2022

Relationship Dynamics, Sexual Practices, and HIV Risk of Black Behaviorally Bisexual Women

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Abstract

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DaJaneil S. McCree

MS, Walden University, 2018

BS, University of Michigan-Flint, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Education and Promotion

Walden University

May 2022

Abstract

The human immunodeficiency virus (HIV) risk that exists among women who have sex with women and men (WSWM) is influenced by behavioral factors related to condom use and penetrative sex with sex toys and body parts. Although women represent a large percentage in HIV diagnoses, research has lacked in determining the sexual behaviors that exist behind health-related risks of young women who have sex with women (WSW) and HIV. This study fills the gap in literature in HIV prevention and testing interventions for WSWM by representing Black young adult WSWM in behavioral research, identifying how their lived experiences in relationships may have influence on HIV risk. This was accomplished by using a phenomenological qualitative approach to explore the lived experiences of these women, examining the connection between their relationship dynamics and sexual practices, in relation to HIV risk. Data were collected via structured interviews with 25 Black young adult participants, ages 18 to 35, who live in the United States. Data were analyzed using an interpretative phenomenological analysis (IPA) to furnish detailed examinations of these lived experiences. The data revealed that WSWM may be at increased risk for HIV based off the sexual practices that exist within their behaviorally bisexual relationships. The results of this study highlight the perceived lack of provider and patient education currently existing in the healthcare system, the need for appropriate healthcare services for LGBTQ+ patients, and the need for healthcare resources within WSWM populations. These highlights help to inform future culturally competent LGBTQ+ trainings that will provide education to health care providers on delivering culturally competent services to all LGBGTQ+ populations.

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Dedication

First and foremost, I dedicate this dissertation to all of those who are still fighting the fight, living with HIV, and those we have lost to the HIV/AIDS epidemic. I have the profound honor of working with people living with HIV/AIDS (PLWHA). The courage and strength these individuals exude continues to motivate me each day to devote my time and efforts to ending the epidemic.

I sincerely dedicate this dissertation to every Black woman who has first handedly experienced racial, ethnic, and cultural disparities in receiving and accessing healthcare. May your stories and voices be heard, listened to, and acted upon. “You’re important in your own right. “People need to value you because of who you are, because of your story. Because of your challenges. That’s what makes you unique” (Former First Lady Michelle Obama).

To my late mother, I hope that you are looking down on me with extreme pride. Making you proud motivates me each and every day. To my siblings, I hope that I can be of inspiration to you all. You all are motivation behind me achieving this accomplishment. I did it for us! Dr. Kelly E. Slay, thank you for being a constant inspiration. You have truly been a support system and mentor throughout this process; thank you for your incessant encouragement. To my parents, thank you for raising me to be the woman I am today. To my father, thank you for continuously imparting wisdom on me and instilling the importance and value of education. I love you all.

“I can do all things through Christ who strengthens me.” (Philippians 4:13)

Acknowledgments

I want to thank my dissertation committee, Dr. Cheri N. Langley, Dr. Kimberly B. Brodie, and Dr. Sandra W. Bever. Dr. Langley, thank you for your continued mentorship, knowledge, support, and encouragement throughout this process. I appreciate you going through each motion with me and presenting me with every possible option in reaching my goal(s) (it’s not over until it’s over!). Dr. Brodie, thank you for being an amazing teacher and advisor. You have assisted me in many ways, from the classroom to the dissertation process. I am grateful for your persistence and genuine desire for me to succeed. Dr. Bever, thank you for your expertise and guidance throughout my dissertation process. You all have helped me to become a better researcher and scholarly writer. I truly could not have done this without you all!

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Chapter 1: Introduction to the Study

Introduction

The incidence of human immunodeficiency virus (HIV) cases, resulting from sexual transmission, continues to increase in the United States. Out of 36,801 people diagnosed with HIV in 2019, 16% were heterosexual women (CDC, 2021). One population that is disproportionately affected by HIV are Blacks and African Americans. Within the previously mentioned year, Blacks and African Americans made up 42% of new diagnoses, representing 13% of the population (CDC, 2021). More specific to women within the specified ethnicity, 3,473 new cases were diagnosed and were among those who had heterosexual contact (CDC, 2021). Women who have sex with women and men (WSWM), or behaviorally bisexual women, and/or women who identify as bisexual, have been recognized among those who have increased risk for sexually transmitted infections (STI) over the last decade (Alexander et al., 2016). Research related to this phenomenon is needed in order to assist in the reduction of HIV contraction and transmission among Black WSWMs. For the purpose of this study, Black young adult women aged 18 to 35 who are considered to be behaviorally bisexual (having reported sexual experiences with both women and men in the past year) will be referred to as WSWM. The term WSWM is used to identify behaviorally bisexual women, allowing a reference to be made only regarding sexual behaviors that are sometimes inconsistent with the way that an individual identifies themselves sexually or considers themselves as a part of a specific sexual orientation (Alexander et al., 2016). The current study identifies participants as WSWM. Women who have sex with women and men concurrently may be at increased risk for HIV contraction, as well as transmission, in their relationships, contributing to increased incidence of the virus.

Related to young women and adolescents, minimal research exists regarding the correlates of sexual risk behavior relevant to HIV risk and transmission for all sexual orientation types (i.e., heterosexual, bisexual, etc.). In this study, the lived experiences of Black young adult WSWM (ages 18 to 35 years old) around HIV risk, resulting from the dynamics of their relationship and the sexual practices that exist within them, will be discussed. For the purpose of this study, the relationship categories of the study's participants can be identified as committed, uncommitted, monogamous, polygamous, gay, homosexual, heterosexual, queer, homosexual, heterosexual, dominant, and inferior. Additionally, the relationship dynamics of participants will be consistent with self-esteem, power, and intimate partner violence (IPV). The dynamics identified may play a role in the agreements that have been made between partners on sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) within these relationships. Discussing these lived experiences with participants will help to identify the existing sexual behaviors resulting from these agreements that are associated with HIV risk. The social implications of this study are related to understanding the challenges WSWM may experience in sexual decision-making. Understanding these challenges can effect positive social change by identifying the resources needed within the target population (Black young adult WSWM) to prevent HIV and potentially decreasing the incidence of acquired immune deficiency syndrome (AIDS). Preventive measures must be taken in order to decrease prevalence and ultimately, deaths, as a result of contraction of HIV/AIDS. This can be accomplished by implementing clinical cultural competence interventions (which incorporate the importance of culture at all levels of care) that focus on HIV prevention efforts to serve the WSWM population. Doing so would prove to increase access to and the availability of HIV preventive methods, providing culturally competent health care practices and services for WSWM.

This chapter provides a brief discussion of the phenomenon being explored in this qualitative study: sexual practices within Black young adult WSWM relationships and increased HIV risk within these relationships, which result from unprotected sex. A phenomenological approach is used to identify the lived experiences of WSWMs in their relationships, related to HIV risk. The sections of this chapter are listed here in the order which they appear: background, problem statement, purpose of the study, research question, theoretical framework for the study, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and summary.

Background

It is estimated that almost nine million individuals living in the United States identify with a sexual orientation other than heterosexual, to include: gay, lesbian, bisexual, and queer (Allen et al., 2016). A large base of evidence of the well-studied health disparity, HIV/AIDS prevalence and incidence has shown that incidence, prevention, and treatment efforts related to the disparity have been carried out among men who have sex with men (MSM; Allen et al., 2016). However, recent evidence has indicated that other LGBTQ populations (i.e., WSWM) also face health risks requiring intervention (Allen et al., 2016). The terms gay, bisexual, and queer can all be used to identify WSWM. Related to these populations of the LGBTQ community, there are many existing health risks that are associated with behavioral outcomes. This includes gay and bisexual adolescents and young adults having higher rates of sexual risk behaviors than their heterosexual peers (Allen et al., 2016; CDC, 2019c; Russell et al., 2016). The higher rates of behavioral outcomes within adolescent and young WSWM associated with health risks calls for additional research to be conducted. Exploring these behaviors can create awareness for healthcare providers regarding WSWM, their sexual practices, and the HIV risk that exists within their relationships. The goal of doing so is to inform clinical cultural competence interventions that will provide education to health care providers on delivering culturally competent services to WSWM.

The relationship dynamics of WSWM may influence sexual practices and could be attributed to increased HIV risk. The effects of relationship dynamics on HIV risk vary according to different literature (Altschuler & Rhee, 2015; Shaver et al., 2018; Wang et al., 2015). Altschuler and Rhee (2015) discuss the relationship dynamic of power in correlation to HIV risk. The authors reported on a pilot study that investigated the degree to which self-esteem and power in sexual relationships influence safe-sex negotiations among older women. Results of the study indicated that individuals who possess higher levels of general relationship power and self-esteem are more likely to have greater power in sexual decision-making (Altschuler & Rhee, 2015). Additionally, perceived physical or sexual threat can cause fear of IPV within the less dominant partner, influencing forced condomless sex, resulting from the inability of the inferior partner to initiate and negotiate condom use (Dworkin et al., 2017). These influences on safe-sex negotiations in sexual relationships may increase HIV risk and could also be present among adolescent and young women. Thus, self-esteem, power, and IPV in the context of sexual relationships among the target population, adolescent and young WSMW, should be explored.

Therefore, this research aims to gain a better understanding of sexual behaviors that exist within a relationship in the context of gender biased issues, such as HIV transmission risk. Gender biased issues related to HIV risk include susceptibility to STIs, unintended pregnancy, and HIV infection (Alexander et al., 2016). The lack of progress in reducing HIV incidence in women calls for new ways to study HIV risk among this population. Therefore, future research efforts should be placed on examining the connection between relationship dynamics and sexual decision-making when it comes to HIV risk (Shaver et al., 2018). To address this gap in knowledge, this study addresses the limited research that currently exists in HIV prevention and testing interventions for women who have sex with women (WSW) to also include interactions with men. More specifically, research that has lacked in determining sexual behaviors that exist in relation to the health-related risks of young WSW and HIV (Boone et al., 2015).

Problem Statement

Young women and adolescents who engage in unprotected sex have been warned about the HIV/AIDS threat through media efforts, education, and by scholarly researchers (Breskin et al., 2017). Yet, these women still account for a large percentage of new HIV/AIDS diagnoses (Breskin et al., 2017). In the second decade of the HIV epidemic, women composed 21% of HIV cases in the United States (Breskin et al., 2017). This new statistic decreased the gap in incidence between men and women, having gone from men being 15 times more likely to contract the disease to only 3 times more likely (Breskin et al., 2017). Although women represent such a large percentage in the HIV epidemic, research has lacked in determining the sexual behaviors that exist behind health-related risks of young WSW and HIV (Boone et al., 2015). Studies have shown that MSM may also have sex with women (Wang et al., 2015). It can be inferred that WSWM concurrently may be at increased risk for contraction, and possible transmission, of HIV within their same-sex partner relationship(s). The lack of information on HIV risk and transmission among WSW calls for additional research to be conducted that highlights the varying relationship categories of WSWM, accounting for patterns in sexual decision-making and consequent sexual-risk taking behaviors related to HIV. Therefore, the primary research question in this study is constructed to better understand the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship (i.e**.,** self-esteem, power, and IPV) and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them.

Self-esteem has been identified as an influencer on the sexual decision-making power of women ages 40 and older who are in relationships (Altschuler & Rhee, 2015). However, this demographic does not identify the effects self-esteem may have on the target population of the current study, adolescents and young adult WSWM aged 18 to 35 years old. Relationship power, a factor in HIV risk, has been previously discussed within same-sex male couples (Dworkin et al., 2017). Additionally, men have been considered to be the more dominant partner and the influencer of IPV against their partner, but women have not previously been considered as an inflictor of IPV (Sabri et al., 2019). The existing literature does not address the relationship dynamics discussed here in the context of adolescent and young women WSWM relationships. Furthermore, some literature does account for the effects these relationship dynamics have on adolescent and young women WSWM sexual relationships in relation to HIV risk (Durvasula, 2012; Manning et al., 2012; Sabri et al., 2019). Research on the lived experiences of participants related to these relationship dynamics is needed to appropriately assess the effects they may have on HIV risk within adolescent and young adult WSWM relationships.

Previous studies have called for further research on HIV prevention and testing interventions for MSM (Shaver et al., 2018; Wang et al., 2015); however, there are limited studies on WSWM. Shaver et al. (2018) explored the sexual decision-making and HIV risk among MSM, accounting for five sexual relationship categories that correspond to patterns in sexual decision making and consequent sexual-risk taking behaviors. These categories included (a) uncommitted, one time, (b) uncommitted, ongoing, (c) transitioning or unknown commitment, (d) committed, nonmonogamous, and (e) committed, monogamous (Shaver et al., 2018). These sexual relationship categories can be used among WSWM to identify patterns in sexual decision making and consequent sexual risk-taking behaviors.

Purpose of the Study

The purpose of this qualitative study was to explore the lived experiences of Black WSWM, ages 18 to 35, in the United States and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. Looking at the relationship dynamics of WSWM (i.e., self-esteem, power, and IPV) may help gain insight on the sexual risk behaviors of WSWMs that exist in those relationships and how they may be related to increased HIV risk. Identifying these dynamics and behaviors may inform future clinical cultural competence interventions which address the problem associated with the phenomena of sexual practices within WSWM relationships, and increased HIV risk within these relationships, which result from unprotected sex.

Research Questions

RQ-Qualitative: What are the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship (i.e., level of commitment, power, authority) and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?

SRQ1. What are the attitudes and beliefs of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?

SRQ2. What are the subjective norms (e.g., normative beliefs and motivation to comply with those beliefs) of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?

SRQ3. Considering the relationship dynamics of WSWM, what are the control beliefs held by WSWM that may affect HIV risk and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within those relationship?

Theoretical Framework for the Study

The theory of planned behavior (TPB) is the theoretical framework that has been selected to identify the sexual risk behaviors that may exist among the target population, in relation to HIV risk. TPB is used to identify an individual's intention to perform a given behavior (Ajzen, 1991). As intention captures the motivational factors that influence a behavior, it serves as an indicator of how much effort one will put into performing a behavior (Ajzen, 1991). In the case of this study, TPB can be used to understand how the dynamics of a relationship may influence risky sexual practices by identifying the behavioral beliefs of participants and their partners, linking behavior to expected outcomes. A behavioral belief is based on personal experiences and is the belief that a specific behavior will produce a given outcome (Knabe, 2012). An example of this is identifying participants' beliefs of the advantages and disadvantages of condom use in their relationship. Additionally, whether the participants believe using condoms will help prevent the outcome of contracting a sexually transmitted diseases, such as HIV, was be researched.

Exploring these topics using the TBP can help inform the research questions by also identifying perceived behavioral control, answering for how the dynamics of a relationship may negatively or positively influence sexual practices, increasing or decreasing chances of HIV contraction and transmission in the relationship. The TPB construct of perceived behavioral control references an individual's perception of their ability to perform a given behavior (Knabe, 2012). This is determined by existing control factors that may facilitate, or impede, performance of the behavior. Perceived behavioral control can be linked to a perceived ease or difficulty associated with a specific behavior (Knabe, 2012). An example of this construct in relation to the study is participants' perceived belief that it will be easy or hard to commit to using condoms in their relationship. As an overall goal of the intended study, understanding the sexual practices of WSWM in relationships can be beneficial in guiding the implementation of clinical cultural competence interventions. These interventions would be aimed at providing education to healthcare providers on how to deliver culturally competent preventive care and services to the WSWM population, thus increasing the availability of HIV preventive methods and ultimately decreasing prevalence of the disease. A more detailed explanation of the TBP and its correlation to the study will be presented in Chapter 2.

