through the Internet. It was definitely through people on YouTube. A lot of YouTubers have been advocating for safe sex: watching videos, learning about safer sex, and stuff like that, kind of help.

Participant #12: Well coming from a sheltered community as I did, there really weren’t that many, it was usually just the only way to have safe sex is to not have sex. But I
actually did a lot of my own research online about it just because I don’t want anybody to be lost.

*Participant #11:* I go online to a women’s activist group or things like that [for more information]. And so, I’m a little bit more of a feminist so I follow a lot of these Facebook pages and they share things.

**Barriers.** All 12 participants offered their perspectives on psychosocial barriers to safer sex practices for lesbian and bisexual women in response to the question “What sort of barriers do you think might be present for lesbian and bisexual female couples that want to engage in safer sex practices?” The most frequently cited “barrier” to practicing safer sex was lack of education, knowledge, and awareness of safer sex practices and risks. Examples of these include lack of “information about the sex act” in general:

*Participant #1:* We’re just told not to have sex at all. And if we do, it’s to be within marriage. So as a lesbian high schooler, I didn’t know how to do sex.

*Participant #2:* I feel like growing up until college, I received nothing that was geared toward the LGBT community. It was all about male and female sex and so I knew nothing except what I learned on the Internet.

*Participant #5:* I guess it just needs to be talked about more. There needs to be more in health and in the 6th grade. It’s a thing now. Okay, we’re not hiding anymore. We’re here and it’s not a phase and we’re here to stay. So teach these fucking kids about all the different types of sex.
Participant #8: My mom doesn’t know how to have a safe-sex lesbian conversation with me so that doesn’t happen.

Participant #9: It might be a little more complicated for me just because I’m interested in sex education. … I’m building a sex education curriculum because I wasn’t informed about what sex entails.

Another example of a barrier outlined by the participants was lack of awareness of “methods of protection women could use:”

Participant #4: I didn’t even know about dental dams and everything like that until I got to college and took Health 160 and a lady came in from the Health Education Office. She came in, and she talked to us about all that stuff and I never knew it.

Participant #6: I just think the information isn’t all out there, isn’t all readily available. So maybe trying to figure out what safe-sex practices you can even use might be hard to just find.

Participant #12: I honestly don’t even think I know that many different methods that lesbian and bisexual women could use with other women. I actually don’t think I’ve ever been taught about that.
The final barrier identified by participants was lack of “focus on female same-sex” sexual activity and risks:

*Participant #7:* I feel like there’s a lot of the idea that a woman having sex with another woman is safer than having sex with a man. And while I know in some contexts, kind of true, but in some contexts, no, that’s not true at all. That’s a difficult one to address though because you can’t get pregnant but can you catch this and that.

*Participant #10:* I feel like it’s just not talked about and the messages about safer sex are way emphasized in gay and bisexual male relationships. But not really talked about in lesbian and bisexual women relationships. I feel like its all focused on gay men and AIDS still and it’s 2015.

**Frequency: Typical**

**Biological risk factors.** Eight participants discussed biological factors that can contribute to increased risks of contracting and spreading an STI. A consistent theme among these women was lesbian or bisexual women who have had or are having intercourse with men are “at a greater risk for contracting an STI.” Some attributed this to sexual promiscuity of men and the women who have sex with them:

*Participant #5:* Not going to do the politically correct thing, but I think anyone who is having straight sex is at the greatest risk.
Participant #7: I would say that I think bisexual women are probably at a little tiny bit higher risk because they would have sex with men. Whereas most lesbians don’t have sex with men, I feel that it just changes the list of stuff you could easily contract.

Participant #8: What I’ve heard a lot of is that bisexual women are promiscuous and are just destined to end up diseased anyways because they like both sexes and that automatically means that they’re going to have sex with everyone they can.

Participant #9: I want to say you’d be more likely to catch an STI from a man. …I would think that you might have more of a chance of catching something from male-female intercourse because penetration can lead to tearing and then there’s seminal fluid.

While others indicated an assumption that men simply always have STIs:

Participant #11: I dunno, maybe I’m a man hater? (laughing) I don’t think I’m a man hater though! But I always imagined that the original STI came from a guy and I guess I just presumed that men sleep around more.

Participant #3: I really only get tested because I have sex with men and I don’t trust them. I think that’s really the only reason I get tested. I had sex with a gay guy … I mean we used condoms and everything but you never know.

Finally, some of the participants disagreed on risks for lesbian and bisexual women, evidenced by the differences revealed in Participant 12 and Participant 6’s responses respectively.
Participant 12: I think lesbian women are at a greater risk for contracting an STI. Because I think at least for bisexual women, if they happen to be with a man at that time, then they know “Hey at least we can use a condom!” So that’s something.

Participant 6: I want to say bisexual women are more at risk just because I feel like the idea of intercourse in general just having slept with a man. It brings to mind a little bit more of a risk for STIs and STDs. But I think the biggest thing for lesbian and bisexual women [having sex with women], is just knowing who we’re sleeping with, who our partner is and things like that. In general, I think because of my knowledge of STDs and STIs in general with straight couples, it just seems that it would be prevalent with bisexual women who have had a male partner at one point.

**Belief of invulnerability.** Six participants noted invulnerability as a barrier to safer sex for lesbian and bisexual women. For some of these women, invulnerability was expressed in this way:

*Participant #3:* But there’s also an assumption that lesbian and bisexual women don’t have any STIs because they’re not being penetrated by a man … or lesbians for the most part at least.

*Participant #8:* I think we’re led to believe we’re invincible to those. Because we’re lesbians I guess. I don’t really hear much. Like even still, when I go to Spectrum, we get a blip of that safe-sex conversation and you know it’s obvious that we can get them but
it’s not obvious how and how to prevent them. Even still and all we know is that we have dental dams. Even still, that’s all we know. And it’s like, “Okay, what else?”

*Participant #2:* I think it’s because we don’t have the penis involved with our sexual activity that we kind of just think we’re immune to STIs. I think because of that, we think we’re immune because we don’t have that super intimate kind of thing.

One participant also disclosed a recent experience with a medical professional during an annual exam that gave her pause:

*Participant #4:* When I went to the doctor this past Thursday, and [what happened] was very ignorant of me, once I got up and she’d left the room and I thought, “Why the fuck would I say that?” ‘Cause she had asked me “Are you sexually active?” and I was like “Yea.” And she was like “Are you using protection?” I was like “No, I’m with a woman.” When she left I thought that’s stupid because being with a woman has nothing to do with having safe sex.

*Interviewer:* Did the doctor say anything to you after you answered her about being with a woman?

*Participant #4:* No! She didn’t make me elaborate, didn’t suggest I get tested, she didn’t say, ‘Well you can use a dental dam, you can use a female condom, you can use all this other stuff.’ She didn’t say any of that! She just left it at that. That makes no sense.

**Stigma and shame.** Seven participants discussed stigma and shame as a barrier. These women expressed feelings of awkwardness at the thought of talking about safer sex practices with other female sexual partners exemplified in the following quote:
Participant #2: It can be awkward a little bit, of course. You’re talking about some pretty serious things. And from just personal experience it can be a little awkward, but it also feels good to just know what you’re getting into. …It may be a little awkward, but you can make it not so awkward.

Others also detailed the idea that a lot of assumptions go along with discussing safer sex practices with new sexual partners. The primary assumption is the initiator of the discussion either assumes the other partner has an STI or is trying to protect her partner from an STI, which is exemplified by the following quote.

Participant #1: So, I know women do not like, lesbians specifically, they do not talk about STIs just because we don’t think that we have them. You know, and so if we were to ever talk about, say using a dental dam that would be really weird. You would probably be thought of as having STIs, is what I’m thinking.

Participant #6: It could have a taboo stigma for a lot of things if you’re not totally forthcoming about your past with your partner like ‘Why do you think we need this? Why do you think blah blah blah.’

Participant #7: I think there is stigma because there is this idea that women who are romantic or sexual with women tend to U-Haul and get together and marry, rather than just having casual sexual encounters. … You don’t need to engage in safe sex if you’re in a monogamous relationship and if you do, it’s because you’re being unfaithful or have something on the side.
Frequency: Variant

**Limited resources for safer sex practices.** Finally, five participants discussed lack of access to and money for testing or engaging in safer sex practices. Three participants noted they did not know where to buy female-friendly products such as dental dams. This is captured well by one participant:

*Participant #7:* Well you can get 5 free condoms a day at the health center but you can only get 1 free dental dam a day. I don’t know if you can get female condoms at the health center. So basic things like access would be a barrier.

