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

Kamila Anise Alexander and Ehriel F. Fannin

Correspondence
Kamila A. Alexander, PhD, MPH, RN,
School of Nursing, Johns Hopkins University,
525 N. Wolfe Street,
Room 436
Baltimore, MD 21205.
Kalexan3@jhu.edu

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ABSTRACT

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

Design: Secondary qualitative content analysis.

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

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

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

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

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

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Kamila A. Alexander, PhD, MPH, RN, is a postdoctoral fellow in the School of Nursing, Johns Hopkins University, Baltimore, MD.

Ehriel F. Fannin, MSN, RN, CNL, is a predoctoral fellow at the Centers for Global Women's Health and Health Equity Research, University of Pennsylvania School of Nursing, Philadelphia, PA.

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

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

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

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

behaviors (Alexander, 2013). In this study, we examined the sexual narratives of young Black WSWM and explored factors that influence sexual safety and sexual security.

Review of the Literature

Establishing sexual risk profiles during health care encounters can be a challenging prospect for nurses. In fact, among a sample of sexual minority women and mostly heterosexual general practitioners, rates of disclosure of sexual identity were correlated with how strongly women identified as a sexual minority (McNair, Hegarty, & Taft, 2012). Among the women that disclosed their sexual identities, almost all of the disclosures were initiated by participants rather than health care providers (McNair et al., 2012). Social institutions, such as family, religion, and peers impose expectations that inform feelings of perceived sexual discrimination. This discrimination is particularly prevalent within the Black community. For example, a study among 355 sexual minority young adults who frequented nonaffirming religious institutions revealed significantly higher levels of internalized homophobia among Black sexual minority adults than White sexual minority adults ($p = .03$) (Barnes & Meyer, 2012). Anticipation of discrimination may inhibit the willingness of a sexual minority to seek out appropriate and relevant sexual health information. This behavior is supported by findings from population-based and community-based studies in which young adult sexual minorities, particularly women, were less likely than heterosexuals to seek and receive social support about sexual issues from their parents and friends ($p < .05$ in both studies) (Friedman & Morgan, 2009; Needham & Austin, 2010).

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

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

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

Methods

We conducted a secondary analysis of data collected from a parent study. The parent study