Nature of the Study

Qualitative research focuses on the lived experiences of a target population, based off the phenomenon of interest. Additionally, in the past 2 decades, qualitative research has become more popular in health services research (Wong, 2008). The key phenomenon being investigated is the decision-making process and the rationalization of sexual behavior choices made by Black young adult WSWM. This phenomenon is best accessed via a qualitative research methodology that allows the researcher to probe deeply into attitudes, beliefs, norms, and relationship dynamics of the participants of the study. The specific qualitative research method selected to explore the relationship dynamics of WSWM and its influence on their sexual practices, related to HIV risk, is a phenomenological qualitative inquiry. Many studies have supported the use of a phenomenological qualitative inquiry to explore participant experiences and behaviors (Atkison et al., 2016; Hall et al., 2016; Teskereci et al., 2019). I selected a phenomenological qualitative research inquiry for the study, as this approach allowed for in-depth data collection, in the form of words, to identify the lived experiences of WSWM in their relationship, as it relates to HIV risk. Placing the focus of HIV research on WSWM can help identify the sexual practices that exist in relationships, along with bringing more awareness to HIV prevention methods, helping to close the gap in incidence of transmission of HIV among men and women.

Definitions

Clinical cultural competence interventions: educational initiatives that aim to teach providers the key tools and skills to deliver quality care to diverse populations (Betancourt et al., 2003).

Cultural competence: acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Betancourt et al., 2003).

Dynamics: a pattern or process of change, growth, or activity (Merriam-Webster.com, 2020).

Gender identity: one’s basic sense of being a man, woman, or other gender, such as transgender (Allen et al., 2016).

Health disparities: preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC, 2018).

Human immunodeficiency virus (HIV): a virus spread through certain body fluids that attacks the body's immune system, specifically the CD4 cells, often called T cells (CDC, 2019b).

Practice: to do or perform often, customarily, or habitually (Merriam-Webster.com, 2020).

Relationship: a romantic or passionate attachment (Merriam-Webster.com, 2020).

Risk: to incur the risk or danger of (Merriam-Webster.com, 2020).

Sexual: having or involving sex (Merriam-Webster.com, 2020).

Sexual orientation: encompasses attraction (i.e., sexual or romantic feelings for people of the same gender/sex, another gender/sex, or multiple genders/sexes), behavior (i.e., sexual or romantic activity with people of the same gender/sex, another gender/sex, or multiple genders/sexes), personal identity (i.e., conception of self as gay, bisexual, straight, etc.) and social identity (i.e., a sense of membership in a social group; Allen et al., 2016).

Women who have sex with women and men (WSWM): 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).

Assumptions

It is assumed that a phenomenological qualitative inquiry is the best possible tool for solving the research problem. Reasoning behind this assumption stems from the focus of a phenomenological inquiry being to identify the commonalities of a lived experience within a particular group. Identifying these commonalities can help to answer the research questions of the study. I also assumed that all participants were honest and open in their interview responses.

Scope and Delimitations

To define the parameters of the study, inclusion and exclusion criteria were created. The criterion for the participant selection is: Inclusion Criteria: Eligible women are between the ages of 18 and 35 years old, live in the United States, are Black, identify as gay or bisexual, have sex with women, have sex with men, have had sex with at least one female partner in the past 12 months, have had sex with at least one male partner in the past 12 months, are HIV positive or negative, and have a relationship duration of 3 months or more. The selection of participants for this study is focused on Black young adult women aged 18 to 35 years old, as these individuals account for a large percentage of new HIV/AIDS diagnoses (Breskin et al., 2017; CDC, 2020). Duration of sexual relationships is important in this study to help identify cases where sexual activity is experienced on more regular basis. Limiting sexual activity to the last 12 months allowed for study participants to provide a more detailed recall of sexual behaviors and choices that are more recent. Both HIV negative and HIV positive women were researched, as the purpose of this study was to identify risk factors that contribute to both contraction and transmission of HIV. A purposive sample of 25 individuals was chosen in order to narrow the participant base. The intent of using purposive sampling in this study was to ensure participants were representative of the population being studied, in order to collect rich data that focuses solely on the objective and purpose of the study (Ames et al., 2019). Using a purposive sample is also one way of achieving a manageable amount of data for the purpose of data analysis and synthesis. There are no other demographic selection criteria for this study (i.e., ethnicity, socioeconomic status, employment, etc.), as sexual history and sexual orientation are the only selection criteria (Ames et al., 2019). The criterion chosen helped to yield the best results to answer the research question of the study, creating a specific basis to gather responses appropriate to the study.

Significance

A great deal of research has been completed regarding sexual risk behaviors and decision-making surrounding HIV risk (Altschuler & Rhee, 2015; Shaver et al., 2018; Wang et al., 2018). However, little research has explored the sexual risk behaviors and decision-making regarding HIV risk for WSWM. Contrary to current research focus, HIV is becoming increasingly prevalent among women across the United States. According to the Centers for Disease Control and Prevention (CDC), women made up 19% of the new HIV diagnoses in the year 2017 (CDC, 2019a). Regardless of this fact, women have been underrepresented, and often excluded, in many realms of medical research (to include HIV; Curno et al., 2016). These factors call for additional research to be conducted related to women in the field of public health to understand the sexual risk behaviors that exist in transmission and contraction of HIV. The current research contributes to filling the gap previously mentioned by representing Black young adult WSWM in behavioral research, identifying their lived experiences in relationships that may have influence on HIV risk.

The current research is important in effecting positive social change in the field of public health through preventive efforts intended to reduce the rates of HIV infections among WSWM. More specifically, it may promote a reduction in the rates of HIV by creation of culturally relevant HIV prevention interventions. This can be accomplished by first seeking to understand the challenges women who identify as WSWM may experience in sexual decision-making related to their sexual practices. Understanding these challenges can effect positive social change by identifying the resources needed within Black young adult WSWM ages 18 to 35 years old to prevent HIV/AIDS. Preventive measures must be taken to decrease rates of infection, prevalence, and ultimately, deaths related to HIV/AIDS. This can be accomplished by implementation of culturally competent HIV prevention interventions to the LGBTQ (lesbian, gay, bisexual, transgender, and queer) community that increase access to and the availability of HIV preventive methods for WSWM. This study intends to provide awareness to healthcare providers who serve the WSWM population, their sexual practices, and the HIV risk that exists within their relationships, to inform future HIV prevention interventions.

Summary

Confirming the reliability of existing knowledge and finding a deviation within that knowledge, related to lesbian and bisexual women in relationships and their sexual practices, are imperative objectives of the study. The information presented in this chapter identified a gap in literature and confirmed the need for further study. In Chapter 2, the purpose and problem statement of the study will be reiterated. Additionally, a literature review will be presented that points to the lack of existing literature related to the research problem. Moreover, the theoretical framework of the study will be discussed in greater detail and used as a tool to identify effective preventive methods.

Chapter 2: Literature Review

Introduction

HIV incidence and prevalence is the most well-studied health disparity among the LGBTQ community (Allen et al., 2016; Shover et. al., 2018). A large base of the current evidence related to HIV incidence, prevention, and treatment efforts have been focused on MSM. However, Allen et. al. indicated that other populations within the LGBTQ community also face health risks related to HIV that require intervention (i.e., women who self-identify as gay, lesbian, or bisexual). The aforementioned population of the LGBTQ community in the United States is burdened by the lack of sexual orientation, sexual behavior, and gender identity being appropriately identified in national surveys (Allen et. al., 2016; Haas et. al., 2015). Inaccurate data collection related to sexual orientation in research affects prevalence statistics within this population (Allen et. al., 2016). For instance, some survey estimates only include those who identify as lesbian, gay, or bisexual, while others do not include those who report same-sex sexual behavior and identify as heterosexual (Allen et. al., 2016). Related to the target population of WSWM, those who self-identify as gay or lesbian may also not be reporting sexual behavior with men and only identify as homosexual (Allen et. al., 2016).

Additionally, gay and bisexual adolescents and young adults are facing health risks that require intervention (Allen et. al., 2016). The population of gay and bisexual adolescents and young adults report having higher rates of sexual risk behaviors than heterosexuals within their same age groups (Allen et. al., 2016). The purpose of this qualitative study was to explore the lived experiences of WSWM, placing focus on young adults and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. Increased health risks in this population called for exploration of the behaviors that are associated with these risks. Exploring these behaviors could serve to create awareness for healthcare providers regarding the health risks that exist in the relationships of WSWMs, which influence HIV risk, in hopes of informing prevention-based LGBTQ interventions. Bringing awareness to the behaviors that exist within these relationships can ultimately help healthcare providers provide culturally competent healthcare practices and services for WSWM.

This chapter highlights HIV risk as it relates to young adult women who have sex with women, who also confirm having sex with men. The TPB was used as the theoretical foundation to understand how the dynamics of participant relationships may influence risky sexual practices by identifying the behavioral beliefs of participants and their partners, ultimately linking behavior to expected outcome. The chapter presents an introduction, literature strategy, literature review on the concepts being studied, and a summary and conclusion. The concepts being studied are listed here in the order which they appear: chosen methodology, gender-biased issues, gender roles in health care and the patient-provider relationship, relationship dynamics, IPV, sexual decision-making and safe-sex practices, sexual risk behaviors, and mental health conditions. The chapter will conclude with a summary of the concepts and literature being presented throughout.

Literature Search Strategy

To better understand the connection between the relationship dynamics, sexual practices, and HIV risk among gay, lesbian, and bisexual women aged 18 to 35 years old, I performed a Thoreau multi-database search using the keywords *WSW, lesbian, bisexual, HIV, AIDS, acquired human immunodeficiency syndrome, human immunodeficiency virus, risk, practices, decision-making, behavior*, *relationship*, and *dynamics*. Google Scholar was also used to identify literature related to these concepts. As there is not a lot of current research being conducted on HIV risk in WSWM, much of the background information of the problem also included research from literature related to MSM, which was found useful and could translate onto the population being studied. To find articles related to the theoretical foundation being used for this study, I performed a Google Scholar search using keywords *theory of planned behavior* and *behavior change*. Government websites, including the CDC and the National Institutes of Health, were used to gather information and statistics on HIV and its prevalence among women in the United States.

Theoretical Foundation

The theoretical foundation, TPB, was used in this study to identify the sexual risk behaviors that may exist among young women WSWM, in relation to HIV risk. The TPB was proposed by Icek Ajzen (1985) as an extension of the limitations of the theory of reasoned action (Azjen & Fishbein, 1980; Fishbein & Azjen, 1975). More specifically, the theory was developed due to the original model (the theory of reasoned action) failing to include information on dealing with behaviors which individuals have incomplete volitional control (Ajzen, 1991). A central concept of the TPB is intention, which amounts to an individual’s motive to perform a specific behavior. The motives that influence behaviors demonstrate how strong the intention to engage in a behavior is

(Ajzen, 1991). For instance, a strong motive to perform a behavior is indicative that an individual will make a strong effort to do so (Ajzen, 1991). It is assumed that determining intention can help to identify the motivational factors that influence specific behaviors (Ajzen, 1991).

It is also assumed by the TPB that both an individual's intention and perceived behavioral control will help to predict behavior (Ajzen, 1991). As such, I explored behavioral belief of participants to identify perceived behavioral control related to sexual decision-making and safe-sex practices among WSWM. As behavioral beliefs are based on personal experience, the study explored what behavioral beliefs exist, as a result of current or past relationships, that are related to expected sexual outcomes. For instance, the advantages or disadvantages of using condoms in the relationship may vary depending on the beliefs of the participant or their partner. In addition, whether participants believe the use of condoms can prevent the outcome of HIV contraction was explored. In addition, perceived behavioral control can be linked to the perceived ease or difficulty with a specific behavior, influencing the ability to perform a behavior, facilitating or impeding performance of behavior (Knabe, 2012). To explore behavioral beliefs within the current study, perceived behavioral control was explored to determine participants' perceived belief that it will be either easy or hard to commit to using condoms in their relationship. Exploring these concepts of the TBP helped to answer the research questions previously identified.

The TPB was used similarly in a study conducted to investigate the psychosocial predictors and HIV-related behaviors among old adults versus late middle-aged and younger adults (Prati et. al., 2015). Questions posed in participant interviews were based on the theory's recommendations for measuring intentions, attitudes, perceived behavioral control, and subjective norms. As previous studies have demonstrated the success of the TPB in predicting condom use, the theory was adapted in the study conducted by Prati et. al. to examine the differences in attitudes, perceived behavioral control, and intentions regarding condom use, HIV/AIDS knowledge, risk perception, and opportunity to discuss HIV/AIDS with friends, relatives, or health professionals among WSWM (Prati et. al., 2015). This adaption of the TPB, implemented by Prati et. al., identifies the behavior (condom use) to be dependent on the strength of an individual's intention to use, or not to use, condoms (Prati et. al., 2015). The aim of the study was to compare HIV-related behaviors (i.e., HIV testing, HIV risk behaviors, and condom use) among younger adults (18-49 years), late middle-aged adults (50-59 years), and old adults (60-75 years; Prati et. al., 2015). The study found that perceived behavioral control and intention related to condom use were lower in old adults. Additionally, the findings of the study suggest intention to use condoms is an explanatory component in the difference in condom use between younger and older adults. The results of the study support the existing theoretical and empirical evidence of the relationship between intention and behavior (Prati et. al., 2015).

Literature Review Related to the Concepts

The following section highlights findings from existing literature related to the research topic concepts (chosen methodology, gender-biased issues, gender roles in health care and the patient-provider relationship, relationship dynamics, IPV, sexual decision-making and safe-sex practices, sexual risk behaviors, and mental health conditions), which help identify the gap this study was designed to address the limited research that currently exists on HIV prevention and testing interventions for women who have sex with women, to also include interactions with men. The literature also justifies the selection of the theoretical foundation, The TPB, for the study.

Chosen Methodology

The chosen methodology for this study is a phenomenological qualitative inquiry. Related to psychology, phenomenological research investigates intentionality, rather than causality (Englander, 2016). To be a participant of a qualitative phenomenological study, an individual is required to have had an experience of the phenomenon being explored (Englander, 2016). As the study explored the intentional sexual practices and behaviors of its participants, the research inquiry selected is most suitable. The qualitative aspect of phenomenological philosophy calls for a researcher to deal with the research on an empirical level (Englander, 2016). As an example, I interviewed individuals about their real experiences that related to the phenomenon. Additionally, it was bestowed upon me to provide an empirically phenomenological analysis of participants' narratives, arriving at phenomenological findings (Englander, 2016). The chosen approach granted the execution of in-depth interviews to discover the lived experiences of participants within their relationships, ultimately identifying the relationship dynamics of participants that possibly influence of sexual practices which attribute to HIV risk. In turn, these interviews were phenomenologically analyzed to answer for the research questions posed.

Cultural Competence

To improve health care services that are being provided to culturally and ethnically diverse patient groups, cultural competency training is a strategy that is used to strengthen the knowledge, attitudes, skills, and behavior of health care professionals (Jongen et. al., 2018**;** Kaihlanen et. al., 2019). Cultural competence can be defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations" (Jongen et. al., 2018). In providing culturally competent care to diverse patient populations, healthcare systems must make improvements in providing culturally competent care, incorporating racial and ethnic diversity measures (Nair & Adetayo, 2019). Incorporating these measures in the workplace will help to diminish health care disparities, improving health care outcomes within these patient populations (Nair & Adetayo, 2019). Additionally, these workplace measures will help to increase cultural awareness in trainings, bridging competency gaps amongst trainees as they make the transition from training to practice (Nair & Adetayo, 2019).

Despite the progression in efforts geared toward community interventions and health care training programs, health care disparities continue to exist amongst racial and ethnic minorities, such as African Americans (Cuevas et.al., 2017; HPI, 2019). This is especially true for those burdened by and living with chronic conditions and illnesses. In the decade since the declaration of HIV as an epidemic, the virus is now considered to be a manageable chronic disease (WHO, 2017). Individuals living with HIV/AIDS may be at a higher risk for contracting chronic illnesses such as asthma, cancer, heart disease, diabetes, high blood pressure, obesity, or anxiety/ depression and may require additional care (HPI, 2019; Rodriguez, 2019). Thus, these individuals' interactions with the health care system are higher (HPI, 2019).