Financial struggles can become a barrier, as shared by this participant:

*Participant #10:* What sort of barriers? Oh geez. Well, as far as, I feel like there are free clinics but getting yourself tested regularly could be costly. Buying the tools could be costly. Like condoms and stuff. Keeping a regular supply could be costly.

**Discussion**

This qualitative study of 12 sexual minority women college students (ages 19-25) used consensual qualitative research (CQR) to explore the psychosocial barriers to safer sex practices for lesbian and bisexual women. Although research in the areas of STIs among female sexual minorities (e.g., Everett, 2012) and sexual behavior and rates of STIs (e.g., Lindley et al., 2008) has garnered some attention from research communities, little research has been conducted to understand psychosocial barriers to safer sex for female sexual minorities. In order to fill in the literature gap, semi-structured interviews were used to elicit the subjective experiences of participants. Domains and core ideas emerged from the data that represented these participants’ psychosocial barriers to safer sex practices.
The four domains, including one domain with four subcategories (Table 1), were repeated across participants and within individual participant interviews, and were relevant to the research topic. A great deal of consistency was present across all interviews. The majority of domains and subcategories identified occurred in all or most interviews, save for one subcategory: limited resources for safer sex practices. Many findings from the current study were consistent with those from similar studies using quantitative methods (e.g., Fortenberry et al., 2002; Jones et al., 2011; Stanger-Hall & Hall, 2011), but this is the first study known to date to use an exploratory, qualitative approach to investigate the broad concept of psychosocial barriers to safer sex practices for college-aged, sexual minority women.

Using this methodology, the four domains that emerged were: methods for safer sex practices, messages received regarding safer sex practices, biological risk factors related to STI risks, and barriers to safer sex practices. The domain *barriers to safer sex practices* included four subcategories: lack of money and access; lack of education, knowledge, and awareness; belief of invulnerability; and stigma and shame. In the following section, domains and subsequent subcategories will be further discussed in the context of the existing research. Limitations of the study and the CQR methodology, as well as directions for future research will be highlighted below.

**Safer Sex Practices**

The first domain was developed based upon participants’ responses regarding methods of safer sex practices. This included core ideas related to physical barrier-methods, such as dental dams or male/female condoms, and core ideas related to sexual health practices, such as regularly being tested for STIs. It also included a component of interpersonal relations in which participants highlighted the importance of discussing sexual history or risk-taking behaviors
(e.g., intravenous drug use) with a sexual partner. This result suggests these women have some sense of different options for safer sex practices. One caveat, however, is many of the safer sex options discussed by participants were described to them in the context of heterosexual sex which they had to then translate into messages that were applicable to sex with women partners. This resulting translation leads to the next domain—messages about safer sex.

**Messages About Safer Sex**

Messages about safer sex reported by participants were coded as such if they endorsed external messages they received about safer sex practices. Much as Jones et al.’s (2011) study found information on safer sex practices was sporadic and subtle or indirect, the women in this sample perceived their experiences with safer sex information to be limited or non-existent. For the majority of participants, these messages included abstinence-only discussions, and when sex was discussed it focused on heterosexual couples in the context of marriage. These narrow discussions led to many of the women reportedly seeking outside sources for information on the ‘how-tos’ for female same-sex sexual activity and sexual health. Similarly, Jones et al.’s participants reported nearly 70% of their information on sexual health came from social media (including television, movies, magazines, and the internet).

**Biological Risk Factors for Contracting an STI**

The third domain was developed based upon the participants’ experiences and perceptions of biological risk factors for contracting an STI. These were coded as such when the women talked about increased risk factors for contracting an STI. The most frequently cited biological risk factor reported by the women had to do with whether and if a woman has had sex with a man. For many, the assumption was men are the carriers of STIs and if a woman did not have sex with a man, she would remain clean. It is true women are more likely to contract an
STI when having unprotected sex with an infected male partner than a man is to contract an STI when having sex with an infected female partner (CDC, 2014). Even further, bisexual women, or women who have sex with women and men, are likely to report a higher lifetime rate of STIs than lesbian or heterosexual women (c.f., Koh et al., 2005). This finding suggests while the participants may have been unaware of the reality of bisexual women’s risks for contracting and spreading STIs, they were cautious of those women who have sex with men.

For other participants, perception of risk for contracting an STI focused on which population would be more likely to use safer sex practices. These participants perceived lesbian women to be less likely than bisexual women to use protective practices during sex. One reason for this line of thinking may be related to the heterosexually focused safer sex education mentioned above. That is, some participants may have expected women who have sex with men (i.e., bisexual women) to have received adequate information about safer sex, and thus to know how to protect themselves and then follow through with it. Additionally, some of the participants disclosed they themselves do not engage in safer sex practices with their female partners due to social pressure related to stigma and shame, as discussed in the next section.

**Barriers to Safer Sex Practices**

The fourth domain, barriers to safer sex practices, was developed based upon participants’ discussion of psychosocial factors that may have prevented the use of safer sex practices. Data revealed four subcategories with regard to barriers to safer sex practices. While all participants discussed barriers to safer sex practices, they did not all discuss the same subcategories.

**Limited resources.** The first subcategory, limited resources for safer sex practices, was categorized as variant in frequency, as less than half of the women interviewed discussed these
Lack of access focused primarily on the perception of limited availability of facilities providing STI testing services to female sexual minorities or sell protective products. Lack of finances included not having enough money to pay for STI testing or prophylactics. This finding is consistent with other health care literature, which has found limited resources significantly impact health equity across the U.S. (e.g., Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010). In the United States, for example, people living in the Southern states—17 states including Washington D.C.—are more likely to report lower access to and quality of care than the three other regions (Adimora, Ramirez, Schoenbach, & Cohen, 2014). As a result, the South, where 37% of the U.S. population lives, has the highest percentage (nearly 45%) of new cases of HIV.

Of interest in this study is that four of the five women who discussed limited resources as a barrier were women of color. This may suggest an understanding of the vulnerability communities of color have with regard to disease prevention and health care (Barr, 2014). Race/ethnicity is often an indicator of socioeconomic status (SES) in the U.S. In many areas of the country, racial and ethnic minorities are more likely to live in poverty, experience poorer health conditions, and lower educational attainment (American Psychological Association, 2016). These social conditions contribute to decreased opportunities to access preventative care, which provides an explanation for why STI rates are significantly higher among racial and ethnic minorities than whites (Barr, 2014).

Perhaps one reason this subcategory was infrequently cited is because most college campuses offer low-cost/free STI testing opportunities and prophylactics. It may be the participants who reported these barriers were unaware of the existence of low-cost/free services. If so, this subcategory appears linked to the second subcategory: lack of education, knowledge,
and awareness. Alternatively, participants who contributed to this subcategory may have been reporting what they believed women outside the university setting might view as barriers to safer sex practices.

**Lack of education, knowledge, and awareness.** All of the participants discussed lack of education, knowledge, and awareness as a barrier to safer sex practices. Some women noted a lack of discussion by both the LGBT community as well as the majority community regarding same-sex sexual activity and related risks. For many, information about the sex act (sex between two women) was nearly non-existent. As a result, they were compelled to learn about sex and risks on their own before they became sexually involved with other women. Those who did their own research reported feeling emboldened to educate those around them while others were content to share the information strictly within the romantic relationship. Several participants also reflected that, prior to participating in the study, they were relatively unaware of methods of protection for women to use with other women. This resulted in disclosures of risky sexual activities with other women and the sober discovery that women can always be at risk of contracting an STI.

Other studies have found similar results for college students in general regarding education, knowledge, and awareness of safer sex practices. Walcott, Chenneville, and Tarquini (2011) sought “to examine the relationship among perceptions of previous sex education and current knowledge, attitudes, and sexual behavior among college students” (p. 831). They did this by comparing the types of sexuality education (abstinence-only v. comprehensive) college students reported receiving through middle and high school. The results suggested only two elements of sex education programs were significantly associated with safer sex behaviors: perceived helpfulness and teaching of negotiation, communication, and peer pressure refusal.
skills. Those who endorsed the use of safer sex practices commonly reported these two elements and reported greater norms toward and positive attitudes about safer sex.

In relation to the current study, it can be assumed the participants found very little of the information they received through sex education to be helpful—hence the seeking of information. Further, these women may not have been adequately equipped with the negotiation skills to introduce safer sex practices in their same-sex sexual encounters. This relates to the negative endorsement of using safer sex practices when having sex with another woman due to stigma and shame.