Providers, organizations, and health care systems must provide culturally competent care in order to avoid negative health consequences for their patients (HPI, 2019) As culturally competent organizations, these health care systems may contribute to the elimination of racial and ethnic health disparities (HPI, 2019). Health care systems that are considered to be culturally competent may help to improve health outcomes and the quality of care amongst their patients (HPI, 2019). Additionally, providing culturally competent services may increase patient satisfaction of services being provided (HPI, 2019). There are many strategies that can be implemented within these organizations to achieve goals related to cultural competence that promote ethnic and racial diversity and inclusion measures. An example of a strategy to achieve cultural competence includes providing relevant training on cultural competence to employees (HPI, 2019). Additionally, training on cross-cultural health issues should be provided to health professionals. Lastly, policies that reduce administrative and linguistic barriers to patient care should also be included (HPI, 2019). Both of these strategies serve to improve and increase the quality of care being provided to culturally diverse patients, helping to decrease racial and ethnic health disparities.

Gender Biased Issues

Gender and sexual minority populations are often merged together under the LGBTQ umbrella (Allen et. al., 2016). In contrast to this normalization, sexual orientation and gender identity capture different populations. It is important to classify individuals in the correct population as each have distinct health care needs, concerns, and disparities (Allen et. al., 2016). Gender biased issues that affect women and are related to HIV risk include susceptibility to STIs, unintended pregnancy, and HIV infection (Allen et. al., 2016). Many individuals in the LGBTQ community are uncomfortable managing STIs, leaving them at increased risk for HIV (Allen et. al., 2016). It has been indicated by Graham et. al. (2017) that lesbian women admit to having a contextualized understanding of personal STI risk. The uncomforting idea of managing STIs may be based off these understandings and personal feelings of lesbian women that they are protected from STIs, such as HIV, due to their trust in women, their community, and social circles (Graham et. al., 2017).

Gender Roles in Health Care and the Patient-Provider Relationship

It is theorized that an individual's understanding of the importance of health can be deemed as socially constructed (Graham et. al., 2017). This theory is based off the idea of what is considered to be healthy, or unhealthy, by the individual defining each term. A large component of categorizing oneself as "healthy" is the comparison an individual makes between themselves and other individuals that they would label as "unhealthy," especially in reference to viruses such as HIV (Graham et. al., 2017). The importance of understanding health and the appropriate preventive care behavior is typically focused on individuals who identify as heterosexual (Barefoot et. al., 2017; Graham et. al., 2017). As a result, lesbian, gay, bisexual, queer and/or transgender people are underrepresented when it comes to these understandings (Graham et. al., 2017). Due to the typical nature of health care experiences being heteronormative, women's health care experiences are affected (Barefoot et. al., 2017).

Shaping understandings of health can be guided by age, gender, and sexual orientation (Allen et. al., 2016). Thus, disclosure of sexual orientation and gender identity is important in receiving more appropriate health care services. Said disclosure is also an influencing factor in effective patient-provider communication, allowing for better understandings of health (Allen et. al., 2016). Though, past experiences in care (i.e., provider discrimination, being denied care) may prevent patients from disclosing their sexual orientation and or gender identify (Allen et. al., 2016). The inability, or a patient's perceived inability, to disclose this information can lead to inappropriate health care and health care recommendations being received (Allen et. al., 2016). Gender and sexual orientation can also play a direct role in health under the guise that some health concerns are only geared towards one gender (Graham et. al., 2017). For instance, contraction of HIV has been, mostly, considered to affect men and as such, preventive efforts (many times) have not been geared toward prevention in women as well (Graham et. al., 2017). This serves as an issue because HIV is not a virus that affects men solely and women are at risk as well and could especially affect women who have non-monogamous intercourse with men.

Many individuals of the LGBTQ community have avoided receiving health care due to their past negative experiences with women's health care providers (WHCP) (Barefoot et. al., 2017). These negligent experiences (i.e., exposure to heterosexism/homophobia-related language/paperwork, rejection, discrimination, and inappropriate care) of patients can lead to the establishment of negative relationships with WHCP's, which are essential to the health and wellbeing of these women (Barefoot et. al., 2017). These experiences may result in a hinderance to future care, disabling these women from receiving preventive health care services (i.e., HIV/sexually transmitted infection (STI) tests, Pap smear, breast exam, and mammograms) (Barefoot et. al., 2017). These factors have influenced lower rates of engagement in preventive behaviors, linked to experiences in not being asked about sexual orientation, leading to inappropriate safe-sex education being provided (Barefoot et. al., 2017).

The negligent experiences with WHCP's described previously have caused LGBTQ patients to educate providers on their health care related needs (Allen et. al., 2016). It is important to first understand how providers perceive and experience gender, to determine how it shapes the patient-provider relationship (Knight et. al., 2019). To create a welcoming environment for LGBTQ patients, examining the strongly held beliefs and biases of providers is necessary (Allen et. al., 2016). Doing so may provide insight into patient behavior and the gaps that are present in HIV care (Knight et. al., 2019). Allen et. al. made recommendations for creating culturally competent health care for the LGBTQ community. These recommendations include educating staff on specific health disparities experienced by LGBT communities, education on how to (competently) collect sexual and social history, use of gender-neutral language on forms and communication, refraining from making assumptions sexual orientation or gender identity, displaying LGBT-friendly symbols, and registering with the Gay and Lesbian Medical Association's online directory (Allen et. al., 2016).

Relationship Dynamics

Defining sexual relationship categories (i.e., committed, uncommitted, monogamous, polygamous, gay, homosexual, heterosexual, queer**,** dominant, and inferior) is imperative to understanding how HIV risk perception and behavior exist within the relationship (Shaver et. al., 2018). The sexual relationship categories identified may have a strong influence on the dynamics that a relationship is comprised of. For the purpose of this study, relationship dynamics were consistent with self-esteem, power, and IPV.

Self-Esteem

Self-esteem in the context of HIV risk has been discussed by multiple researchers (Altschuler & Rhee, 2015; Copelyn et. al., 2019). Self-esteem has the potential to influence sexual decision-making power that exists in relationships (Altschuler & Rhee, 2015). This relationship dynamic can also be an influencing factor of self-harm (Altschuler & Rhee, 2015). Related to women, self-esteem dependent on approval from a male partner may influence self-injurious behaviors. These self-injurious behaviors may include, unsafe sex, and denial of HIV/AIDS (Altschuler & Rhee, 2015). Additionally, a strong connection between self-esteem and self-harm has been identified (Copelyn et. al., 2019). This connection could possibly be linked to an individual's increased vulnerability to depression, as well as serve as a symptom of depression (Copelyn et. al., 2019). The state of mind of an individual, based off their level of self-esteem (or lack thereof) and the influence of depression, may have a negative impact on decision-making related to sexual practices (Copelyn et. al., 2019). Results of a study conducted by Altschuler and

Rhee (2015) reported that participants who held higher levels of self-esteem exercised greater power in sexual decision-making (i.e., having sex, and choosing sexual acts). Additionally, higher self-esteem was found to be associated with more favorable condom attitudes (Altschuler & Rhee, 2015).

Power

The relationship dynamic of power has been discussed by many researchers **(**Altschuler & Rhee, 2015; Dworkin et. al., 2017; Mackenzie & Brooks, 2018); Haberland, 2015). Unequal power in relationships can influence exposure and risk factors that increase women's risk of HIV (Haberland, 2015). Relationship power can be defined as the power one partner has in the relationship relative to the other partner (Dworkin et. al., 2017). As a central component of active heterosexual relationships, power can shape HIV risk in women (Dworkin et. al., 2017). Reports on lower power in sexual relationships of women and female adolescents suggest lower power to be correlated with negative sexual and reproductive health outcomes (Haberland, 2015). These negative sexual and reproductive health outcomes include higher rates of STIs and HIV infection (Haberland, 2015). Additionally, younger women in these relationships may be subjected to health threats, such as risk for HIV, which are influenced by the dominant partner's sexual request (Haberland, 2015). For instance, a dominant partner may influence the inferior partner to engage in sexual intercourse without a condom (Altschuler & Rhee, 2015). HIV risk in this population can be due to the power dynamics within the relationship causing vulnerability and feelings of powerlessness in the less dominant partner (Mackenzie, & Brooks, 2018). These factors relevant to power can influence safe-sex practices (i.e., condom use), as well as encourage sexual-risk taking behaviors (Altschuler & Rhee, 2015).

Intimate Partner Violence (IPV)

IPV and HIV are two interrelated public health issues that have a complex relationship (Sabri, et. al., 2019). IPV that is sexually related influences HIV risk resulting from forced condomlesses sex or the inability to initiate and negotiate condom use (Sabri, et. al., 2019). Differences in age between a couple may be a contributing factor to violence in a relationship and correlate with HIV risk (Campbell et al., 2016; Newcomb & Mustanski, 2016; Dworkin et. al., 2017). Older men are typically viewed by their primary partner as having a higher status within the relationship, giving them more power by identifying them as the dominant partner. The shift of power from woman to man can influence women's ability to initiate and negotiate condom use (Dworkin et. al., 2017). This is due to the perceived threat of physical or sexual violence that exists within these relationships. Additionally, intimate partner violence is strongly associated with positive HIV status and thus should be addressed in the context of sexual relationships (Dworkin et. al., 2017).

Sexual Decision-Making and Safe-Sex Practices

As previously discussed, power can influence safe-sex practices (i.e., condom use), as well as encourage sexual-risk taking behaviors (Altschuler & Rhee, 2015; Dworkin et. al., 2017; Haberland, 2015). Those who are considered more dominant (having more power) in the relationship typically have greater power in sexual decision making (Altschuler & Rhee, 2015). The power in this form of decision making includes the decision to have sex and deciding which sexual acts will be performed (Altschuler & Rhee, 2015). Power given to the "decision maker" may potentially influence sexual risk behaviors that contribute to HIV risk, such as not using condoms, based off what has been decided as "best" or "unnecessary" for the couple. For instance, in uncommitted, ongoing relationships, tension between knowledge of risk-limiting behaviors and the momentary decisions to use those methods with a partner exist (Shaver, et. al., 2018). This tension can create cause for an inferior partner to give into the decisions being made for fear of creating more tension within the relationship. Thus, interventions that are tailored toward expressing the importance of an equal partnership, influencing safe-sex negotiations made consensually, have been effective in reducing HIV risk behaviors (Shaver et. al., 2018).

Sexual Risk Behaviors

The identification of sexual risk behaviors in relationships has mostly been focused on those who identify as LGBTQ or as sexual minorities (Alexander et. al., 2016). Thus, sexual risk behaviors associated with WSWM have been scarcely researched and studied (Alexander et. al., 2016). Limited research related to sexual risk behaviors among WSWM is a problem because it has been found that these individuals have poorer sex health outcomes and also exhibit riskier sexual behaviors (Alexander et. al., 2016). Risker sexual behaviors for this population include higher STI rates than those who identify as solely lesbian or heterosexual (Alexander et. al., 2016). Additionally, WSWM have reported more male sex partners, engaged in more sex while using drugs, initiated vaginal intercourse at a younger age, and were less likely to use condoms

(Alexander et. al., 2016). The sexual risk behaviors exhibited by WSWM may be contributed to increased risk for HIV. Increased risk for HIV could be associated with barriers WSWM face in relation to accessing and receiving health care, to include proper health education, aiding the lack of HIV prevention efforts (Alexander et. al., 2016).

Mental Health Conditions

Another contributing factor that may increase risk for HIV among WSWM is mental health. LGBTQ populations tend to have a higher prevalence of mental health conditions than the general population (Allen et. al., 2016; Flanders et. al., 2015). Though, health professionals tend to over-identify MSM populations with having HIV, while simultaneously ignoring the high rates of sexual and mental health challenges other LGBTQ populations experience (Allen et. al., 2016). Related to the bisexual population (for the purposes of this study WSWM), psychological distress may be more common in those who identify as bisexual than their counterparts (Allen et. al., 2016). These conditions can include anxiety and depression, which may subject individuals to more emotional, physical, and sexual trauma than those who identify as heterosexual, gay, or lesbian (Allen et. al., 2016; Flanders et. al., 2015). Additionally, women who consider themselves bisexual have reported higher prevalence in negative sexual reproductive health outcomes (Flanders et. al., 2015). These women have been identified as less likely to use condoms during vaginal intercourse and more likely to contract sexually transmitted infections than women who identify as heterosexual (Flanders et. al., 2015).

Summary and Conclusions

The findings of the literature review reiterated the need for additional research to be conducted related to HIV prevention and testing issues among WSWM. The studies presented aimed to discuss the importance of cultural competence measures in the workplace, understand HIV as a gender biased issue, identify gender roles in health care and highlight relationship dynamics, intimate partner violence, sexual decision-making and safe-sex practices, sexual risk behaviors, and mental health conditions among the LBTQ population, which yielded supporting evidence for the current study. Though, none of the studies presented in the review were geared specifically toward the WSWM population and the implications these concepts have on HIV risk. In this chapter, I highlighted the health risks WSWM face related to HIV that require intervention (i.e., decreased condom use, contraction of STIs). The increase in health risks LGBTQ+ communities, to include WSWM, face called for exploration of the behaviors (i.e., having male sex partners, sex while using drugs, initiation of vaginal intercourse at a younger age, likelihood of condom use) that are associated with these risks in order to initiate preventive measures.

The theoretical foundation of the study, The Theory of Planned Behavior, was used to identify the risk behaviors of the target population associated with HIV. By identifying the behavioral beliefs of participants, use of the TPB aided in understanding how the dynamics of participant relationships may influence risky sexual practices, ultimately linking behavior to expected outcome. Thus, the existing gap in literature related to the limited research that currently exists on HIV prevention and testing for

WSWM can be addressed to inform preventive methods. In Chapter 3 the research design, rationale, and the role of the researcher for study will be discussed. Additionally, a more in-depth discussion of the chosen methodology (to include including instrumentation, procedures for recruitment, participation, and data collection, including data analysis plan) will be provided. Lastly, a discussion the issues of trustworthiness of the study will be presented, ending the chapter in summary.

Chapter 3: Research Method

Introduction

Related to young adult women, minimal research exists regarding the correlates of sexual risk behavior relevant to HIV risk and transmission, which calls for additional research to be conducted (Allen et. al., 2016). The purpose of this qualitative study is to explore the lived experiences of WSWM and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. Looking at the relationship dynamics of WSWM (i.e., self-esteem, power, and IPV) may help gain insight on the sexual risk behaviors of WSWMs that exist in those relationships and how they may be related to increased HIV risk. To explore the lived experiences of participants, a qualitative phenomenological approach was selected for the study. Burkholder et. al. stated: “phenomenology is a collection and analysis of people’s perceptions (or alternatively, lived experience), related to a specific, definable phenomenon” (p. 203). Collection of data related to participant perceptions and experiences, based off the dynamics of their relationship, can help highlight the issues (i.e., communication, negotiation) that women are experiencing or have experienced within these relationships. Additionally, the lack of appropriate health care services and resources being received by participants can be identified in hopes to inform future culturally competent LGBTQ+ interventions. This chapter presents information to support the selected research design (phenomenological qualitative inquiry), offering a rationale for its selection, of the study. Additionally, the role of a researcher in qualitative research, the research methodology, and issues of trustworthiness will be discussed. The chapter will conclude with a summary of the main points presented in the sections of the chapter.

Research Design and Rationale

In the second decade of the HIV epidemic, the gap in HIV incidence has decreased between men and women in the United States (Breskin et. al., 2017). Despite this fact, young women and adolescents who have been warned about HIV/AIDS threats through social media outlets still account for a large portion of new HIV/AIDS (Breskin et al., 2017). Additionally, research has lacked in determining the sexual behaviors that exist behind health-related risks of young women who have sex with women and HIV despite women's large representation in the HIV epidemic (Boone et. al., 2015). The major research question used to guide this study is: What are the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them? The primary phenomenon studied is the lived experiences of WSWM ages 18 to 30 years old in relationships and how the dynamics of their relationship may have contributed to negative sexual practices, increasing HIV risk. Using a phenomenological approach, key concepts, themes, and lived experiences were identified through data analysis to answer for the research question.

The phenomenon being explored in this qualitative study is the dynamics of WSWM relationships, the sexual practices that exist within them, and their associations with increased HIV risk among these women, which result from negative sexual practices. The choice of approach for the intended study is a qualitative phenomenological inquiry. The purpose of using phenomenology as a research design is to help a researcher understand the human factors involved in an experience (Burkholder et. al., 2016, p. 206). Additionally, phenomenology helps to answer for how people perceive a phenomenon in order to place it within a context to understand human perceptions (Burkholder et. al., 2016, p. 206). The rationale for the chosen approach was that this form of inquiry allows for the experiences and conversations in participant relationships to be described in detail as it relates to safe-sex practices and sexual decision-making. In-depth interviews to discover the lived experiences of participants within their relationships were conducted, ultimately identifying the relationship dynamics of participants that possibly influence sexual practice that contribute to HIV risk. In turn, these interviews were phenomenologically analyzed to answer for the research question posed.

Role of the Researcher

A researcher conducting research under a phenomenological philosophy must deal with the research on an empirical level (Englander, 2016). For instance, the role of the researcher is to conduct interviews that answer for the lived experiences of a participant and relate to the phenomenon being studied. As such, the researcher's role in a study is to observe participants during the interview process of data collection (Burkholder et. al., 2016, p. 284). Interviewing participants requires a researcher to pay very close attention to detail in order to capture the correct data. Essential to the interview, questions must be prepared beforehand by the researcher and must also be clear (Burkholder et. al., 2016, p. 284). Some tasks of the researcher related to interviewing participants include preparing, conducting, and transcribing each interview (Burkholder et. al., 2016, p. 284). The researcher is also in charge of providing an empirically phenomenological analysis of participants' narratives, arriving at phenomenological findings (Englander, 2016). Due to the researcher's involvement in data analysis, it is imperative to eliminate any potential research biases when conducting a study to prevent misleading results.

In my previous work in HIV prevention, I worked as an implementer of Satellite Health Care Centers in the city of Detroit, Michigan. Although I did not directly provide services to patients, I played a hand in assuring services were provided with cultural sensitivity and competence. In my current professional endeavors, I sit on the Michigan HIV/AIDS council (MHAC), which also does not entail providing direct care to patients. My role in HIV prevention for MHAC is geared toward putting on and attending community events that provide HIV prevention education and HIV testing to underserved individuals and populations. These experiences could bring about bias if there were any personal relationships between the researcher and potential participants, as a result of the care or resources they received under my employment. To avoid such bias, participants were only be considered if there were no personal relationships between the individual and myself. A screener questionnaire to screen out potential conflict of interest was completed by each potential participant before participant selection occurred. As such, there was no conflicts of interest with any recruited participants for the study. Any potential researcher biases were managed by implementing a data analysis process where all data were considered, collated, and sorted.

Methodology

Participant Selection Logic

The target group of interest is WSWM who are currently in relationships in the United States. It is suggested by Creswell (1998) that a phenomenological study should include five to 25 participants (p. 64). The sampling strategy selected for this study is a purposive sample of 25 participants. A purposeful sampling strategy is used in qualitative research for the selection of participants who will provide rich information related to the phenomenon of interest (Palinkas et. al., 2015). Participants are purposively selected using this technique based off their knowledge or experience with a specific phenomenon (Palinkas et. al., 2015). The sample size for this study was selected as a result of qualitative research samples being typically smaller than that of quantitative research (Vasileiou et. al., 2018). This is due to qualitative research's requirement of an in-depth understanding of a phenomenon, focused on meaning versus generalizability, and the why and how of a particular issue (Vasileiou et. al., 2018). The choice to include 25 participants allowed for a sample that is large enough to unfold a new and richly textured understanding of the phenomenon of interest and small enough to not preclude deep, case-oriented qualitative data analysis, in an effort to achieve saturation (Vasileiou et. al., 2018).

A sample size in qualitative research can be affected by saturation, meaning that the sample size may either be higher or lower than originally anticipated, depending on when saturation is reached (Mason, 2010). The concept of saturation can be considered as the "gold standard" in qualitative research inquiries (Vasileiou et. al., 2018). Saturation is most widely used for determining and evaluating the sufficiency of the sample size of a study (Vasileiou et. al., 2018). Saturation can be achieved when no new theoretical insights or categories can be achieved. Additionally, saturation is achieved when no new data or codes related to the study can be identified (Vasileiou et. al., 2018). The goal of achieving saturation involves the selection of participants who can cover all aspects of the phenomenon that are being examined (Palinkas et. al., 2015).

The criterion for the participant selection was: Inclusion Criteria: Eligible women are between the ages of 18 and 35 years old, live in the United States, are Black, identify as gay or bisexual, have sex with women, have sex with men, have had sex with at least one female partner in the past 12 months, have had sex with at least one male partner in the past 12 months, are HIV positive or negative, and have a relationship duration of 3 months or more. Participants were invited for this effort via partner organizations and online passive recruitment tactics (i.e., advertising the study's flier in LGBTQ support groups on Facebook, Instagram) from which they were directed to complete a participant inclusion survey determining their eligibility. After individuals were identified as "meets all inclusion criteria," based off survey scoring, a direct message and or email was sent to each individual to confirm interest in participation. Through these confirmations, I was able to provide next steps to all participants.

Instrumentation

In phenomenological based qualitative studies, data collection typically consists of multiple in-depth interviews conducted with its participants (Creswell, 2013). The key instrument used to collect data in qualitative research is the researcher (Creswell, 2013).

Qualitative researchers collect data from participants by examining documents, observing behavior, and interviewing (Creswell, 2013). As the key instrument in data collection, it is not typical of a qualitative researcher to use instruments developed by other researchers, rather than creating an instrument of their own, using open-ended questions (Creswell, 2013). Data from these individual interviews were collected from individuals who have experienced the phenomenon of interest. Each participant of this study partook in an (individual) estimated 45 minute to 1-hour in-depth interview in which they answered open-ended exploratory interview questions. In light of COVID-19 pandemic, Zoom was chosen as the video/tele conferencing platform to conduct and record participant interviews. All interviews were recorded, with the permission of each participant, and used (verbatim) for transcription of interviews during data analysis.

Qualitative studies that use a phenomenological approach require individual interviews as they intend to identify themes from individual experiences (Burkholder et.al., 2016, p. 283). Structured interviews were conducted for the study, using a script of questions created by myself, the researcher. These questions were asked directly and exactly as they are written, using the sequence outlined in the script. The purpose of using a structured interview style is to be able to precisely compare participant responses (Burkholder et.al., 2016, p. 283). Burkholder et al. (2016) suggested an interview protocol that this study followed to ensure consistency in the interview process (p. 284). This protocol entails including a location to record name of interviewee, date and time of the interview, location of the interview, name of the interviewer, and all other relevant details (Burkholder et.al., 2016, p. 284). Additionally, introductory and closing remarks were included in the protocol tool along with the questions to be asked to participants (Burkholder et.al., 2016, p. 284).

Participants answered open-ended exploratory questions that provided explanations of their lived experiences and sexual practices in relationships with both women and men, influenced by the dynamics of these relationships, that may have attributed to HIV risk. To gain a better understanding of the relationship dynamics and factors influencing sexual practices, each interview included broad, general questions. Examples of these broad open-ended questions include: Who would you say has the most power in decision-making in your relationship?, What do you think about using male or female condoms and dental dam?, How do you think using male or female condoms and dental dam would affect your sex life? And: What would happen if you asked your partner to use a male or female condom? The purpose of these broad questions is to focus the attention on gathering data that will lead to both a textual and structural description of participant descriptions of their experiences, answering for the research question (Creswell, 2013). Furthermore, these descriptions provided an understanding of the experiences that are common among participants (Creswell, 2013).

Content validity in qualitative research refers to whether research conclusions are sound, just, and well-founded (Sundler et. al., 2019). To confirm content validity, there are a range of questions the researcher must answer (Sundler et. al., 2019). These questions may include how well the analysis was presented, whether it is clear how themes were derived, if findings are presented in a logical way, if findings are relevant and meaningful, and whether the findings of the study contribute to new knowledge

(Sundler et. al., 2019). Additionally, content validity will be confirmed by participants in their review of their interview transcription. Review of interview transcriptions ensured that the information transcribed was accurate, confirming that the information is exactly what the participant said and meant by their responses.

Procedures for Recruitment, Participation, and Data Collection

Recruitment of participants for this study was done via my professional connections. As a member of the Michigan HIV/AIDS council, I gathered recommendations for potential participants from each member of the council. Additionally, each council member was provided a copy of the flier via email to disseminate among their respective organization to recruit potential participants. The fliers consisted of information related to the study, participant criteria and requirements (45 minute to 1-hour interview), stipend for participation ($25 Amazon gift card), and a link to the participant inclusion survey to assess eligibility. Online passive recruitment tactics (i.e., advertising the study's flier in LGBTQ support groups on Facebook, Instagram) were also used to engage potential participants. Once eligible participants were identified via completed participant inclusion surveys, individuals were invited to interview for the study via email. Once this type of recruitment resulted in too few participants, other social media platforms (i.e., Twitter, Instagram) and the Walden University Participant Pool were used to draw in additional people.

An informed consent document was provided to all potential participants detailing the full scope of the study, nature of participation, purpose of the study, duration of the research, possible risks, possible benefits, assurances regarding confidentiality, right to withdraw without penalty, and opportunities for participants to have questions or concerns regarding the research addressed prior to their interview. This was done in order to protect participants' rights during recruiting, data collection, and the debriefing process. Following the acceptance of the invitation to participate and consent being provided, participants were scheduled for interviews. Data for the study were collected via video conference, using Zoom (to include video recording), over a 12-month period. I conducted interviews on a weekly basis. Video-recordings were transcribed in Otter and sent to each participant for content validity review. All participants were debriefed via email, to include discussion of the accuracy of transcription, after the conclusion of their interview.

Data Analysis Plan

The primary research question in this study is: What are the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them? Twenty-seven specifically structured exploratory questions were asked to participants in order to answer for the research question. Each question was posed to participants to tie their relationship dynamics and sexual experiences within their relationships to HIV risk. The best data analysis plan for the chosen approach (phenomenological qualitative inquiry) is an interpretative phenomenological analysis (IPA). IPA is used in qualitative research to furnish detailed examinations related to personal lived experiences (Smith, & Osborn, 2015). Using an IPA approach allowed for an account of participants lived experiences to be furnished without using pre-existing theoretical preconceptions (Smith, & Osborn, 2015).

In interpretative phenomenological analysis, participants first make meaning of their world and then a researcher makes sense of that meaning (Smith, & Osborn, 2015). For this study, this was accomplished through the process of data coding, using MAXQDA 2022 software, where the researcher identified patterns and created categories, codes, and themes relevant to participant experiences. While the researcher may have had pre-existing theme ideas, the data collected from each participant was the true suggestion of these themes (Smith, & Osborn, 2015). Line-by-line coding was used to provide short summaries of material, later using these summaries to create themes. These themes were then grouped into categories, highlighting commonalities in negative sexual practices that may increase HIV risk, to inform the results of the study. Audio from the video-recordings were transcribed using Otter.ai (Voice Meeting Notes), and Microsoft Word were used to create columns for the themes, categories, and codes depicted from the coding process.

Issues of Trustworthiness

To establish trustworthiness in qualitative research, four criteria have been created: credibility, transferability, dependability, and confirmability (Forero et. al., 2016). The purpose of achieving credibility is to ensure that research findings align with reality, by establishing confidence that the results of a study are true, credible, and believable (Forero et. al., 2016). To ensure credibility of this study, member checking was used. Member checking involves respondent validation, where participants review results to verify accuracy and resonance with their experiences (Birt et. al., 2016). As a part of the data collection process, audio from the video-recordings were transcribed in Otter and sent to each participant for content validity review to ensure credibility. Transferability is the concept of generalizing research to other contexts or settings (Forero et. al., 2016). To establish external validity (transferability), a method of thick description was used. Using a technique of thick description, the researcher provided a detailed account of the experiences of data collection, connecting cultural and social contexts (Lincoln, & Guba, 1985). Thick descriptions of the data included information such as the interview process and where interviews occurred to provide a better understanding of the research setting (Lincoln, & Guba, 1985). Highlighting social and cultural environments that the study was framed around will allow other researchers and readers to make their own judgements on transferability (Lincoln, & Guba, 1985).

Dependability relates to the findings of a study's ability to be repeated if used within the same target population, coders, and context (Forero et. al., 2016). An inquiry audit (or external audit) was used to accomplish dependability. The execution of an inquiry audit consisted of an outside researcher examining the process of data collection, data analysis, and the results of this study. Doing so allowed confirmation of the accuracy in the findings of the study to ensure that they match the data that has been collected. Additionally, an audit trail was used to establish dependability, creating a detailed track record of the data collection process (Forero et. al., 2016). Confirmability relates to shaping the findings of study by the respondents and not researcher bias (Forero et. al., 2016). The strategy of reflexivity was used to establish confirmability in this study. To do so, reflexive journals were used by the researcher to record all issues regarding sensitive topics and potential ethical issues, as these issues can possibly affect data analysis (Forero et. al., 2016).

Ethical Procedures

In research that involves human participants, any potential ethical issues that may arise in planning, conducting, and reporting the research must be taken into consideration (Smith, et. al., 2015). The first ethical procedure for this study, before data collection could occur, was obtaining approval to conduct the study from the Institutional Review Board (IRB) at Walden. This review began after final approval of the Proposal. Form A "Description of Data Sources and Partner Sites" is required to initiate IRB review, enabling the board to provide a tailored guidance to the researcher. Documentation which may be required as a part of the IRB approval process are the interview protocol and confirmation of completion of the web-based training course: "Protecting Human Research Participants" conducted by the National Institutes of Health. An ethical concern related to recruitment materials and the process itself involves coercion. To avoid coercion, a detailed explanation of the study and participant requirements were provided to ensure full understanding of participation (Smith, et. al., 2015). Clearly worded information sheets, along with verbal explanation, were provided to each participant to assist in this effort (Smith, et. al., 2015).

Ethical concerns may have also come into play as it relates to using video conferencing for participant interviews. As previously mentioned, Zoom was chosen as the video conferencing platform to conduct participant interviews. One ethical concern pertaining to this matter was the limitedness of a video conferencing platform, such as Zoom, in building rapport (Lo Iacono et. al., 2016). Rapport between the researcher and participant was important in gaining trust and comfortability. Additionally, using a method of video conferencing to conduct interviews could have influenced intimacy and nonverbal communication (Seitz, 2016). Intimacy could be forfeited in these settings, while nonverbal cues are limited (Seitz, 2016). Technical issues arose, such as audio problems and drop calls, which also had an affect the intimacy and cause a negative impact on rapport (Seitz, 2016). Privacy is another ethical concern of using a video platform such as Zoom. As such, it was important to ensure that all the participants in the Zoom call are in a secure, private location to ensure confidentiality.

Voluntariness as a research participant refers to an individual's willingness to enroll, continue, or withdraw from the study on their own free will, having full knowledge of the consequences of both participation and withdrawal (Smith et. al., 2015). As the research topic being explored is sensitive in nature, participants may have been hesitant to participate and/or be hesitant to answer more sensitive and personal questions truthfully. To avoid such possibility, it was important that the researcher make an effort to understand what factors may influence voluntariness, for instance, the influence gender-biased issues may have on voluntariness within this study, design information, and procedures, to minimize this influence (Smith et. al., 2015). Addressing these ethical concerns included a detailed explanation of why the research is being conducted, why they are being asked to participate, possible benefits, risk, and burdens of participation, and what expected benefits the research would have on them and the community, in the informed consent process (Smith et. al., 2015).