**Belief of invulnerability.** Half of the participants reported a belief of personal invulnerability. Statements about invulnerability were coded as such when women discussed believing female sexual minorities, especially lesbians, were not at risk for contracting an STI. This construct aligns with the belief of invincibility (Elkind, 1970, cited by Wickman, Anderson, & Greenberg, 2008). This belief is often correlated with the increased likelihood youth will engage in risky behaviors such as unprotected sex and sex with multiple and/or high-risk partners (CDC, 2009). The belief of invulnerability is also consistent with many studies, which found women-with-women sexual contact was assumed to preclude STI transmission (Marrazzo et al., 2005; McNair, 2005; Namaste et al., 2007; Power, McNair, & Carr, 2008). Moreover, anecdotal information (e.g., the interaction between one participant and a health care provider described above) may point to lack of attention by the medical community to female sexual minorities’ sexual health risks.

General beliefs of invulnerability against negative consequences are developmentally common for emerging adults. Since the average age of participants in this study was 20.6 years old, the belief of invulnerability not surprising. Beliefs of invulnerability are not only restricted
to risky sexual behaviors. Ravert et al. (2009) found “emerging adult college students engage in a high degree of health compromising behavior” (p. 767). Of the 1690 college students who participated in the study, over 20% reported driving while intoxicated and over 40% reported riding with someone who was intoxicated in the last 30 days. Further, nearly half the participants reported having sex while drunk or high. Exploring other health related behaviors, Greenhawt, Singer, and Baptist (2009) examined food allergy trends and behavioral attitudes of college students. Their goal was to understand risks for fatal food allergy-induced anaphylaxis. The results suggested of the 513 students surveyed, 57% reported an allergic reaction to food but only 40% of them avoided foods they were allergic to and only 6.6% reported carrying self-injectable epinephrine.

Even in less life threatening scenarios, emerging adults are likely to engage in health compromising behaviors. Rawool and Colligon-Wayne (2008) examined auditory life styles of college students. They found nearly half of the participants used noisy equipment without protection and 66% had experienced tinnitus and most were unconcerned. The researchers noted while most of the participants considered hearing loss to be serious, they also believed they would not lose their hearing until much later in life and subsequently did not use hearing protection devices.

**Stigma and shame.** More than half of the participants also discussed stigma and shame as a potential barrier for safer sex practices. This finding supports that of Martson and King (2006) regarding use of protection as a symbol of distrust. In the current study, distrust occurred as a result of women having sex with men. That is, the majority of participants expressed the view lesbian or bisexual women who had sex with men were “less-than” and undesirable sexual partners; they were seen as tainted by men. This concept has appeared elsewhere in the form of
a within-group stereotype among lesbian women, known as the “gold star lesbian.” The phrase refers to a lesbian who has never had sex with a man, and elevates the status (i.e., desirability) of such a person over a lesbian who has had sex with a man. Not surprisingly, then, stigma reported by participants in this study was associated with the assumption that to discuss safer sex practices is to assume one’s female sexual partner has had sex with a male sexual partner in the past. An overwhelming majority of participants viewed women who had sex with men as the primary source of STIs within the LB community, though they often expressed guilt about holding this belief.

Also related to stigma and shame, and consistent with Fortenberry et al.’s (2002) findings, the participants acknowledge fear of social repercussions played a role in whether they used safer sex practices. Participants reported there were times when they did not introduce barrier methods because they did not want to be seen as hiding something. Specifically, they did not want to be seen as hiding a sexual history with a man. Finally, the women noted embarrassment at the prospect of purchasing safer sex products. Their embarrassment signified shame might have prevented them from engaging in safer sex practices.

**Study Strengths and Limitations**

As an exploratory qualitative study, the research has both strengths and limitations. Strengths of the study include the methodology, representativeness of the population, and diversity of the sample. Limitations of the study include limitations to qualitative methodology, demographics of the research team, biases in questionnaire development, and limited ability to generalize results.

**Strengths.** Strength of the methodology used in the current study is CQR is well suited to explore phenomenon about which there is limited understanding. Qualitative methods,
including CQR, are appropriate for studies aiming to provide descriptions of the personal experiences of a small group of people. It also allows the researcher to describe the phenomenon in rich detail while taking into consideration the participants’ context and unique perspectives. The current study attempted to focus on the experiences of lesbian and bisexual women to explore their subjective and personal perspectives on barriers to safer sex practices. The data were saturated for the study, meaning by the last few participants, no new domains or subcategories emerged from the data.

The demographics of the participants in this study were fairly representative of the range of self-selected, sexual minority women attending mid-sized, Midwest universities. This is true with respect to age (19-25 years old), year in school (first year undergraduate student through graduate student), race/ethnicity (Black, African American, Hispanic, White, and Caucasian), and self-identification of sexual orientation (pansexual, bisexual, lesbian, and homoflexible). It was also apparent in the participants’ relationship status (single or partnered), the biological sex of their partner (male or female), the gender identity of their partner (transgender, woman, and man), whether or not they had sexual contact with another female, and how involved they were in the LGBTQ community. Therefore, the data gathered included thoughts and experiences from female sexual minority students in a variety of social locations, allowing for a wealth of views and experiences.

**Limitations.** As with any method, limitations must be taken into account when interpreting the findings. The limitations of this study primarily relate to the use of qualitative research methods and CQR specifically. While CQR attempts to control for bias among research team members, each member views the data through their own lens, which could impact the interpretation of the data. The demographic composition of the research team, while in some
ways a strength to the study as it provides a diversity of perspectives, could also have contributed to bias. The all-White research team included one gay man and two sexual minority women and two heterosexual women (including the auditor). It is possible cultural identities, such as gender, race, or sexual orientation may have biased how the research team coded and interpreted the results, as the research team is exploring and coding interviews through their own unique lens. For example, the all-White research team may not have been aware of or correctly interpreted the experiences of the women of color in the study. CQR attempts to control for bias among research team members by encouraging members to acknowledge their biases on the topic and participants to the rest of the group. This was done to ensure biases could be examined throughout the data interpretation process to prevent any undue influence on the creation of domains, categories, and cross analysis.

The semi-structured interview questionnaire may have also restricted participants’ responses. The questionnaire and individual interviews were developed and conducted by the PI. As a result, the interviews were guided by the PI’s decision to explore responses and move through the interview protocol. While the questions were open-ended, the content of the questions guided participants’ responses to specifically focus on messages, experiences, and barriers to safer sex practices. Though some of the same domains and subcategories may have emerged if participants had been invited to freely discuss safer sex for female sexual minorities, the probability of the same frequency of responses may have varied greatly. For example, there were no domains or subcategories with the frequency rare. Results of less structured interviews may have revealed rare responses. In order to explore this possible restriction, it would be beneficial to create a less structured interview protocol and even conduct the interviews as focus groups rather than one-on-one interviews.
While the information gathered from participants was detailed, rich, and compelling, it was also limited in scope. The above results and discussion represent a one-time individual qualitative interview with just 12 participants from one campus; therefore, generalizing the findings to other college populations of lesbian and bisexual women should be done with appropriate caution. Random samples of female sexual minorities are nonexistent because it is difficult to clearly identify these populations without self-reporting, and subsequently there is no effective way to compare these results to the general population. The use of convenience sampling, for instance, may have resulted in the self-selection of lesbian and bisexual women who were more comfortable discussing sexual activity, more comfortable with their sexual orientation identity, and more accessible through technology than the average lesbian or bisexual woman. Therefore, it cannot be assumed these factors describe the general population of lesbian and bisexual college women. Assuming this particular sample does represent female sexual minorities as just described, it is likely the actual usage and understanding of safer sex by the majority of female sexual minorities is even lower. Beyond these limitations, however, these findings contribute to the understanding of barriers to safer sex practices for lesbian and bisexual women.

**Directions for Future Research and Interventions**

In future research studies, quantitative research methods should be used to survey a larger, more representative population of lesbian and bisexual women to gain further understanding of messages, experiences, and barriers to safer sex practice. Additionally, further research should compare the experiences of non-college student women with college student women, and how these differing statuses affect access to and use of safer sex practices.
The exploratory nature of the study makes it hard to identify what barriers to safer sex practices are specific to female sexual minorities vs. heterosexual females. Future research should use quantitative approaches in order to test whether and if the barriers identified in this study are present among all sexually active women. It could be hypothesized lack of education, knowledge, and awareness; belief of invulnerability; and stigma and shame are unique experiences of female sexual minorities.

The current study brought up discussions around bisexual erasure and biphobia (defined as aversion toward bisexuality and bisexual people). Future research should explore the effects this belief has on negotiating safer sex practices. It may be stigma and shame are directly linked to feelings of biphobia for female sexual minorities and, as a result, decrease the likelihood prophylactic negotiation will occur.

As evidenced in one participant’s experience, there also may be a lack of attention from medical professionals in the discussion of safer sex, particularly for female sexual minorities. This lack of discussion of patient sexual practices by health care providers has appeared in other studies. Sobecki, Culrin, Rasinski, and Lindau (2012), examined OB/GYNs’ practice of communicating with patients about sexuality. The study found, while most providers discussed sexual activity, they did not talk about “sexual identity or orientation, satisfaction, pleasure, or sexual problems/dysfunction” (p. 1293). Gott, Galena, Hinchliff, and Elford (2004), used qualitative interviews to evaluate general practitioners and nurses’ barriers to discussing sexual health concerns. Results suggested, for the participants, discussing sexual health is difficult. Partially it was due to the limited time one has with a patient and a fear if sexual health were discussed, it would “open a can of worms” (p. 531) requiring more time than could be provided. With regard to sexual minority patients, participants disclosed they felt uncomfortable discussing
non-heterosexual practices, and had difficulty reconciling their views of non-heterosexual orientations with their clinical practice. In other words, many of the participants in Gott et al.’s study perceived non-heterosexual sexual orientations as abnormal and felt ill equipped to treat sexual health concerns of sexual minorities.

Taking the results of the current study together with the findings of Sobecki et al. and Gott et al., a potential intervention would be to specifically target medical health professionals. By providing education on female sexual minorities’ risks of contracting STIs, barriers to safer sex practices, and reducing the stigma around sexual health conversation, this vulnerable population of women will have more opportunities to protect themselves. Specifically on a college campus, working with student health centers, women’s centers, health education and wellness offices, and health science departments can enhance the impact of the information provided.

Future implications of these findings suggest a population of sexually active adults who have little-to-no information about safer sex practices. While many of the women were able to identify safer sex methods, they were unaware how to access the materials. Many women also shared even within the context of LGBTQ affirmative groups, sexual health needs of female sexual minorities were often left out of the discussion. Providing psychoeducational opportunities and outreach services to female sexual minorities may help support these women’s needs and desires for education and knowledge. As a result, it may also destigmatize and normalize the discussion and use of safer sex practices among lesbian and bisexual women who are having sex with women.
Conclusion

Limited attention has been paid to lesbian and bisexual women’s barriers and risks for STIs, yet these women are as likely as their heterosexual counterparts to report contracting an STI in their lifetime (McNair, 2005). While the sexual and gender minority communities create a secure and open environment for discussions, female sexual minorities continue to experience a lack of attention with regard to their sexual activity. In this way, many of these women are left seeking information on their own with limited discussion between themselves and people close to them.

The current qualitative study explored psychosocial barriers to safer sex practices for female sexual minorities. The participants’ quotes were used to show an eclectic array of barriers to engaging in safer sex practices. Their responses were grouped into the following subcategories: limited resources; lack of education, knowledge, and awareness; belief of invulnerability; and stigma and shame. After participating in the study, almost all of the women reported worry for other female sexual minorities who are not aware of the issues raised in this study. Perhaps a 21-year-old participant who identifies as lesbian best summarizes this shared experience:

It worries me about our community just because it’s not talked about so what are people doing? I don’t know! I’ve talked about it with my friends and most lesbian or bisexual women don’t practice really safe sex. It worries me a little bit. I really wish that the world would just talk about it!
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doi:10.1177/0743558411400908


doi:10.1097/01.olq.0000175417.17078.21


Appendix A

Initial Letter

Dear Participant,

My name is Kodee Walls, M.A. and I am currently a doctoral student in the Counseling Psychology program at Ball State University, Muncie, Indiana. I invite you to participate in a study that examines intimate relationships for lesbian and bisexual women. To be eligible to participate in the study you must meet the following criteria:

- Identify as a lesbian or bisexual
- 18 years of age or older
- Currently attending Ball State University

If you believe that you meet the above requirements, please consider being involved in the research study.

The purpose of this research is to explore the experiences of lesbian and bisexual women as they relate to safer sex practices. The goal of the study is to advance the research fields in understanding of perceived barriers to safer sex practices by women who identify as sexual minorities.

By participating in this research, you will have the opportunity to discuss your personal beliefs and attitudes toward safer sex practices for lesbian and bisexual women. No studies to date have specifically explored this issue in women who identify as lesbian or bisexual. This research could be especially useful for professionals who work with individuals (especially college-aged women) and assist them in better understanding the experiences of lesbian and bisexual women.

If you agree to be considered as a possible participant in the study, your initial questionnaire will be screened and a decision will be made whether you meet the requirements for the next stage of the study. If you do, I will then contact you to set up a time that is convenient for you to complete a face-to-face interview. When we meet, I will again briefly introduce the study, remind you of the information that was presented on the consent form, and answer any questions you may have before beginning the interview itself. For the interview, I will ask a series of questions. The total interview should between 30 and sixty minutes in total.

In exchange for your participation you will be entered into a drawing for a chance to win a $25 Amazon gift card OR you will be eligible for research credit for a Counseling Psychology course.

There are no foreseen risks involved in the study; however, you will be provided with referral information to your college counseling center should any psychological distress come from the interview. I have included in the email an informed consent for you to review and sign.
I am looking forward to learning more about the personal experience of lesbian and bisexual women as it relates to safer sex practices and hope that you will consider being an essential part of this research project. I am passionate about this area of research and hope that with your help, we can gain a better understanding of barriers to safer sex practices for lesbians and bisexual women.

If you are interested in participating in the study, you may reply to this email with contact information so that I may contact you about the interview. If you have any questions regarding the study or the procedures, you may contact me via email at klwulff@bsu.edu.

I look forward to hearing from you and thank you for considering being a participant in this study!

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Appendix B

Informed Consent

**STUDY TITLE:** Intimate relationships for lesbian and bisexual women

**Purpose of the Research:**
The purpose of this research is to explore the experiences of lesbian and bisexual women as they relate to safer sex practices. The goal of the study is to advance the research fields in understanding of perceived barriers to safer sex practices by women who identify as sexual minorities.

**Rationale:**
No studies to date have specifically explored the personal experiences of lesbian and bisexual female college students and their perceptions of safer sex practices. This research could be especially useful for health care professionals who work with women (especially college students) who identify as lesbian or bisexual.

**Inclusion criteria:**
To be eligible to participate in this study, you must be a female older than 18 years of age, personally identify as lesbian or bisexual, and attend Ball State University. You also must be fluent in English.

**Explanation of Procedures:**
For this study you will initially be asked to fill out this informed consent and a contact form, and email these back to the principal investigator (PI). Once you have emailed the consent form and the contact form to the PI, she will contact you via telephone in order to ask you a few demographic questions and to make initial contact. Along with the collection of information, if you meet criteria for the study, you will be invited to set up an appointment for a one-on-one, face-to-face interview. The phone conversation should take approximately 5-10 minutes. The face-to-face interview, which will be set up at a time that is convenient for you, will last roughly 30-60 minutes.

**Audio Recording:**
For the purpose of accuracy, with your permission, the interviews will be audio recorded. Any names used in the audio recording will be changed to pseudonyms (fake names) when the recordings are transcribed. The recordings will be destroyed after they are transcribed and the transcriptions will be kept as password protected files on the principal investigator’s computer for three years and will then be deleted.

**Confidentiality:**
Any and all information that is shared with the principal investigator and the research team is private and confidential. Name and other identifying information will not be used in the reporting of the data. Written data will be saved on the principal investigator’s computer for three years and will then be deleted. Only members of the research team will have access to the data.
**Risks:**
Participation in the proposed study would include minimal risk to you. Minimal but disturbing psychosocial distress could occur while discussing your personal experience as a lesbian or bisexual woman, your perceptions of safer sex practices within the lesbian and bisexual women community, and perceived barriers to safer sex practices. Counseling services are available to you through The Counseling Center at Ball State University (765-285-1736) if you develop uncomfortable feelings during your participation in this research project. You will be responsible for the costs of any care that is provided [note: Ball State students may have some or all of these services provided to them at no cost]. It is understood that in the unlikely event that treatment is necessary as a result of your participation in this research project that Ball State University, its agents and employees will assume whatever responsibility is required by law.

**Benefits:**
The current study may directly benefit you by allowing you to have a safe environment to talk about your experiences (positive and negative) of barriers to safer sex practices as a lesbian or bisexual woman. This study could also help researchers better understand the experience of lesbian and bisexual women who are interested in safer sex practices.

**Compensation:**
If you are found eligible after the brief screening telephone questionnaire to participate in the study and begin an interview, you will have the option of either accepting 1-2 hours of research credit (depending on the amount of time it takes for the interview) for a CPSY course or being entered into a drawing for a $25 Amazon gift card. You can only choose one option. Additionally, if at any point you begin the interview you decide to end or withdraw from participation, you will still receive the research credit or be entered in the drawing for the gift card.

**Withdrawing from the Study:**
Participation in this study is completely voluntary and you are free to discontinue participation at any time without question from the investigator.