All data is anonymous and confidential, protecting participants from any potential harm. Participants are referred to by code names, with the information linking actual names to these codes kept separately in a secure file. Only the researcher is able to access this information. Data will only be disseminated to other parties at the consent of each participant. After a 5-year period, as per the rules of Walden University, all data retrieved will be destroyed by a professional entity. This will include all interview video recordings, reflexive journals, and transcripts. There were no conflicts of interest between the researcher, the participants, and the data collection site and environment. A gift card ($25-Amazon) incentive was used to thank participants for being involved in the study but was not used as an act of coercion for participation. Documentation necessary to ensure ethical procedures were upheld were submitted along with my application for IRB approval (10-21-20-0727617) through Walden University.

Summary

This chapter presented information to support the selected research design (phenomenological qualitative inquiry), stating the rationale for its selection. A phenomenological qualitative inquiry allowed for the experiences and conversations in participant relationships to be described in detail as it relates to safe-sex practices and sexual decision-making. The role of the researcher has been made clear in their duty to conduct, while being observant of participants, interviews which answer for the lived experiences of a participant related to the phenomenon were studied. Issues of trustworthiness (credibility, transferability, dependability, and confirmability) and the ways to achieve each criterion have been discussed as well. Chapter 4 will present the demographics of participants and provide information regarding the setting for data collection. Additionally, a more detailed description of data collection and analysis will also be provided. Next, evidence of meeting the four criteria to achieve trustworthiness will be presented. Finally, the results of the study will conclude Chapter 4.

Chapter 4: Results

Introduction

The purpose of this phenomenological qualitative study is to explore the lived experiences of Black WSWM, ages 18 to 35, in the United States, and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. A phenomenological approach was used to address the following primary research question: What are the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship (i.e., level of commitment, power, authority) and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them? Sub research questions for this study are as follows:

SRQ1. What are the attitudes and beliefs of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?

SRQ2. What are the subjective norms (e.g., normative beliefs and motivation to comply with those beliefs) of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?

SRQ3. Considering the relationship dynamics of WSWM, what are the control beliefs held by WSWM that may affect HIV risk and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within those relationship?

Through the execution of in-depth participant interviews, I was able to understand which sexual practices and relationship dynamics that exist within participant relationships could potentially put them at risk for contracting and or transmitting HIV. I was also able to better grasp the sexual decisions that were made within participant relationships and how these decisions may have progressively changed, potentially putting these individuals at greater risk for HIV overtime. Additionally, these interviews were useful in identifying what information should be included in the education given to healthcare providers in training(s), in relation to the LGBTQ+ community. Overall, participant interviews shed light on the lack of appropriate health care services and resources currently being received, attributing the goal of the study: to inform future culturally competent LGBTQ+ interventions that will provide education to health care providers on delivering culturally competent services to LGBGTQ+ populations.

This chapter provides extensive details of the results of this qualitative study and the phenomenon being explored: sexual practices within Black young adult WSWM relationships, and increased HIV risk within these relationships that result from unprotected sex. A phenomenological approach was used to identify the lived experiences of WSWMs in their relationships, related to HIV risk. The sections of this chapter are listed here in the order which they appear: setting, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary.

Setting

Data for this study were collected between December 2020 and December 2021. Participants (25 individuals) answered open-ended exploratory questions that provided explanations of their lived experiences and sexual practices in relationships with both women and men, influenced by the dynamics of these relationships, that may have attributed to HIV risk. In light of the COVID-19 pandemic, the Zoom platform was chosen as the video/tele conferencing platform to conduct and record participant interviews. All participants consented to being interviewed and recorded, in accordance with Walden University IRB policies, by selecting the checkbox next to "I consent" on the consent section of the participant inclusion survey that was used to deem eligibility. Participants were also sent a consent form to keep for their records via email. All virtual interviews were scheduled respectful to the availability of participants. To reconfirm consent of being recorded, I asked each person if it were okay to record their interview before the start of each. To maintain confidentiality, each participant was labeled with a pseudonym as Participant 1-25, according to the order of their interview. There were no personal or organizational conditions that influenced participants, or their experience, at the time of the study that may influence interpretation of study results.

Demographics

Participants included 25 Black women, ages 18-35, who live in the United States. The specific state each participant resided in was not reported within the participant inclusion survey. Instead, the participant inclusion survey question "Do you live in the United States?" confirmed participants met inclusion criteria and eligibility for participation in the study by participant selection of the "Yes" response. Despite not specifying residential state of participants on the participant inclusion form, it can be determined the majority of participants were recruited from Michigan, as a result of online passive recruitment tactics (i.e., Michigan-based professional connections of the researcher). All participants confirmed being either bisexual or pansexual, engaging in sexual activity with both women and men, and having had both a female and male partner in the past 12 months and being in a relationship (whether with a female or male) for a duration of 3 months or more at the time of completing the participant inclusion survey. Additionally, all participants of this study were identified as HIV negative.

Data Collection

Recruitment (i.e., via professional connections of the researcher, online passive recruitment tactics) of 25 Black women, along with the data collection process, were consistent with the plans for recruitment and data collection as identified in Chapter 3. After initial IRB approval in October of 2020, participant recruitment began and interviews were conducted between December 2020 and December 2021 via Zoom, which lasted an average of 35 minutes. To ensure privacy, each participant was asked if they were in a secure (private) location and if they felt comfortable answering the interview questions at the beginning of each interview. I conducted each interview in a private room, secluded from other individuals and outside distractions. Those who had technical issues using Zoom (four participants total) were directed to fill in their answers to the interview questions using Microsoft Word, emailing them back to me. This was done only after an attempt was first made to use Zoom. This initial attempt allowed me to verify participant identities (as the video option was turned on) and confirm that they were in fact the interviewee by using the chat function of the platform. In the closing of each interview, I informed participants of the “next steps” of the process which included receiving an electronic $25 Amazon gift card incentive, as well as informing them of the opportunity to receive the study results after its completion. Each participant requested an opportunity to receive and review a summary of the study results via email once it has been concluded.

The interview transcript created for the study was used to guide each interview (Appendix). Two interviews were conducted in December 2020, two were conducted in May of 2021, another was conducted in August 2021, and one was conducted in September 2021, with the remainder of interviews being conducted on a weekly basis between November and December of 2021. Recruitment issues (i.e., lack of partner organization involvement, potential participant's disinterest) led to the gap in completing the interview process. Audio from the video-recordings were transcribed in Otter and sent to each participant for content validity review. There were no unusual circumstances encountered in the data collection process.

Data Analysis

MAXQDA 2022 software was used to aid in the data analysis process. An interpretative phenomenological analysis approach was selected and used to furnish detailed examinations of participants' personal lived experiences (Smith & Osborn, 2015). This process allowed for these details to be furnished, absent of pre-existing theoretical preconceptions (Smith & Osborn, 2015). Otter.ai (Voice Meeting Notes) software was used to transcribe participant interviews, while MAXQDA 2022 software helped to identify patterns and create categories, codes, and themes relevant to participant experiences. Line-by-line coding allowed for short summaries of material (main ideas) to be identified, later using these summaries to create themes. These themes were then grouped into categories, highlighting commonalities in negative sexual practices that may increase HIV risk among participants. There were no discrepant cases factored into the data analysis.

The codes generated from the transcribed data were reviewed to confirm that these depictions were addressing similar concepts within the data by comparing participant responses. Eighteen descriptive codes emerged from the data analysis: (a) commitment level, (b) sex toys, (c) safety, (d) risk, (e) education, (f) access, (g) care, (h) sex life, (i) attraction (j) power, (k) authority, (l) sexual decisions, (m) provider competency, (n) provider education, (o) provider ethnicity, (p) resources, (q) future care, and (r) disclosure of sensitive information. Category names were selected based off commonalities within the collected data, identifying shared language across participant interviews. In this study, seven categories emerged from the created codes: (a) relationships, (b) sexual behaviors and sexual practices, (c) HIV/AIDS, (d) healthcare, (e) condom usage, (f) decision making, and (g) providers After the naming process of each category, main ideas and themes were developed. Through the creation of the identified codes and categories, I was able to recognize repeating ideas and meanings within the data that allowed me to derive unified themes. Seven final distinct themes emerged:

1. Perceived level of exclusivity and its influence on power and self-esteem.
2. Use of penetrative sex toys and preventive measures.
3. Perception of individual risk in contraction and transmission of HIV and other STIs.

4. Accessibility to appropriate healthcare, treatment, and health insurance.
5. Condom usage with partner(s), to include emotional connection and sexual attraction.
6. Sexual decisions and level of power and authority in decision making.
7. Healthcare provider competency and healthcare resources for LGBTQ+ community.

Evidence of Trustworthiness

Credibility

Achieving credibility ensures that research findings align with reality (Forero et. al., 2016). This is done through establishing confidence in the truthfulness, credibility, and believability of study results (Forero et. al., 2016). For this study, member checking was used to establish credibility. Each transcribed interview was sent to the designated participant to verify the accuracy and resonance with their experiences to ensure credibility.

Transferability

In this study, transferability was established by following the procedures delineated in Chapter 3. The data were able to be generalized to other contexts, to include cultural and social connections. Thick description was used to provide a detailed account of the experiences of data collection, connecting these cultural and social contexts (Lincoln & Guba, 1985). This detailed account included descriptive information such as the interview process and how interviews were conducted to provide a better understanding of the research setting (Lincoln & Guba, 1985). A connection between cultural and social contexts can be identified within the content of participant interviews, which highlight that the sex-education previously received by these individuals have, historically, only been focused on safe-sex practices related to sexual interactions with men. This lends to the need for patient education, along with the type of healthcare service(s) being provided, to be tailored toward the sexual experiences and interactions (i.e., sexual activity with both women and men) of the patient being serviced. The connection between these social and cultural contexts, highlighted throughout the data, may allow other researchers and readers the ability to make their own judgements related to transferability (Lincoln & Guba, 1985).

Dependability

Dependability relates to the findings of a study's ability to be repeated if used within the same target population, coders, and context (Forero et. al., 2016). An audit trail consisting of a detailed record of the data collection process was used to establish dependability. Additionally, an inquiry audit (or external audit) was used to confirm the accuracy in the findings of the study. This was completed to ensure that the findings of the study match the data that has been collected. This process corroborated the reliability of the study, confirming its ability to be repeated in the same target population and context.

Confirmability

Reflexivity was the strategy used to establish confirmability of the study. Reflexive journals were created and used to ensure the findings were shaped by the respondents and not researcher biases (Forero et. al., 2016). It was important to remain neutral during this process for the sake of confirmability. From reflexive journals, direct quotes from participant interviews were included, in leu of providing my personal analysis of the phenomena.

Results

For this study, I sought to gain a better understanding of the relationship dynamics and sexual practices of WSWM, in relation to HIV risk, by answering for the primary research question underpinning this study's scope: What are the lived experiences of WSWM around HIV risk, resulting from the dynamics of their relationship (i.e., level of commitment, power, authority) and the sexual practices (i.e. condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them? Additionally, the following sub research questions were addressed: SRQ1. What are the attitudes and beliefs of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?, SRQ2. What are the subjective norms (e.g., normative beliefs and motivation to comply with those beliefs) of WSWM around HIV risk, resulting from the dynamics of their relationship and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within them?, SRQ3. Considering the relationship dynamics of WSWM, what are the control beliefs held by WSWM that may affect HIV risk and the sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) that exist within those relationship?

I conducted confidential Zoom (video-recorded) interviews with 25 Black young adult participants. Each participant was asked the same series of 27 open-ended questions that addressed the study's research questions. From data analysis, seven final distinct themes emerged: (1) Perceived level of exclusivity and its influence on power and self-esteem; (2) Use of penetrative sex toys and preventive measures; (3) Perception of individual risk in contraction and transmission of HIV and other STIs; (4) Accessibility to appropriate healthcare, treatment, and health insurance; (5) Condom usage with partner(s), to include emotional connection and sexual attraction; (6) Sexual decisions and level of power and authority in decision making; and (7) Healthcare provider competency and healthcare resources for LGBTQ+ community (see Table 1).

Table 1

Emergent Themes

Themes	Main ideas	Categories
Perceived level of exclusivity and its influence on power and self-esteem	Committed Uncommitted Monogamous Open	Relationships
Use of penetrative sex toys and preventive measures	Vibrator (rose) Butt plug Does not use condoms Cleans sex toys/get new ones STI testing Uses condoms with new partners	Sex toys
Perception of individual risk in contraction and transmission of HIV and other STIs	No risk/No concern	HIV/AIDS
Accessibility to appropriate healthcare, treatment, and health insurance	Inaccessible Treatment dependent on insurance	Healthcare
Condom usage with partner(s), to include emotional connection and sexual attraction.	Does not like smell/Does not use Partner confusion/questioning Emotional/Sexual attraction	Condom usage
Sexual decisions and level of power and authority in decision making	Equal power 1 Partner favored over other Condom use Getting tested	Decision making
Healthcare provider competency and healthcare resources for LGBTQ+ community	Competency Incompetency Knowledge Race Stigma Non-biased care Comfortability Implementing new LGTBT+ healthcare facilities/more LGBTQ+ providers Information/Pamphlets	Providers

Theme 1: Perceived Level of Exclusivity and its Influence on Power and Self-Esteem

Participants shared details of their current relationship status as it relates to monogamy and exclusivity. Many participants perceived their relationship to currently be monogamous and exclusive. It was revealed in participant interviews that, for most, the perceived level of exclusivity (monogamous, exclusive) may have been associated with the power they hold in their relationship(s), in turn, potentially influencing the self-esteem they held within their relationship(s) in making sexual-decisions. Participant 6 had an interesting take on the monogamy within her relationship. She stated:

> “We were committed, but he wasn't monogamous. I was monogamous”.

Within their relationships, some participants have discussed being open and or polyamorous with their partners. When asked about commitment and exclusivity, Participant 12 expressed:

> “Hmm I will say we're committed and monogamous currently, but we've also had the poly (polyamory) conversation but it's harder to navigate than what people think”.

Participant 18 added:

> “Oh, yeah. We're committed and monogamous. If we want to step outside of relationship, we would do it with each other. But we won't, yeah”.

For those who considered themselves uncommitted, it was mostly due to their relationship being open in the sense of dating others. In some cases, it was due to not having the exclusivity conversation with their partner and only casual dating. Participant 22 mentioned:

> “We see other people”.

Participant 19 also considered their relationship to be uncommitted stating:

> “Um, it's not exclusive. It's just casually dating”, adding: “I would say it's more we just haven't had the exclusive conversation yet”.

When asked about their take on using male or female condoms in their exclusive relationships, Participant 7 stated:

“Since we are exclusive now ,we don't use any form of contraceptive”.

Participant 8 added:

> “Um, so me and my partner that I live with, we don't use condoms anymore. But he uses them with other people, um, and then myself, um, I don't interact with other guys too often. I also tend to be with my partners like long term and then like the testing and things like that. So sometimes those safe practices aren't always practice after like, a couple of months”.

Participant 9 reiterated:

> “I think once we got to a certain point, I was okay with whatever came with not using condoms between the two of us, like, you know, in the beginning, we used them. But after we was locked in, it was like, All right, you know, this is what it is”.

In cases where the participant deemed themselves as an inferior partner (related to power) in their relationship(s), there was discussion surrounding how using condoms would affect their partner. Participant 1 spoke to this by stating:

“Um, now that we are used to each other, and I am on birth control, I think the male will feel like it's not comfortable. I don't know why they say that”.

Participant 6 added:

“Um, I don't think it would affect it. Well, I feel like it would affect my partner more so than me”.

Participant 4 spoke to her stance on how condoms would affect her sex life :

“Oh, it wouldn't stop it. But I don't want it”.