**Cost of Participation:**
There is no cost to participate in this study. The only exception that might be if you give the principal investigator a cellular telephone number to call for the telephone interview, then you are responsible to pay for any minutes used on your personal cellular telephone.

**Questions:**
If at any time you have questions regarding your rights as a subject, please contact The Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5070, irb@bsu.edu.

If at any time you have questions regarding the researcher, Kodee Walls, M.A., please contact Dr. Sharon Bowman, Ph.D. at (765) 285-8040 or sbowman@bsu.edu.
Additionally, you may ask Kodee Walls, M.A. at (765) 702-5914 or klwulff@bsu.edu any questions before, during, or after the telephone interview. Please also contact Kodee Walls, M.A. should you have questions to research related injury.

Do you wish to have the results and explanation of the study sent to you via email at the conclusion of the study? No_____ Yes _____

******************************************************************************

Consent
I, ________________, agree to participate in this research project entitled, “Safer sex for Lesbian and Bisexual Women.” I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I will receive a copy of this informed consent form to keep for future reference.

To the best of my knowledge, I meet the inclusion criteria for participation (described on the previous page) in this study.

__________________________________________________________
Participant’s Signature (Electronic) Date

Research Contact Information

Principal investigator: Faculty Supervisor:

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Appendix C

Telephone Screening Questionnaire

Directions to be read to potential participant: Please answer the following questions in a way that most consistently describes your experience.

1. Age (in years): __________

2. Biological sex (ex. male, female, intersex): __________

3. Gender identity (ex. male, female, trans, queer, etc.): __________

4. Sexual orientation (ex. gay, lesbian, bisexual, queer), etc.): __________

5. Race: __________

6. Nationality: ________________

7. Are you fluent in English: YES _______ NO _______

8. Year in school (ex. freshman, sophomore, graduate student, etc.): ________________

9. Current place of residence (ex. on campus, off campus, with parents/guardians, etc.): ________________

10. How much do you feel you know about safer sex practices for LGB people?
    A great deal _______ Some _______ Very little _______ None at all _______

11. Would you be willing to participate in a 30-60 minute audio-recorded interview?
    YES _______ NO _______
Appendix D

Research Team Demographics

Research team demographics are listed below in the following order: age, gender, race/ethnicity, sexual orientation, level/year in education at time of analysis and coding, areas of research interest, and educational experiences with safer sex.

Primary Researcher:
28-29, Female, White, bisexual, third-fourth year doctoral student, LGBT issues and multiculturalism, abstinence-only education throughout secondary education and comprehensive education post-secondary.

Research Team Member:
26, Male, White, gay, first-second year master’s student, diversity and multiculturalism especially African-American and LGBT communities, religion and spirituality, and intersection of these identities, and abstinence-only in secondary education.

Research Team Member:
23-24, Female, Caucasian, pansexual, first-second year master’s student, gender, sexuality/sexual orientation, and emotion regulation, and abstinence-only in secondary education, comprehensive post-secondary.

Research Team Member:
34, Female, Caucasian, heterosexual, second-third year doctoral student, trauma and minorities, specifically refugees, immigrants, and the disabled and the effects of cumulative trauma that is passed down from generation to generation, social justice with focus on immediate interventions, and diversity issues, and abstinence focused education with some discussion of contraceptives.
Appendix E

Semi-structured Qualitative Interview

1. Before we get started, I want to get to know you a little bit. I’m wondering if you could share with me, you’re in college, maybe this is the first time you’ve been away from home, what does this time in your life mean to you? (If she asks for clarification: Is it a time for defining yourself? Of unpredictability? For settling down? For focusing on you? Or something in between?)

2. Tell me a little bit about your personal experience of identifying as a LB woman. (Invite her to share her coming-out story [including but not limited to coming-out to self, significant other, family, etc.]).

3. What are your perceptions of the LB community as a whole?

4. When you hear the words “safer sex” what comes to mind?

5. In general, what sort of messages have you received regarding safer sex practices?

6. What sort of messages do you think LB women receive regarding STI/STDs?

7. Do you think LB women are at risk for contracting STIs? Please explain.

8. Do you believe bisexual women are at a greater risk for contracting STIs than lesbian women? Please explain.

9. If two LB women want to have sexual contact, can you list a few things they might do to engage in safer sex?

10. What sort of barriers do you think might be present for a LB couple who want to engage in safer sex practices?

11. Is there anything about your experience as a self-identified LB woman, safer sex practices for LB women, or STD/STIs risks for LB women that we did not discuss but you feel is important for me to know?
Appendix E

**Extended Literature Review and References**

Historically, literature on sexual health compared men vs. women, and gay men vs. heterosexual adults, while paying little to no attention to lesbian or bisexual women who have sex with women. Although researchers have continued to study sexual health risks among heterosexual adults, and gay and bisexual men, existing literature provides an inadequate understanding of sexual health risks, including barriers to safer sex practices, for lesbian and bisexual women. The lack of attention to lesbian and bisexual women perpetuates the inaccurate assumptions, even within the LGBT community, that their sex activities are inherently safe (Marrazzo, Coffey, & Bingham, 2005).

This extended literature review outlines the need for psychologists to give greater attention to the sexual health of lesbian and bisexual women. To achieve this aim, the author will address the following topics: (a) sexual behavior in the United States, (b) sexually transmitted infections (STIs) and rates that result from engaging in unsafe sexual practices, (c) safer sex practices in the United States, (d) psychological impact of contracting an STI, and (e) risks and rates unique to women who are sexual minorities. This review also incorporates literature related to barriers to condom use among heterosexual couples and gay/bisexual men, as the literature specifically focusing on barriers to safer sex practice for lesbian and bisexual women remains limited.

**Sexual Behavior in the U.S.**

In the U.S., the spectrum of behaviors considered “sexual” by one group or another is vast. The range of generally accepted behaviors amongst heterosexual couples, for example, may differ from those behaviors accepted by lesbian and bisexual (LB) women. Foundational
knowledge about the prevalence of various sexual behaviors in the U.S. is crucial to facilitating psychologists’ understanding of the barriers to safer sex for LB women. Safer sex is the use of barrier methods during oral, vaginal, and/or anal sex to reduce risks of contracting or transmitting STIs (Planned Parenthood Foundation of America, 2014). In turn, this knowledge may enhance psychological research and clinical practice when working with this population.

In the United States, the largest study done on human sexuality can be found in The Kinsey Reports, a two-volume series comprised of Sexual Behavior in the Human Male and Sexual Behavior in the Human Female (Irwin, 2010). Much of Kinsey’s data were collected between 1948 and 1953; however, the Kinsey Institute at Indiana University continues to update information on various sexual activities. One finding remaining constant is participants report a variety of activities they consider to be sex, including anything from kissing a partner to penetration by a non-human object such as a dildo (Sanders et al., 2010). For example, Sanders et al. (2010) found nearly 45% of participants included manual-genital stimulation as a type of sexual activity. In addition, 71% of participants felt performing oral sex was sex and 80.8% considered anal sex to be sex. “Considerations of ‘sex’ also varied depending on whether or not a condom was used, female or male orgasm, and if the respondent was performing or receiving the stimulation” (Sanders et al., 2010, n.p.n.). Overall, this suggests little uniformity of what activities define sex in the general public’s opinion.

Similarly, according to findings from the National Survey of Sexual Health and Behavior (NSSHB), when U.S. adults engage in sexual activity, a variety of sex acts are reported during a single encounter (Herbenick et al., 2010). It is not uncommon for people to report oral sex in addition to vaginal sex in a single sexual encounter, for example.
Herbenick et al.’s (2010) findings suggest men and women engage in a variety of sexual activity throughout their lifetime. The researchers explored rates of both solo and partnered sexual activity in the last month for males and females ages 14-94. While not longitudinal, the study does provide information on lifespan sexual behavior. The majority of men aged 70 or older, or those aged 25-29, reported performing solo masturbation (27.9% and 68.6%, respectively; Herbenick et al., 2010). Men’s frequency of having vaginal intercourse was also high, though percentages decreased across cohorts: from 85% of those in their 20s and 30s to 73.6% in their 40s and 57.9% of those in their 50s (Herbenick et al., 2010). Males in all age groups reported partnered noncoital behaviors (mutual masturbation and receiving/performing oral sex) with female partners. Boys aged 14-15 were least likely to report partnered noncoital behavior while men aged 25 to 49 reported the highest proportions (between 20.5% to 49.4%; Herbenick et al., 2010). Insertive anal intercourse—gender of partner not reported—was less common than other partnered behaviors, with the highest rates (just above 10%) reported by men aged 25-29.

Over 20% of women across all age groups reported performing solo masturbation (Herbenick et al., 2010). Women aged 25-29 reported the highest rates in the past month, with nearly 52% reporting solo masturbation. Vaginal intercourse in the past month was the sexual behavior most reported by women over the age of 18. Much like their male counterparts, there was a decline in female reports of vaginal intercourse in older cohorts. The highest percentage of vaginal intercourse was among women aged 25-29 (74.3%), followed by 63.5% of women aged 30-39, 55.8% of women aged 40-49 and 39.9% of women aged 50-59.

Regarding self-identified sexual minorities and same-sex sexual behaviors, little information was reported in the overall findings by NSSHB (Herbenick et al., 2010). That being
said, while the study found 7% of adult women and 8% of adult men identified as lesbian, gay, or bisexual (LGB), the total percentage of people who reported some type of same-sex sexual activity was much higher (Herbenick et al., 2010). This suggests a discrepancy between self-reported sexual orientation and self-reported sexual behaviors.

While reported same-sex sexual behaviors were relatively uncommon for both men and women, for the most part, participants reported similar types of sexual behaviors regardless of the gender of their partner. Between 4.8% and 8.4% of men aged 18-59 reported receiving oral sex from another man; similarly, 4.3% to 8.0% of men reported performing oral sex on another man (Herbenick et al., 2010). Receptive penile-anal intercourse was the least common behavior reported, with less than 6% of men in all age groups reporting the behavior. Fewer than 5% of women in all age groups reported receiving oral sex from another woman, with the exception of women aged 20-24 (8.5%). A range of 2.0% to 9.2%, depending on cohort, reported having performed oral sex on another woman in the last year. Information regarding performing or receiving other types of sexual behavior from another woman were not specified.

Reece et al. (2010) reported while individuals engage in a variety of sexual activity, regardless of their sexual partners’ gender, safer sex practices vary by age cohort. Sexually active men and women over the age of 40 are least likely to report condom use, while male teenagers 14-17 are most likely to report using a condom during the last eight of ten vaginal intercourses (Reece et al., 2010). The lack of condom use in adults 40 and older may be the result of decreased overall concern for pregnancy or the decreased likelihood of exposure to multiple new partners. Among college-aged populations, men aged 18-24 reported using condoms an average of five times in the last ten vaginal intercourses; women aged 18-24
reported using condoms four times in the last ten vaginal intercourses. Information on condom use during anal intercourse was limited due to the low occurrence of the behavior.

Sanders et al., Herbenick et al., and Reece et al.’s research offer a detailed picture of sexual behavior throughout the lifetime. In general, the sexual repertoire of an individual varies as he or she ages and appears to be the most dynamic in his or her 20’s. By identifying more detailed patterns of behavior and safer sex practices, these studies provide a foundation for psychologists, and specifically counseling psychologists, involved in health-related policy and practice. With regard to STIs, a brief discussion of the most common STIs and their biological, as well as psychological, impact will now be presented.

**Sexually Transmitted Infections**

STIs, like any other illness or infection, are classified in two ways: bacterial or viral. The main difference is bacterial STIs can be cured and viral STIs cannot. The most common bacterial infections in the United States are chlamydia, gonorrhea, and syphilis (CDC, 2014f). One infection uniquely experienced by women and exacerbated by sexual activity is bacterial vaginosis. Common viral infections in the United States include human papillomavirus (HPV), herpes simplex virus, and human immunodeficiency virus (HIV), which can turn into acquired immune deficiency syndrome (AIDS; CDC, 2014f).

**Bacterial STIs.** Bacterial STIs are spread primarily through sexual contact, which includes oral, anal, and vaginal sex. Chlamydia is the most commonly reported STI and has been since 1994, with nearly 1.5 million new cases reported each year (CDC, 2014b). Though chlamydia is easily treated with antibiotics, its symptoms can be minimal or completely non-existent in men and women. This can be problematic in many ways for both sexes but can have a greater impact on women, including the potential of premature birth in pregnant women, and
pelvic inflammatory disease (PID), which can lead to infertility or chronic pelvic pain.

Demographically speaking, African-American women and men aged 20-24 are at the highest risk for contracting chlamydia.

Gonorrhea is the second most prevalent STI in the U.S. with roughly thirty-three thousand new cases (CDC, 2014c). Gonorrhea became a considerable problem in the United States during World War II due to servicemen’s use of prostitutes. During that time it was treated quickly with a large dose of antibiotics, but in the past few years antibiotic-resistant strains of gonorrhea have made an appearance. This causes great concern for the medical community because pharmaceutical companies rarely develop new antibiotics (Unemo & Nicholas, 2012). Left untreated, gonorrhea can lead to infertility in both men and women as well as the life threatening disseminated gonococcal infection (DGI), which occurs after gonorrhea spreads to the blood. African-American men who have sex with men (MSM) are at the highest risk for contracting gonorrhea.

Syphilis, though far less common when compared to other bacterial STIs, appears in approximately 14,000 new cases a year (CDC, 2014f). Symptoms of syphilis tend to be more pronounced than other bacterial STIs but vary, depending the stage of the infection. If left untreated, syphilis can lead to paralysis, blindness, and death. Rates of syphilis have decreased significantly in the general population but the CDC (2014f) has found 75% of new cases are reported in MSM aged 20-29. This cohort is also more likely to have co-occurring HIV than other demographic groups. When syphilis is present in the body an individual can expect a 2 to 5 times increased risk of acquiring HIV.

Finally, a bacterium commonly found in women is bacterial vaginosis (BV). BV is the most common vaginal infection in females ages 15-44 (CDC, 2014a) and is the result of an
imbalance of the vaginal flora. While it is beyond the scope of this literature review to discuss vaginal flora (c.f., Larsen & Monif, 2001) or the technical nature of the vagina as a self-cleaning mechanism (c.f., Chaban et al., 2014), it is important to note when vaginal flora is out of balance, the vagina becomes vulnerable to bacteria and viruses. The most common way vaginal flora can become imbalanced is through sexual activity with new or multiple partners or by vaginal douching (Martino & Vermund, 2002). BV is not transmitted through sexual activity, per se, but there is a strong correlation between the presence of BV and these aforementioned behaviors.

For many women, BV is asymptomatic and resolves on its own. For pregnant women, however, there is an increased risk for premature birth or infants with low birth weight. Additionally, BV contributes to an increased vulnerability to contracting other bacterial and viral STIs.

**Viral STIs.** In the United States, the most common viral STI is HPV; it infects nearly 6 million people a year (CDC, 2015b). Because it is spread through skin-to-skin contact, traditional barrier methods such as the male condom may not provide sufficient protection. The viral group is made up of over 150 different viruses with only a few leading to the well-known symptom, genital warts. Some strains have been linked directly to the development of cervical, oral, throat, and anal cancers (Gillson, Chaturvedi, & Lowy, 2008). A vaccine (trade name: Gardasil) has been approved for the use on males and females ages 9 to 26 for protection against the most common strains that lead to genital warts and cancers.

Herpes simplex virus (herpes) is another common viral STI. Satterwhite et al. (2013) estimates roughly three hundred and fifty thousand new cases of herpes are identified each year in the U.S. The virus can be spread through sexual contact, skin-to-skin contact, and kissing (CDC, 2014e). Any contact with the lesions increases the likelihood of contracting the virus
because the lesions themselves are vessels for viral transmission. There are still risks to contracting the virus through fluid exchange even when the sores are not present. Aside from the lesions, which can be painful and possibly embarrassing, the only other health risk is for infants during childbirth whose mothers have herpes, as transmission can occur during childbirth.

The final viral STI to be discussed is HIV. Similar to other viral STIs, HIV is spread through any fluid exchange but not skin-to-skin contact. Unlike in the early 1980s, a diagnosis of HIV is no longer a death sentence, but it does require constant and proactive control of viral load. HIV is unique because it specifically targets the T-cells in the human body, cells that are the building blocks for our immune system. The CDC (2015a) estimates more than 1.1 million people in the United States are living with HIV, with one in six people unaware they have been infected. It is estimated there are approximately 50,000 new infections each year; one in four new infections occurs in those aged 13 to 24. The group most at-risk is MSM, who make up only 4% of the population but represent 78% of the new infections in men and 63% of all new infections. White MSM have the greatest risk in terms of total numbers (11,200 new cases), but Black MSM have the greatest risk by proportion (10,600 new cases).

Daily treatment for HIV is essential but can be costly; in the long run, prevention is the best option. One drug, trade name Truvada, is being used as a pharmaceutical prophylaxis for people who do not already have HIV. Studies have shown when taken daily, the drug can protect its user from contracting HIV. For one example, please see Volk et al.’s (2015) most recent results from a two and half year longitudinal study on the drug.