Theme 2: Use of Penetrative Sex Toys and Preventive Measures

In most cases, participants used penetrative sex toys. A few participants used butt plugs and anal beads, with either partner (male or female). The most common penetrative sex toy was the use of the dildo with a female partner. For personal pleasure, the most common sex toy was the rose vibrator. Participant 9 stated:

> “We've never like used anything together. That's like alone time. I got a little rose. But that's alone time. We've never used it together”.

Participant 16 reiterated:

“Hmm I only know the rose; the rose is that girl”.

When asked about condom use while using penetrative sex toys, participants admitted to not using them.

Participant 6 confirmed:

“No, no, we don't just because they're, they're just ours”.

Though, many participants spoke about either cleaning their sex toys or getting new ones

Participant 2 stated:

> “We bought toys together and like, go through a system of like cleaning them”.

Participant 6 reiterated:

> “Mmmm. No, because I clean all the stuff and I keep it in my possession and it's just ours”.

Participant 7 expressed:

> “We've also agreed to be keeping our sexual items clean so as to have safer sex”.

Participant 18 stated:

> “No, I actually just boil my sex toys. And I do things like that just to make sure that they're clean”.

As it relates to purchasing new toys, Participant 10 added to the conversation, stating:

> “No, you typically only buy a new one or something”.

Theme 3: Perception of Individual Risk in Contraction and Transmission of HIV and Other STIs

Many participants showed no concern for and perceived themselves not at risk for contracting HIV. Thus, these individuals did not perceive themselves to be at risk for transmitting HIV. Participant 21 stated:

> “I don’t think we ever thought there was a HIV risk, I don’t have it and she doesn’t have it so there’s no risk”.

When asked about their use of penetrative sex toys, condoms and or dental dam and whether use of any of these items could increase risk of contracting and transmitting HIV, Participant 7 expressed:

> “No, not that I know of.”

Participant 1 mentioned:

> “I think in a way they're safe. Yeah, not unless maybe the condom busts. Or maybe the dental dams. I don't know if they are rubber, maybe the material or maybe one occasion when you like, maybe high. Then the dental dam falls off. And many people have found themselves in such situations which have led to them now being positive”.

Participant 3 stated:

> “If someone else is using them? Yes. If it's just me, no”.

Though, many participants had concern for pregnancy and contracting STIs. When asked about what they thought about using, and what their concerns related to having sex without the use of, a male or female condom were, Participant 24 stated:

> “It's a very advisable thing, for those especially who are new in a relationship, and have not yet gone for test. For those who are trying to like avoid pregnancy, and maybe other infections, aside from HIV”.

Participant 11 mentioned:

> “Without them, I worry so much more. Cuz I'm like, am I pregnant? Like, I get tested way more, because it’s just like, well, even if we are exclusive, you never really know what's going on”.

Participant 3 added:

> “I have a concern about pregnancy sometimes, but mainly like STIs. Yeah”.

Participant 8 reiterated:

“STDs. And pregnancy, the unwanted thing. So yes, yeah, that would be it”.

Participant 10 expressed:

“I'm not trying to get pregnant. I'm not trying to catch anything”.

Specifically related to pregnancy, participant 23 stated:

“Um, I guess pregnancy would be my only concern”.

Theme 4: Accessibility to Appropriate Healthcare, Treatment, and Health Insurance

Healthcare experiences varied among participants, with commonalities being related to the quality of care, according to patients’ health insurance company. It was observed by participants that when having an active healthcare insurance plan, they received excessive care and treatment, while receiving inadequate care and treatment when they did not have any insurance. Additionally, many participants felt that they received more services and were treated better, than they would have been not having insurance, depending on what type of health care insurance they had at the time of service (i.e., Blue Cross Blue Shield versus government funded insurance.) Though, for these individuals, more services did not equal a better quality of care. In these cases, participants felt that these healthcare providers and or health care systems were providing these additional services to accrue a larger payment from them, versus addressing the root cause of their visit and providing them with the services needed to address their specific problem. When asked about participant experiences related to healthcare, there were almost an equal number of participant’s who perceived their healthcare experiences to be good, with the other half of participants perceiving their healthcare experiences as poor. Participant 3 stated:

> "Presently, I would say now they're good. In the past, there was a situation where I got an STI and an asked for PrEP, and I was just told to basically, you know, use condoms. And I'm just like, that's an issue. And that's why I feel like PrEP would be helpful since I got an infection from this person twice. So that that was like, maybe a few years ago, but I feel like now, better experiences".

Participant 4 mentioned:

> "I've had very few negative dealings with the healthcare system, and I think as I grew older and more sturdy in my voice there are just certain things I won't accept".

Participant 6 reiterated:

> "I haven't really had a problem with my providers".

As it relates to poor experiences, Participant 8 stated:

> "I had terrible, terrible experiences".

Participant 16 reiterated:

> "Oh, my experience suck every time I'm petrified. I have had a lot of health experiences where it was just bad".

Participant 11 expressed:

> "One thing I'm noticing is like, I have to really, really imprint in their brains that something is wrong for them to like, take me serious. Like I have stomach issues. I had to make four visits for them to actually like run tests".

Participant 12 mentioned:

> "I think I'm a little traumatized, it goes back to my sister had cancer, so she spent a lot of time in hospital. In 2020, I had an abortion and like it was something I wanted to do or whatever. The care that I received before they knew I was getting an abortion was way better than afterwards, like after they knew that I was getting and abortion they did not want to prescribe me meds. And they didn't want to help me with anything. Like, they basically just was like, well, you about to get rid of the baby anyway, you will feel better, soon enough. It's insane".

In describing why it was felt that their healthcare experiences were good, Participant 21 stated:

> "I don't look "gay", whatever that means to people, so doctors assume that I am straight and treat me as such so I don't have any bad experiences".

Participant added to the conversation stating:

> "So I've had experiences, most of, I believe all my experiences with, like doctors and nurses and stuff like that has been positive, because knowing just with the right questions to ask, knowing my body just and being around, because my mom would teach me and my sister, like just certain things like, you know, they take your blood pressure, you have to ask how much it is? And what's high, what's low, what's good, what's not, um, you know, if you have questions ask them, so she kind of raised us to do that".

Participant 2 mentioned:

> “I just lucked up with like a good doctor where I feel like he doesn't assume anything. He always asked questions. This is my primary care doctor. I'm still looking for like a gynecologist. Honestly, that is not just like, assuming like my lifestyle is like heteronormative or anything”.

In describing why it was felt that their healthcare experiences were bad, Participant 13 stated:

> “I have had horrible experiences with my health care providers. One experience in particular was in the process of working to rid the Myoplasmic Genitalium that I had contracted from a previous partner. My doctor did not take me seriously, would repeatedly talk over me and was very negligent. It took me bringing test results from another place for him to even look into the virus which he knew nothing about but refused to admit. He also tested me for the wrong things, so I was given a negative test result even though I was positive and it took me 3 months before getting tested elsewhere to know”.

Participant 13 added:

> “Umm, if I had a problem, only time I ever had a problem with my providers is like I'll go to like a center to get tested. Before I actually saw like, an OB that I liked before, it was, I was really uncomfortable. I felt judged when I would go to an appointment”.

Participant 23 spoke to her bad experiences in healthcare stating:

> “Um, sometimes I felt like I was put in, how can I put it, like in a generalized bargin, maybe since my body is shaped like this, I have to be this, or I have to

> have this. So that was a struggle in the healthcare field. Um, I was pregnant about three times, so pain level, they really didn't listen to me when I said like I was in pain and stuff like that. So, I did experience that and then also, umm kind of almost a bullying tactic for breastfeeding".

Making a correlation between the quality of care received while insured and different types of and healthcare insurances, Participant 5 stated:

> "In a health care system, you have to remember that your health care, the level of care that you're going to receive is dependent upon your insurance. Say, people who are more so dependent on government funded insurance, are going to be screwed, no matter what. So, for instance, I was throwing up blood, I had just lost my job, which meant I was losing my insurance that same day. All of this happened the same day I lie to you not, they sent me home with a shot of Tramadol and told me, that's the only care that they gave me. Now like a year later, I got bit by two pit bulls. They tried to admit me into the hospital. They tried to keep me, try to make me stay because I had insurance so they know that they can get more money. So, the level of care is going to be different, they gave me a room, they gave me everything I needed".

Participant 9 reiterated:

> "I've had some experiences that have worried me, and I feel like the worry came at the price, right? Like it was like, umm, we don't really need to be doing this, but you got Blue Cross Blue Shield, and you know, we gone do it and scare the hell out of you, just because we can".

Participant 18 added:

> "Do you have insurance? I hate when they asked me that. They assume that I don't have insurance. And then when they see that I have Blue Cross Blue Shield. They like, oh, okay let's get you into some X rays. I don't need an X ray ma'am, they want to run up my check at that moment".

When asked about whether appropriate and competent healthcare had been received by those encountered in the healthcare system Participant 16 mentioned:

> "Not really, I feel like when it comes to black people that they think that black people either, like, don't have pain or like tolerate pain differently and stuff like that".

Participant 5 added her take on care received while insured, versus not being insured:

> "When I had insurance? Yes. When I did not have insurance, like I said, we sat in the hallway on a gurney for a long time. It was it was very poor".

Participant 23 gives her take on treatment being based on the type of healthcare insurance a patient has, stating:

> "Um, I did feel a little stuck a few times where I had to get medications that compromise my pregnancy because of the insurance that I had".

Theme 5: Condom Usage With Partner(s), to Include Emotional Connection and Sexual Attraction

Condom usage with primary partner(s) was mainly nonexistent across participant interviews. Participants typically had begun using condoms in the early stages of their relationship, progressively ridding themselves of them overtime. In other cases, participants had not used condoms for the entirety of their relationship. Many participants did not like using condoms due to the barriers that they placed on intimacy, the smell of them, and or the irritability of them. When asked about the use of condoms in their relationship(s). Participant 6 stated:

> “I don't remember the last time we used a condom. It's been years.”

Participant 14 expressed:

> “We do not at all. We never have. We never did. I hate them”, adding: “I just feel like it changes the level of connection to me, I feel like it puts like a barrier in between and, obviously, for good reason if it's somebody you're not meant to be connected with, but I feel like this is like my soul mate. Like, I feel like when we're having sex. I'm very spiritual person, I feel like it's all very spiritually connected, our energy is being shared, you know, all that stuff”.

Participant 13 added:

> “It's really confusing for me because it's like I am. When it comes to women and men, I am more sexually attracted to women, but I am more emotionally attracted to men”.

Participant 23 confirmed:

> “Um, I don't really like using barriers”.

Participant 9 mentioned:

> “ But I think they are beneficial. I hate the way they smell. I think people should use them more”.

Participant 12 added:

> “Condoms also stink”.

Participant 14 stated:

> “The smell. I hate the smell of condoms The smell would bother me”.

Participant 20 reiterated:

> “With male condoms, I really don't like them. I would use them if I needed to. But, you know, I don't like it. That's because of the smell and then you know, it's just it's a hassle sometimes”.

Participant 25 added her take on the irritability of condoms stating:

> ‘The use of condoms sometimes they can irritate you”.

Participant 13 added her take on emotional and sexual attraction and the barriers condoms place on intimacy:

> “It's really confusing for me because it's like I am, when it comes to women and men, I am more sexually attracted to women, but I am more emotionally attracted to men. But yeah, so we don't, I just felt like, I don't know, I just feel like it changes the level of connection to me, I feel like it puts like a barrier in between and, obviously, for good reason if it's somebody you're not meant to be connected with, but I feel like this is like my soul mate”.

Participants were adamant about using condoms with a new partner. When asked about using condoms with a new partner in or outside of their relationship, Participant 2 stated:

> “It’s almost a requirement. So, like I said, that’s something that we do talk about, like if we ever had like another partner. And if that does happen, yeah, we would definitely use condoms”.

Participant 4 added:

> “It has to be done. So, it's like it's a non-negotiable”.

Participant 12 reiterated:

> “Absolutely necessary. No if ands or buts”.

Participant 23 mentioned:

> “I do believe in protection outside of relationships, but inside, then no”.

Partner confusion and questioning was also a commonality across interviews, related to condom use. When asked what would happen if their partner was asked to wear a male or female condom, Participant 14 stated:

> “He would question me and wonder why I wanted to start”.

Participant 13 reconfirmed:

> “I know he would probably think something was off. I feel like he probably think like, are you cheating on me or, you know, whatever, something like that”.

Participant 16 mentioned:

> “Um, oh, okay, we're talking about partner um, they will look at me insanely. They would look and be confused”.

Participant 17 added:

> “Um, I mean, with like, a new partner definitely. And stuff .So I don't have sex, like, I don't know I guess like with like a random person. I can't just do like a

> hookup. Because I get, I have like anxiety because I'm like, I don't know what you have, like, gotta get tested. Like I'm very, like, kind of paranoid and stuff like that, I guess because like with my uncle, like, his partner didn't tell him that he had HIV. So then they had sex and then my uncle got it. And I guess it's like, a big fear of mine is like, someone not saying something".

Participant 18 reiterated:

> "I don't know. I really, I don't know how he would react. It has to be like, Oh, I'm on my period? That's the only reason like I don't know. Like, I wouldn't know why I would ask but he would probably feel like a type of way. Yeah, for sure".

Participant 7 stated:

> "Since we are at a good place in our relationship. I don't think my partner would be in support of that".

Theme 6: Sexual Decisions and Level of Power and Authority in Decision Making

Individual and partner STI testing came up as a main idea across participant interviews. When asked about the sexual decisions ultimately made between themselves and their partner, Participant 18 stated:

> "Yeah. It was just mostly; I was just seeing. Like, is he like recent? Like, has he had sex recently? And since you had sex, have you got tested? How many partners if you are, like continually having sex, actively having sex right now? How many partners are you having sex with because all it takes is one person. But if you have multiple people, that just increases your chances of being exposed. So that was more so like, just asking those questions beforehand and getting that

> proof of like the testing. And yeah, that's pretty much just the precautions that I took".

Participant 12 mentioned:

> "We go get tested pretty often. I mean, not that often. Like we try to go get tested when we think about it. If we have a new partner, we gotta get tested before and after".

Participant 23 reiterated:

"So, like I said, testing, definitely testing and making sure you're there with them.".

Participant 24 mentioned:

> "Frequent testing now, we are open. And now without condoms. So yeah".

Participant 7 reconfirmed:

> "Go for testing every 4-6months".

Participant 10 stated:

> "Um, so typically I get tested like at least twice a year. But when, so I've been with my guy partner for a while, so I wasn't really concerned there. But right before being with my new woman partner, I had just gotten my lady physical and all that stuff too. So, I was already good. And then they had just done theirs. So, we kind of just knew, so, it just worked out".

When asked what concerns participants had about not using condoms, and the effects condoms would have on their sex life, Participant 6 answered:

> “The only reason I say I don't have a concern is because I actually talked to my partners. I actually like want to see test results before I actually go to a point in which I may open myself up in the sense of using or having unprotected sex. I don't put myself at those risks for that so it but if it's someone which I don't really know those kind of situations something happened I'm making sure I use a condom if it's not one around it's nothing happening”.

Participant 9 stated:

> “Umm, now using them, I don't think I would like it. Because it takes away, I mean, I don't know. They do got some little thin ones that might be okay, that might work. But I think it takes away that piece of the connection”.

Participant 12 added:

> “It would probably be less fun, it would be safe, it's not going to be as good. Condoms also stink. Um, yeah. I mean, it wouldn't like be nothing drastic, but it just wouldn't be as good. Like, raw sex is better. Sorry, I'm that girl”.

Participant 13 reiterated:

> “Yeah, yeah, I feel like it would be like a level of disconnection between us if there was like a protective barrier between us”.

Participant 14 mentioned:

> “The smell would bother me”

Participant 16 reconfirmed:

> “Um, ah, it probably would take a toll on it. Um, yeah, it would take a toll on it”.

Most participants either perceived their relationship to have equal power and authority, or one partner favored over the other as it relates to power and authority. When asked about who holds the power in decision-making in their relationship, Participant 8 stated:

> “Yeah, it depends on what it's about. Like, I want to say me, cuz I feel like I just debate more. Um, but, but it just depends on the thing though”.