Rates of STIs. According to the CDC, roughly one third of the U.S. population will have an STI within their lifetime (CDC, 2015c). Of those cases, as noted above, racial/ethnic minorities and male sexual minorities are more likely to report having an STI than their White,
heterosexual counterparts. Information on LB women or women who have sex with women (WSW) is not reported in many of the data summaries for STI risks.

The CDC (2015c) reported African-American women are diagnosed with chlamydia, gonorrhea, and syphilis at greater rates than for White women—5.7, 10.7, and 9.2 times respectively. For African-American men chlamydia, gonorrhea, and syphilis cases were reported at 7.3, 10.6, and 5.3 times more often than for White men. Similarly, for Hispanic/Latino American women and men, rates of chlamydia were 2.1 times greater than White women. For Hispanic/Latina women gonorrhea and syphilis occurred at 1.8 and 2.2 times higher rates than White women. Hispanic/Latino men experienced 2.0 and 2.1 times higher rates of gonorrhea and syphilis compared to White men. Gay and bisexual men and MSM are more likely to contract syphilis and HIV than heterosexual men (CDC, 2015c). Men and women who hold double-minority status—i.e., sexual minority, person of color—are the most likely to report having an STI within their lifetime (Mojola & Everett, 2012).

Factors contributing to increased rates. Systemic factors that may be contributing to the elevated rates for these minority populations include lower socioeconomic conditions, higher rates of poverty, income inequality, lower educational attainment, and geographic isolation (Gonzalez, Hendriksen, Collines, Duran, & Safren, 2009). Taken together, these challenges make it very difficult for racial/ethnic and sexual minorities to protect their sexual health, as they may be less likely to obtain routine medical care when sexual health problems occur. When health care is available, fear and distrust of the medical community can negatively impact health-seeking behaviors, as these marginalized groups continue to report social discrimination and provider bias (c.f., Tao, Irwin, & Kassler, 2000). Finally, with each new sexual partner, an individual is putting him or herself at risk for contracting an STI. In places where STI
prevalence is high, it can be difficult to reduce risks of infections due to the constant vigilance required to maintain a clean bill of health (Hogben & Leichliter, 2008).

**Rates of STIs for lesbians and bisexual women.** As mentioned above, LB women reported lifetime rates of STIs similar to heterosexual women—between 10 and 20% (McNair, 2005). Although this may not appear problematic when compared with other groups within minority populations, assumptions women cannot spread STIs to other women continue to persist. LB women report instances of spreading trichomoniasis, genital herpes, HPV, and HIV between female partners (Marrazzo et al., 2005). Additionally, research throughout the years has demonstrated consistent findings bisexual women are at a greater risk for contracting STIs than lesbian and heterosexual women (Everett, 2013; Koh, Gomez, Shade, & Rowley, 2005; Lindley et al., 2008; Reisner et al., 2010).

Bacterial vaginosis is frequently reported in the LB community. In one study, Marrazzo et al. (2005) postulated that between LB partners, vaginal flora is altered due to an exchange of infected cervicovaginal secretions and direct mucosal contact. This exchange of fluid can happen in multiple ways. Explicitly, fluid can be exchanged through digital-vaginal sex, digital-anal sex, and shared penetrative sex toys (Marrazzo et al., 2005). The authors also reported, while 5-23% of heterosexual women in the study reported being diagnosed with BV in their lifetime, over 27% of the 392 LB participants had experienced the disease.

**Lesbian and bisexual women’s unique risk.** A major factor increasing the risks of contracting and spreading STIs for LB women is the myth of invulnerability. Rooted in the heteronormative assumption of what ‘counts’ as sex (i.e., penile penetration), this myth precludes STI transmission in LB sexual activity (Everett, 2013). The medical community also inadvertently perpetuates this myth by demonstrating a lack of awareness regarding STI risks for
LB women (McNair, 2005). When a female discloses current sexual activity with another female, health providers may assume she has not had sexual contact with a male. Evidence suggests this is a dangerous assumption, in that LB women are more likely than heterosexual women to report unprotected sex with gay and bisexual men (Koh et al., 2005). The researchers also found LB women were more likely than heterosexual women to report use of substances when engaging in sexual activity, which can lead to other risk taking behaviors during sex.

Overall, regarding rates of STIs in the general population, racial/ethnic and sexual minorities are more likely to contract an STI than White, heterosexual individuals. Even so the psychological consequences of being diagnosed with an STI potentially impact both the individual diagnosed and his or her partner. Because of this, a brief review of psychological impacts will be presented.

**Psychological Impact of STIs**

In addition to the physical health effects of having an STI, those who are diagnosed with an STI also report psychological impacts (Foster & Byers, 2013). For many, feelings of guilt, shame, embarrassment, and feeling like “damaged goods” are commonly reported (Melville et al., 2003). These can be exacerbated by stigma from others, including health care workers, partners, and other social contacts (Newton & McCabe, 2004). Fear of others’ reactions may also act as a barrier to safer sex practices such as routine testing and open communication with partners. Additionally, especially for individuals with HIV, it is likely unhealthy coping strategies will be used; this may include less effective strategies such as drinking, substance use, increased risk taking behaviors, and active thoughts of suicide (de Ridder, 1999; Newton & McCabe, 2008).
These psychological impacts provide strong evidence for the importance of involving counseling psychologists in STI prevention and awareness. By focusing on personal strength, adaptation, and resiliency (Kagan et al., 1998), counseling psychologists may intervene in the psychological impact of an STI. Group therapy in particular has been shown to significantly decrease shame and isolation for individuals who are HIV+, which in turn led to safer sex practices and a decrease in risk taking behaviors (Choi, Lew, Vittinghoff, Catania, Barrett, & Coates, 1996). Further, this research suggests, with supportive therapeutic interventions, people diagnosed with an STI can, due to engagement in safer sex practices, decrease their current partners’ risks of contracting an STI. Consequently, not only is it important for counseling psychologists to provide therapeutic support, but also to have knowledge of safer sex practices.

In summary, nearly a third of all U.S. adults will contract some form—bacterial or viral—of STI. In addition to the physical impact of an STI, individuals who have been diagnosed with an STI report substantial psychological impacts. Interventions by counseling psychologists, including but not limited to psychoeducational interventions and psychotherapy, can alleviate some of the mental health concerns experienced by STI positive individuals.

**Safer Sex Practices**

A wide variety of safer sex methods are available in the U.S., but the majority of them tend to be contraceptive in nature with decreased risk of STIs seen as a secondary benefit. For same-sex couples the risk of contraception is generally zero. Therefore, for the purpose of this discussion, the author will focus on safer sex methods minimizing the exchange of all fluids between partners, and thus, decreasing the risk of STIs.

**Abstinence.** Undoubtedly, the only safe sex is no sex, or solo sex. Yet, as evidenced by the aforementioned studies’ results on sexual behavior (e.g., Herbenick et al., 2010), the vast
majority of Americans are engaging in sexual behaviors with other people. Conceptually, abstinence assumes refraining from all sexual activity—typically vaginal intercourse—(Dailard, 2003) but interpretations of abstinent behavior by the general public vary a great deal. For example, researchers asked 298 college students to evaluate whether or not 17 different behaviors were congruent with their personal definition of abstinence (Byers, Henderson, & Hobson, 2009). Suffice it to say, differences were found between what the students’ considered to be abstinent behavior and the zero-sexual-activity expectation of abstinence.

On average, of the 17 behaviors listed—which include intimate touching (e.g., bathing together), deep kissing, oral sex, and penetrative sex—students listed eight behaviors in their definition of abstinence (Byers et al., 2009). This suggested most students believed they could engage in some of the activities while still being seen as abstinent. The authors’ also found students were less likely to interpret behaviors resulting in an orgasm as abstinent. For example, 48.6% of students indicated touching a partner’s genitals to orgasm was abstinent behavior, while 59.2% indicated touching a partner’s genitals without orgasm is considered abstinent behavior. The researchers interpret these results as suggesting students believed the goal of sexual behaviors is an orgasm; thus, if orgasm is not achieved (or attempted) the behavior was not deemed sexual.

This study (Byers et al., 2009) adds evidence that important differences exist between the theoretical and practical views people hold regarding abstinent behavior (see also studies by Horan, Philips, & Hagan [1998] or Remez [2000] which found similar results). This results in ambiguity both for sex health educators and people having sex. A consequence of this ambiguity could be an increased risk for contracting and spreading STIs because people may be unsure whether they need to engage in protective action for a number of sexual behaviors. Barrier
methods, when used correctly during any genital contact behavior, can significantly decrease these risks.