Participant 10 mentioned:

> “Ah, it's shared. Yeah. Like, I don't like listening to people”.

Participant 11 confirmed:

> “Honestly, I would have to say both because we do communicate”.

Participant 3 stated:

> “I think my partner does”.

Participant 13 reiterated:

> “Definitely I would say him”

Participant 16 added:

> “Umm, Partner?”.

Participant 20 expressed:

> “Me, it's me”.

Participant 21 reconfirmed:

> “I would like to say me when it comes down to it, but we try to make it as much as a equal choice as possible”.

When asked about whether they had more or less authority in their relationship, Participant 2 stated:

“I feel pretty equal. I don't feel like I have more or yeah, or less. I don't think he does”.

Participant 21 expressed:

“It’s more of a partnership, nobody has more authority over the other”

Participant 5 mentioned:

> “We actually are both really headstrong. So, I want to say in my mind, I get more, but realistically it's like, 50/50”.

Participant 1 confirmed:

“I think my husband, my partner, sorry, does”.

Participant 3 stated:

“Depends on the area. I guess there's maybe a little bit less authority, I would say”

Participant 24 added:

“He has the authority”.

Participant 6 expressed:

“Less. Only because I'm very submissive”.

Giving an interesting take on both power and authority, Participant 12 stated:

> “Yeah. I just don't think that authority and power are things that belong in a romantic relationship. My partner and I, we for the most part, like we share, power share authority, and especially when it comes to like making decisions regarding sex like it's for sure an equally yoked decision”.

Theme 7: Healthcare Provider Competency and Healthcare Resources for LGBTQ+ Community

The perception of provider competency varied, based on the healthcare experiences of each participant. Across participant interviews, 9 main ideas regarding the competency and education of providers, care, and resources surfaced: competency, incompetency, knowledge, race, stigma, non-biased care, comfortability, implementing new LGTBT+ healthcare facilities/more LGBTQ+ providers, information/pamphlets.

Competency/Incompetency

When asked "What do you feel could help healthcare providers provide better care to their patients who identify as a member of the LGBTQ community?", Participant 2 stated:

> "Just like I guess, just be more competent and understanding of like, we are at risk for like, it'd be nice to like show up to a healthcare provider. And they know like, oh, well, when you're with women, you're at more risk for this or whatever, you know, like them telling me some stuff".

Participant 1 added:

> "The healthcare provider should be open minded, and should address the situation as it is, and just help these people because at the end of the day, they really need your help. And the service that you give to them is what they'll be following closely. And their advice also really is important. And also, it can save someone maybe who's in a dilemma or something".

Participant 2 mentioned:

> “It's just hard to like, find people in my area that are like really competent”

Participant 3 added:

> “I would say oh, like you did earlier, like ask them what name that they would like to be addressed by, what are their pronouns. And also stating what, like the healthcare providers stating what their pronouns are. Yeah, and also understand that just because someone identifies a certain way, doesn't mean that next patient that identifies the same way is going to have the same meaning.”

Participant 12 confirmed:

> “To be careful with your words, be sensitive and to be willing to be educated”.

Participant 14 expressed:

> “If doctors were more open and had more humility for all humans”.

Knowledge

When discussing knowledge among healthcare providers, Participant 7 stated:

> “A doctor's lack of knowledge can make LGBTQ patients feel scared since most of the time you have to be your own doctor”.

Participant 2 added:

> “Younger doctors are just; I think they're just educated a little bit better. And we're exposed to like, the nuances of like relationships and health care”.

Participant 15 reiterated:

> “Um honestly, to get educated, I know, in medical school, they don't really teach you a lot of it, like my sister's in medical school right now. And, you know, like, really study anything about different genders and how you should talk to them in

> a way, I feel like, medical schools are more so like, either they're like really hands on, or he's just like you reading a textbook, but they're not really telling you how you should be empathetic".

Participant 8 mentioned:

> "Um, I definitely think as much knowledge as possible on the community, maybe even like terminologies and things like that and how best to help your patient based off of like, their, their sexual orientation, as well as their as well as their race. I think it's like just a key part".

Race

Across participant interviews, individuals have felt more comfortable receiving care from Black doctors and thus, seek Black doctors when accessing healthcare services. Participant 5 stated:

> "And so that's why I'm like really particular about, like, if I go see the fertility doctor or reproductive specialist, I want it to be a Black person. I don't want it to be anybody who can't identify what I'm talking about".

Participant 8 reiterated:

> "So, I go out of my way to try to find Black people in the medical field. So, like, my dermatologist now is Black. That wasn't the case before. And I had terrible, terrible experiences. My physician, my OBGYN is a black woman. My dentist is a Black woman. Um, so now my experiences are a lot better. I feel more heard and things like that. But prior to that, I would not say that that was the case. So basically, out of college, I've had a Black doctor".

Participant 20 expressed:

> “I do have like, you know, Black doctors, actually from the same neighborhoods that I come from”.

Participant 21 mentioned:

> “Luckily for me my doctor is a Black woman, so she made me feel comfortable about disclosing my information”.

Participant 10 added:

> “My black therapist is the one that helped me find my primary care physician. And then I found a black eye doctor and a black chiropractor, and stuff like that. So, I felt more supported”.

Participant 15 confirmed:

> “Now I'm more so just going to like black doctors. I have to literally ask for like a Black doctor. You know, I mean, I don't feel comfortable just being in there with White people, if that makes sense. Yeah, for sure. That prejudice. but I just find they don't really take care of African Americans, like they should”.

Stigma

In discussing the context of stigma, Participant 4 highlights sexual orientation related to stigma by mentioning:

> “I think for certain providers, they have to remove a lot of the stigma that is associated with the LGBTQI community. And treat people who come to them just as a person and not their sexual orientation. Unless it has to deal with what is going on with them. Just having trainings on stigma”.

Participant 24 reiterated:

> “They should give services without discrimination, they should be friendly to them, they should encourage them to come out because others feel like stigmatized. So, they better deal with their problems. So, it's better that like they come up with a program specifically for them, to encourage them to treat them fairly”.

When later asked about hopes for the future of health care provided to those in the LGBTQ+ community, Participant 24 added:

> “I would wish like they're treated fairly like they are able to access the services whenever they need them. And the not suffer stigmatization for coming out. And they should be treated with a lot of caution and friendliness so that they feel like they belong, and not shy away from their problems that can be solved”.

Participant 4 mentioned:

> “And I know it's gotten a lot better for people, but it also hasn't. I think this stigma, it's kind of like just, help this person. It doesn't, like, the idea that, why does it matter if they, of whom they sleep with or how they identify, it doesn't have no bearing on you, and how you perform medicine. So just help that person regardless of their status or orientation, whatever it is”.

Participant 10 stated:

> “Um, just to be less stigmatized and more comforting, or understanding, like, regular ass people that need-to-know things. And the opinions aren't necessary”.

Non-Biased Care

The absence of biases was revealed as a main idea in healthcare providers providing better care to their patients who identify as a member of the LGBTQ+ community. Participant 8 stated**:**

> "Yeah, you gotta be non-biased. You gotta be able to relate or not even relate but just understand where they coming from if you don't understand ask them questions and listen to what they talk about".

Participant 4 agreed by mentioning how personal biases might impact those around you, stating:

> "Knowing your own biases would actually assist a lot of doctors, nurses, and even, you know, people in the front, at the front desk, you know, see someone walk in and they automatically assume everything, because of the way they appear. I think that that deters people from you know, getting help".

Participant 21 added:

> "Not be bias towards their patients, my family doctor doesn't know how I identify because she looks at me and assumes I like men and I think that would be such an awkward conversation to have. Also, maybe have something in the lobby that shows that the office is LGBTQ + accepting"

Participant 7 stated:

> "And they can simply do this by visibly posting a nondiscrimination statement or displaying educational materials about LGBTQ health concerns".

Comfortability

Most participants felt comfortable disclosing sensitive information to healthcare providers, dependent on the provider. When asked “Are you comfortable disclosing sensitive information to healthcare providers? Why or why not?” Participant 7 answered:

> **“**That really depends on the person who's attending to us. If they seem to be respectful and non-judgmental well in that case, I would feel comfortable sharing some of the information that I feel are personal”.

Participant 9 reiterated:

> “I guess it all depends on who it is. And again, it's all about the feel of the appointments”.

Participant 10 stated:

> “Oh. I guess it makes me a bit more confident when I'm able to disclose them. And it's not like, some type of weird reaction to it. And I guess that in turn is like helps them figure out all whatever they got to figure out. But I guess just like trying to take the leap to be as honest as possible, has only helped, even though it's been like mad uncomfortable, or I've had to do it more than I would like to”.

Participant 11 added:

> “Uhh yes, because I guess the root of what I'm trying to do is like gets the issue. So, I want to be honest with you. So, the only way you can like really, well, I hope that they can, like really get down to stuff is like knowing the truth about what's going on in my life, whatever, however sensitive that information is”.

Related to comfortability and the hope for the future of healthcare provided to those in the LGBTQ+ community, Participant 9 stated:

> "And so, if we remove those personal feelings, I think that will open up the floodgates for people to feel comfortable to get care to come in and see help".

Participant 8 reiterated:

> "So, um, my hope is that more people feel more comfortable".

Implementing New LGBTQ+ Healthcare Facilities/ More LGBTQ+ Providers

Participants made mention of feeling more comfortable going to LGBTQ+ centered/focused healthcare facilities, along with hoping that there would be more made available to them in the future. Participant 8 stated:

> "So maybe having those like, hey, this is a queer friendly, entire, like doctor office where everybody's going to be super knowledgeable on all things queer. Maybe even having the ability to have those types of labels on like, doctors and stuff like that".

Participant 21 reiterated this hope of having access to more LGBTQ+ healthcare facilities in the future by stating the following:

> "I just hope that there are more LGBTQ + health clinics developed. It's not just the topic of STD/STI health, its trans people seeing health providers that make them feel comfortable, its women that want to start IVF with their partners. There are so many things partnered with the health and safety of the LGBTQ+ community and having a healthcare provider that understands that is very important.".

Participant 9 mentioned:

> "As a Black woman period, the health care system is not a safe space. So, I definitely prefer the smaller the more intended, focused clinics where I know I can run in here real quick. If I got a yeast infection or BV to get what I need, get in get out. No judgment" Places like Planned Parenthood and other little clinics like that are so important because it opens the door for those people to come in and get the care that they possibly wouldn't get without those places existence".

Participant 2 added:

> "It's hard to find like LGBT, like friendly healthcare".

Participant 18 expressed hope for more LGBTQ+ providers in healthcare by stating:

> "So, I'm really hoping that like more like there's going to be more gay doctors and you know, that can like help their peers and help their counterparts and just like educate them and yeah, like help them get a more open mind".

Participant 18 stated:

> "Have more LGBTQ+ people in the health care system".

Information/Pamphlets

Participants felt that there should be more information, education, and resources provided to those who identify as a member of the LGBTQ+ community, to include pamphlets. When speaking on education as a resource, Participant 2 stated:

> "No one has, like, in the healthcare fields ever explained to me like, hey, like, if you're swapping toys, you might want to consider… a kind of a toy you might want to use…, like, no one's taught me".

Participant 11 confirmed:

> “Again, like we were talking about, like when you ask that question, there should be like, a certain education package, just something to like, educate people who don't know. Like when I started messing with girls, I didn't even think about dental dams or female condoms, or I didn't think about using different toys because there isn't like anything out there. They're like, it is between like, male and female sex”.

Participant 9 mentioned:

> “And then, you know, teaching instead of talking. We talk at people so much, instead of just educating and educating correctly, where it's not okay, let me make you feel like shit for your life decisions. But let me teach you what your life decisions could lead to if you don't handle them correctly, you know, if you don't do and operate correctly within the life that you are living with this could possibly lead to”.

Participant 13 added:

> “Education. My sexual orientation does not take away from who I am as a human being and how I deserve to be cared for. No one has a say in who I sleep with, and the oath for medicine was sworn to help us all...not just those who they agree with. Also, why should it even be a factor in my care? Unless you’re going out your way to test/help me with things that may be more common for LGBTQ community members...it shouldn’t even matter”.

Participant 2 reiterated:

> “Have more tools and resources for me to use”

As it relates to information and pamphlets being provided, Participant 11 stated:

> “I guess that we'll have more information, as far as like, sex, how HIV can be transmitted between two females, whatever, whatever it is, I don't I don't know exactly what it is, but just more information for people”.

Participant 10 reconfirmed:

> “Probably just providing more information of about the risks. Because like, instead of just being, this'll just be like, Hey, you're gay. So, you might get HIV, like not that. So, like me just being a woman and providing those risks to everyone because you don't like, well some people do look gay, but most people not out here looking gay. So, it's like, if you just broaden the spectrum, and just provide everybody with the things that they need, I feel like it would just be much more understood, then less criticized and less scary of a thing”.

Participant 15 reiterated:

> “Just being more informative, having more information and pamphlets about it, just so you know, and just figure out how to always like make someone feel comfortable like if a transgender person walked into the room. How do you deal with them? Would you treat them with the same respect, especially knowing that you know they're transgender like it shouldn't just be because you're making money, you're doing this, but also like the people who are like in the low-income community”.

Summary

The purpose of this phenomenological study was to fill a gap in existing literature that currently exists in HIV prevention and testing interventions for women who have sex with women, to also include interactions with men. This was achieved by representing Black Young Adult WSWM in behavioral research, identifying their lived experiences in relationships that may have influence on HIV risk. 25 Black women voluntarily answered 27 open-ended exploratory questions that provided explanations of their lived experiences and sexual practices in relationships with both women and men. Based off participant interviews, it can be concluded that these women may be at higher risk for HIV overtime, based off the level of power and authority they hold in their relationships and their sexual decisions and practices (i.e., condom use, penetrative sex toy use, etc.). Participants suggested that education provided to healthcare providers should include humility teachings and training(s) on stigma within the LGBTQ+ community, to include education on appropriate pronouns and identifying genders.

Data collected from participant interviews also highlighted the need for more LGBTQ+ identifying providers in the healthcare field, along with the addition of more LGBTQ+ friendly/focused healthcare facilities, that provide care to LGBTQ+ patients. Implementation of such would provide better comfort to patients in seeking healthcare and disclosing sensitive information to healthcare providers. In Chapter 5, I provide an interpretation of the study findings, identify the study limitations, provide recommendations for future research, discuss the implications for positive social change, as well as provide an overall conclusion of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological qualitative study was to explore the lived experiences of Black WSWM, ages 18 to 35, in the United States and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. The study was conducted to fill the existing gap in literature that exists in HIV prevention and testing interventions for women who have sex with women, to also include interactions with men. More specifically, the study conducted highlighted Black young adult WSWM, who are underrepresented in behavioral research. Exploring the relationship dynamics of Black young adult WSWM helped to gain insight on the sexual risk behaviors of WSWMs that exist in those relationships and how they may be related to increased HIV risk. Data analysis of the study results unveiled seven final distinct themes:

1. Perceived level of exclusivity and its influence on power and self-esteem.
2. Use of penetrative sex toys and preventive measures.
3. Perception of individual risk in contraction and transmission of HIV and other STIs.
4. Accessibility to appropriate healthcare, treatment, and health insurance.
5. Condom usage with partner(s), to include emotional connection and sexual attraction.
6. Sexual decisions and level of power and authority in decision making.
7. Healthcare provider competency and healthcare resources for LGBTQ+ community.

The findings of the study indicated that many participants deemed their relationship to be monogamous and exclusive. Within these relationships, most participants did not use condoms with their primary partner but felt it necessary to use them, in or outside of their relationship, with a new partner. Most participants also used penetrative sex toys but did not use condoms while using them. Participants highlighted the need to purchase new toys with new partners or to clean their existing ones. As a result of the status of their relationship (i.e., monogamous, exclusive), participants did not deem themselves as at risk of contracting or transmitting HIV or other STIs.