**Barrier methods.** By definition, barrier methods prevent individuals from coming into direct contact with a partner’s fluids by creating a barrier between them and pre-ejaculate, ejaculate, or cervico-vaginal secretions, and blood. The three main barrier methods are male condoms, female condoms, and dams. Failure rates of these barrier methods with regard to STI prevention are unknown; Weller and Davis-Beaty (2002) note ethical concerns make studying these methods’ effectiveness at STI prevention difficult. Nevertheless, failure rates on male and female condoms with regard to pregnancy will be outlined to highlight the importance of proper use.

Failure rate of condoms is measured by the number of pregnancies occurring with three types of use: perfect use, imperfect use, and typical use (Trussell, 2011). Perfect use occurs when the barrier method is used as directed, correctly and consistently. Imperfect use occurs when a barrier method is used, but not correctly. For example, a male may release his ejaculate in a condom, but only after engaging penetrative intercourse. Typical use is a term used to account for human error. In other words, failure rates for typical use include situations in which people use condoms perfectly, use them imperfectly, or do not use them at all.

**Male Condoms.** The most commonly used barrier method in the U.S. is the male condom (Mosher & Jones, 2010). A male condom is a thin latex (or polyurethane or animal skin, for individuals with latex allergies) sheath placed over an erect penis during sexual activity. The initial use of condoms was not for protection against disease, but rather as a way to prevent pregnancy. Prior to the development of vulcanized rubber in the early 1800s, condoms were made from animal intestines or linens and due to the expense were washed and reused (Prono,
2000). It was not until the early 1920’s that latex condoms were developed, which led to the mass production of condoms and increased access.

Coinciding with the HIV/AIDS crisis, the benefits of male condoms as a barrier method to protect against STIs were not openly discussed until the late 1980’s (La May, 1997). It was during this time condoms were glamorized and more openly distributed. This trend continues with the open access to condoms on college campuses where it is not unusual to find free condoms in Student Health Centers and Women’s Health Centers.

Failure rates of male condoms range from 2% (perfect use) to 18% (typical use) (Trussell, 2011). Weller and Davis-Beaty (2007) completed a meta-analysis to estimate male condom effectiveness in reducing HIV transmissions in heterosexual couples. Results of the meta-analysis, which evaluated 14 studies, found consistent use of condoms lead to an 80% reduction in HIV infections. The authors note methodological limitations of the analyzed studies lead to only being able to estimate effectiveness rather than efficacy.

**Female condoms.** Though used markedly less frequently, female condoms are very similar to male condoms. A female condom is an eight-inch long nitrile tube, closed at one end with two flexible rings at either end (AVERT, 2014). The closed end of the condom is inserted into the vagina and the other end is left outside the vagina to guide insertion and to prevent the condom from moving up inside the vagina. Some women may opt for the female condom due to the greater degree of personal control the method provides. Female condoms are more difficult to find compared to male condoms, which may partially contribute to the significant difference in use compared to male condoms. Failure rates of female condoms range from 5% for perfect use to 21% for typical use (Trussell, 2011).
**Dental dams.** Dental dams, also known as dams, are latex barriers used for oral sex. The dam is placed directly over a partner’s vulva for cunnilingus or over the anus for analingus.

Dental dams are also not widely available; however they can be purchased in bulk on the Internet and can be found at Planned Parenthood and other STI clinics. Failure rates of dental dams have not been identified due to the ethical dilemma similar to those noted for male condoms.

To summarize, there are a variety of methods available for safer sex practices. Abstinence is the safest, but barrier methods that include condoms and dental dams can provide protection when engaging in sexual activity. Aside from the obvious barriers, such as availability of the products, other psychosocial barriers exist that prevent consistent use of safer sex methods.

**Barriers to Safer Sex Practices**

Many factors exist contributing to the spread of STIs. Whether these factors are perceived or actual barriers, they have a negative influence on the likelihood of someone engaging in preventative action. Broadly these barriers are psychosocial in nature. By understanding the barriers present to engaging in safer sex practices, psychologists can provide greater insight and contributions to STI prevention efforts.

**Psychosocial Barriers**

It is a fallacy to assume the greatest predictor of future behavior is past behavior (Franklin, 2013). However, studies have shown past behavior can influence the *intention* of future safer sex practices. One example by Carter, McNair, Corbin, and Williams (1999) found retrospectively, when men and women intended to use condoms prior to a sexual encounter, it was highly likely they would use condoms. In other words, when an individual is preparing for a sexual encounter and tells him or herself “I’m going to use a condom” it is likely he or she will,
in fact, use a condom. This would suggest one barrier to safer sex practices is lack of preparation and foresight.

This lack of preparation could be a direct result of a lack of education at key developmentally appropriate times (Stanger-Hall & Hall, 2011). Adolescents report safer sex practice information tends to come from school, family, and friends but such information is sporadic and subtle or indirect (Jones, Biddlecom, Hebert, & Mellow, 2011). In many ways, this can perpetuate the stigma around sex, sexuality, and STIs and can further inhibit a potential user from seeking out condoms or dental dams. For LB women, this may be an even greater concern, as sexual education about non-heterosexual relationships is almost non-existent.

Stigma and shame about being tested for an STI is also a barrier for safer sex practices because it implies the individual has done something wrong by having sex (Fortenberry et al., 2002). Being tested can also lead to an awkward position for someone diagnosed with an STI, as it is essential to contact current and former partners to ensure they remain healthy. Consequently, many people do not get tested for STIs for fear of social repercussion for receiving an STI diagnosis (Fortenberry et al., 2002).

Gender role expectations regarding sexual behavior can also present a barrier for safer sex practices, especially when negotiating condom use. Condom negotiation is an active process in which both partners should be involved. Yet due to a power imbalance, many women reported a lack of control when negotiating condom use in heterosexual, sexual encounters (Serewicz & Gale, 2008). Ultimately, men tend to report a greater role in the condom-use decision-making process (Carter et al., 1999). When power imbalances due to gender are not present, such as in male same-sex relationships, barriers such as cost of condoms are often reported (Hubach et al., 2014). Though embarrassment is certainly not unique to gay or bisexual
men, it was cited as a barrier to purchasing condoms (Mustanski, DuBois, Prescott, & Ybarra, 2014). While no literature was found that surveyed LB women’s use of condoms, it is possible that LB women do not consider the use of condoms necessary in WSW encounters because contraception is not a consideration.

Both psychosocial and biological developmental processes, such as adolescents’ assumption of invulnerability with optimistic bias, also act as a barrier to safer sex practices, and may also provide an explanation for the disproportionate number of new STI cases in people aged 18-25. When considering risky behaviors, many adolescents are likely to assume negative consequences will happen to someone else, while they will personally experience positive outcomes (Lapsley, Aalsma, & Halpern-Felsher, 2005). When an individual assumes he or she is at a decreased risk for contracting an STI, it is likely that person will not engage in routine safer sex practices.

Finally, communication, or rather a lack thereof, can act as a barrier to safer sex. Keeping in mind the social stigma and general awkwardness surrounding frank discussions of sexual history, the discussion of safer sex may also be inhibited. Additional barriers include: the perception condoms (or other barrier methods) will decrease sexual pleasure (Crosby et al., 2004); substance use prior to a sexual encounter (Parkes, Wight, Henderson, & Hart, 2007); implication condom use (or other barrier methods) means lack of trust in a relationship (Martson & King, 2006). And, if LB women perceive safer sex practices are designed to avoid contraception instead of avoiding STIs, which creates another barrier.

**Conclusion**

In conclusion, although evidence exists to support the biopsychosocial impact of STIs and barriers to safer sex that may be present in the U.S., the existing literature for lesbian and
bisexual women is limited. First, barriers to safer sex practices tend to focus on heterosexual relationships and condom use. Second, when the literature does acknowledge sexual minorities, the focus tends to be on gay and bisexual men and boys. This provides limited insight into the unique risks and barriers to safer sex for lesbian and bisexual women and girls. Yet, STIs do not discriminate; LB women may be more vulnerable in some ways because they are overlooked and thus are less likely to receive appropriate education on safer sex practices.

Given these shortcomings, a clear need exists for studies that work to identify the unique barriers to safer sex for lesbian and bisexual women. Furthermore, studies are needed that account for the unique cultural experiences contributing to these barriers. Consistent with previous recommendations (e.g., Everett, 2012; Munzy et al., 2011), researchers are encouraged to employ qualitative designs and analyze women’s perceived barriers rather than restrict their responses to items that focus on barriers to condom use. This narrow view neglects the sexual behaviors of female sexual minorities and may not fully capture their experiences. It is believed methodologies that give voice to LB women’s personal stories, such as Consensual Qualitative Research (Hill, 2012) or focus groups (Vaughn, Schumm, & Sinagub, 1996) will yield dynamic and contextual data that will greatly enhance our understanding of psychosocial barriers for LB women.
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