A main idea related to the identified codes “safety” and “sexual decisions” pertains to participants’ view in the importance of individual and partner STI testing in their relationships, many times accomplishing this prior to sexual encounters. As it relates to power and authority in these relationships, most participants either perceived their relationship to have equal power and authority, or one partner favored over the other as in relation to power and authority. The perception of provider competency varied among participants based on the healthcare experiences of each participant, with commonalities in the perception that increased education, awareness, and knowledge of appropriate pronouns and identifying the appropriate genders should be the focus of provider trainings. Additionally, participants felt that more information, education, and resources should be provided to LGBTQ+ patients seeking services, with an increase in LGBTQ+ centered healthcare facilities being implemented across the nation. Chapter 5 will present an in-depth interpretation of the study’s findings, identify the limitations of the study, provide recommendations for future research in Black young adult WSWM behavioral research, and conclude the study.

Interpretation of the Findings

Interpretations of the findings of this study derived from an interpretative phenomenological analysis approach. Seven distinct themes emerged from data analysis that corroborates with the primary research question and peer-reviewed literature conducted by researchers within behavioral research pertaining to WSWM and HIV risk, as outlined in Chapter 2. Moreover, each emergent theme from the data were prominent in understanding how the dynamics of a relationship may influence risky sexual practices by identifying the behavioral beliefs of participants and their partners, linking behavior to expected outcomes. In the following section, the seven themes unveiled from thematic analysis of the interview data are examined and discussed, to include how these findings confirm, disconfirm, or extend knowledge in the HIV/AIDS field, more in-depth:

1. Perceived level of exclusivity and its influence on power and self-esteem.
2. Use of penetrative sex toys and preventive measures.
3. Perception of individual risk in contraction and transmission of HIV and other STIs.
4. Accessibility to appropriate healthcare, treatment, and health insurance.
5. Condom usage with partner(s), to include emotional connection and sexual attraction.
6. Sexual decisions and level of power and authority in decision making.

7. Healthcare provider competency and healthcare resources for LGBTQ+ community.

Theme 1: Perceived Level of Exclusivity its Influence on Power and Self-Esteem

Self-esteem and power in sexual relationships have the potential to influence safe-sex negotiations (Shaver et. al., 2018). In this study, the level of exclusivity (monogamous, exclusive) of most participants, the level of power and authority the participants' held in their relationship(s), and the sexual decisions made within their relationship(s) attributed to the non-use of condoms in participant's relationship with their primary partner(s). The perceived level of exclusivity of most participants may have been associated with the power they hold in their relationship, in turn influencing the self-esteem they held within their relationship(s). This became evident in cases where participants who deemed themselves as the inferior partner (as it relates to power) felt that using condoms would affect their partner, in some cases, more than themselves. Results of the current study determined that their partners may question participant's sexual decision(s) (i.e., to use or not to use condoms), which may influence their self-esteem. Self-esteem and power in sexual relationships have the potential to influence safe-sex negotiations (Shaver et. al., 2018). Results of the study determined that partners may question the individual's sexual decision(s) (i.e., to use or not to use condoms), which may influence their self-esteem. Self-esteem dependent on approval from a male partner may influence self-injurious behaviors (Altschuler & Rhee, 2015). These self-injurious behaviors may include, unsafe sex, and denial of HIV/AIDS (Altschuler & Rhee, 2015). Factors present in the data collected that may facilitate or impede performance of risky sexual behavior are the sexual decisions made by the majority participants to not use condoms. Additionally, obtaining negative STI test results from partners in exclusive relationships may influence riskier sexual behavior as most participants found comfort in engaging in sexual activity, without the use of condoms, as a result of obtaining STI results. These results may increase risk of contraction and transmission of HIV as participants have sex with both women and men.

Power, identified as a relationship dynamic, is discussed in an article written by Altschuler and Rhee (2015). The authors reported on a pilot study that investigated the degree to which self-esteem and power in sexual relationships influence safe-sex negotiations among older women. Results of the study indicated that individuals who possess higher levels of general relationship power and self-esteem are more likely to have greater power in sexual decision-making (Altschuler & Rhee, 2015). Related to inferior partners in relationships, Dworkin et al. (2017) reported that perceived physical or sexual threat can cause fear of IPV within the less dominant partner, influencing forced condomless sex, resulting from the inability of the inferior partner to initiate and negotiate condom use. The results of the study conducted for this dissertation, in relation to Theme 1: Perceived level of exclusivity and its influence on power and self-esteem, aligns with the current known knowledge in existing literature (Altschuler & Rhee, 2015; Dworkin et. al., 2017; Shaver et. al., 2018) by confirming that the sexual decisions of the target population may be influenced by their partners, potentially impacting their self-esteem, and influencing self-injurious behaviors. These influences may result from the level of power (i.e., dominant, inferior) in decision-making held by the participants' partners within these relationships.

Theme 2: Use of Penetrative Sex Toys and Preventive Measures

In most cases, participants used penetrative sex toys. While using penetrative sex toys, participants did not use condoms. Instead, these individuals either boiled their current toys or purchased new ones before use, especially when engaging in sexual activity with a new partner. Although the intention for prevention exists, not using condoms while using penetrative sex toys may still play a role in the risk associated with contracting or transmitting HIV. Additionally, when participants were asked about their use of penetrative sex toys and condoms (while using penetrative sex toys) and whether use of any penetrative sex toys could increase risk of contracting and transmitting HIV, most participants felt that use of these items would not increase risk. Kennedy et. al., (1995) suggested that prevention interventions for WSW must address behaviors that put WSW at risk for HIV infection. This suggestion is inclusive to unprotected penile sex and sharing of sex toys with women, additionally stating that the possibly of sexual transmission of HIV via female-to-female sex should not be discounted (Kennedy et. al., 1995). As such, results from this study (in relation to theme 2) suggest that concept of condom use while using penetrative sex toys should be addressed in prevention interventions as nonuse of condoms exemplifies sexual behaviors that may put WSW at risk for HIV infection. The results of this study extend the knowledge of existing literature (Kennedy et. al., 1995), as there was no evidence in literature found within the past 5 years on prevention interventions that connect increased HIV risk in WSWM to the use of and or sharing of penetrative sex toys while engaging in sexual activity with either sex (male or female). Unprotected sex along with sharing sex toys with other women, to include nonuse of condoms while using penetrative sex toys, may increase risk of contracting and transmitting of HIV through bodily fluids and or oral activity among WSWM.

Theme 3: Perception of Individual Risk in Contraction and Transmission of HIV and Other STIs

Concerns related to having sex without the use of a male or female condom were attributed to potentially becoming pregnant or contracting an STI. Many participants had concern for pregnancy and contracting STIs but did not have concern for, and perceived themselves not at risk for, contracting or transmitting HIV. Engaging in sexual activity without the use of condoms or dental dam, or one's perception that they are not at risk for contracting and or transmitting HIV, may put them at greater risk for doing so, as they may become lax in incorporating preventive measures into their sex life. As a result, the self-injurious behavior of denial of HIV/AIDS (in this case, denial of risk for HIV/AIDS) exists.

Limited research currently exists related to sexual risk behavior among WSWM. Although it has been found that individuals in this population have poorer sex health outcomes and exhibit riskier sexual behaviors, the intention behind these riskier behaviors (i.e., relationship dynamics, sexual practices) has yet to be studied (Alexander et. al., 2016). Risker sexual behaviors for this population include higher STI rates than those who identify as solely lesbian or heterosexual (Alexander et. al., 2016). The results of this study contributes new knowledge to the existing body of research on riskier sexual behaviors (Alexander et. al., 2016) by identifying the intention (related to partner influence in decision-making) behind these riskier sexual behaviors, attributing to the greater risk of these individuals (WSWMs) contracting and transmitting HIV. This is accomplished by identifying the relationship dynamics (i.e., self-esteem, power) and sexual practices (non-use of condoms in penile sex and while using penetrative sex toys), that exist within WSWM relationships and how they may influence HIV risk. Self-esteem dependent on approval from a male partner may influence self-injurious behaviors (Altschuler & Rhee, 2015). These self-injurious behaviors may include unsafe sex and denial of HIV/AIDS (Altschuler & Rhee, 2015). The results of the study corroborate with the literature (Alexander et. al., 2016; Altschuler & Rhee, 2015) that highlights WSWM exhibiting riskier sexual behaviors by confirming that the study population mainly does not use condoms with primary partners and ultimately does not find themselves at risk for HIV.

Theme 4: Accessibility to Appropriate Healthcare, Treatment, and Health Insurance

When asked about experiences related to healthcare, there were almost an equal number of participants who perceived their healthcare experiences to be good and those who perceived their healthcare experiences as poor. Commonalities in healthcare experiences related to quality of care among participants existed according to patients' health insurance company. Participants felt that based on their health insurance company, the level of care received differed. Additionally, participants believed that those who do not have health insurance or are dependent on government funded insurance may be treated with a lower quality of care than those who are not insured by government funded programs. Of those participants who were insured, many participants felt that they received more medical attention and services than they would have if not insured. However, these individuals also suggested that they did not feel that they received better care as a result of being insured, many times attesting this to their race and comparing it to the quality of care they have witness be received by their White counterparts. These experiences highlight the lack of comprehensive services currently being provided to these Black WSWMs when accessing the healthcare system.

Cultural competency training is a strategy used to strengthen the knowledge, attitudes, skills, and behavior of health care professionals (Jongen et. al., 2018; Kaihlanen et. al., 2019). These trainings intend to improve healthcare services being provided to culturally and ethnically diverse patient groups (Jongen et. al., 2018; Kaihlanen et. al., 2019). Such trainings should be incorporated in higher education settings (i.e., at the medical and nursing school level), to include teachings and or seminars on LGBTQ+ culture and providing these patients with appropriate care, before these providers are in practice. Additionally, healthcare systems must make improvements in providing culturally competent care to diverse populations, incorporating racial and ethnic diversity measures (Nair & Adetayo, 2019).

These diversity measures should also incorporate improvements in care, tailored toward serving LGBTQ+ community, as all races and ethnic backgrounds are included in this population (Bass & Nagy, 2021). Some of these measurements include advertising that a practice accepts LGBTQ+ patients, educating staff on sexual orientation and sexual practices, and including LGBTQ+ individuals as staff and or in training (Bass & Nagy, 2021), as discussed by the participants of this study. The results of the study related to Theme 4: accessibility to appropriate healthcare, treatment, and health insurance, confirm the knowledge known in the literature (Bass & Nagy, 2021; Jongen et. al., 2018; Kaihlanen et. al., 2019; Nair & Adetayo, 2019) by highlighting the need for improvements within healthcare systems (i.e., advertising acceptance of LGBTQ+ patients, educating staff and providers on sexual orientation and practices) to help diminish healthcare disparities, improving healthcare outcomes in diverse and LGBTQ+ populations.

Theme 5: Condom Usage with Partner(s), to Include Emotional Connection and Sexual Attraction

The behavioral beliefs (i.e., perceived behavioral control) that exist among participants, as a result of current or past relationships, can be related to expected sexual outcomes. For instance, the advantages or disadvantages of using condoms in the relationship may vary depending on the beliefs of the participant or their partner. Condom usage with primary partner(s) was mainly nonexistent but condom use with a new partner was deemed as a necessity. Many participants did not like using condoms with their primary partner(s) due to the barriers that they placed on intimacy and or the smell of them. When asked what would happen if their partner were asked to wear a male or female condom, participants felt that their partner would either be confused or would disapprove of such. The disadvantages of using condoms viewed by participants and or their partners lends to the self-injurious behavior of unsafe sex.

WSWM have been reported to be less likely to use condoms (Alexander et. al., 2016). The self-injurious behavior of unsafe sex was identified as an existing sexual risk behavior among the study population, which may contribute to HIV risk. These results confirm existing knowledge in the literature (Alexander et. al., 2016) by producing corroborating evidence that establish WSWM as being less likely to use condoms. These facts further amplify the need for increased access to appropriate healthcare services, to include proper health education, for WSWM.

Theme 6: Sexual Decisions and Level of Power and Authority in Decision Making

Whether the participant holds the most power and authority in decision-making within their relationship may attribute to unsafe sexual decisions being made. For instance, many participants believed their partner would not be in favor of using condoms in their relationship. When asked about the effects condoms would have on their sex life, participants stated that using condoms would have a negative impact on their sex life, believing that sex would be less fun, be lesser in quality, or that a connection would be lost. Most participants either perceived their relationship to have equal power and authority, or one partner favored over the other as it relates to power and authority.

Unequal power in relationships can influence exposure and risk factors that increase women’s risk of HIV (Haberland, 2015). For those who viewed themselves as having less power and or authority in their relationship, their partner(s) influence may play a role in the sexual decisions that they make for themselves. For instance, a dominant partner may influence the inferior partner to engage in sexual intercourse without a condom (Altschuler & Rhee, 2015). Thus, potentially putting them at more risk for contracting and or transmitting HIV. The results of the study, in relation to theme 6: sexual decisions and level of power and authority in decision making, confirms existing knowledge in the literature (Altschuler & Rhee, 2015; Haberland, 2015) through reiteration of the potential of partner influence on condom usage and the likely risk for HIV existing in these sexual relationships.

Theme 7: Healthcare Provider Competency and Healthcare Resources for LGBTQ+ Community

The perception of provider competency varied, based on the healthcare experiences of each participant. Across participant interviews, 9 main ideas regarding the competency and education of providers, care, and resources surfaced: competency, incompetency, knowledge, race, stigma, non-biased care, comfortability, implementing new LGTBT+ healthcare facilities/more LGBTQ+ providers, information/pamphlets. Participants felt that providers should become more educated on appropriate pronouns and identifying the appropriate genders within the LGBTQ+ community. Additionally, inclusion of additional resources such as information (potentially a pamphlet of sorts) provided to patients and an increase in LGBTQ+ healthcare facilities across the nation emerged as a common main idea within the data.

Culturally competent healthcare systems may help to improve the health outcomes, quality of care, and patient satisfaction of its patients (HPI, 2019). In order for there to be culturally competent healthcare systems, ensuring that staff members and providers have had training in relevant competencies must first be accomplished. More specific to LGBTQ+ populations, this can be accomplished by ensuring that providers receive training (beginning in medical or nursing school) on sexual orientation and identifying appropriate genders. Through this study, the lack of provider and patient education, appropriate healthcare services, and resources that currently exist within LGBTQ+ populations were identified, helping to achieve the goal of the study; to inform future culturally competent LGBTQ+ interventions that will provide education to health care providers on delivering culturally competent services to LGBGTQ+ populations. Existing knowledge on sexual behaviors and health-related risks of young WSW (in relation to HIV) (Boone et. al., 2015; Shaver et. al., 2018; Wang et al., 2015) is extended via the results of this study by representing Black young adult WSWM in behavioral research. This is accomplished by determining the sexual behaviors that exist behind health-related risks of young WSW and HIV, which inform the types of improvements to be made in providing culturally competent care to ethnic, racial, and culturally diverse population, to include members of the LGBTQ+ community. This study offers evidence on the kinds of information and education healthcare staff and providers need to ensure that culturally competent care is made available to LGBTQ+ populations. The results of this study also provide information on what additional education and resources should be provided to WSWM populations, both in hopes of helping to decrease racial, ethnic, and LGBTQ+ health disparities that currently exist in healthcare.

Connections With Theoretical Framework

Azjen's Theory of Planned Behavior (TPB) (1991) was used as the theoretical framework to guide this study. TPB intends to identify an individual's intention to perform a given behavior and serves as an indicator of how much effort one will put into performing a behavior (Ajzen, 1991). This theoretical framework was used to understand how the dynamics of a relationship may influence risky sexual practices by identifying the behavioral beliefs of participants and their partners, linking behavior to expected outcomes. By identifying the behavioral beliefs of participants, use of the TPB aided in understanding how the dynamics of participant relationships may influence risky sexual practices (i.e., non-use of condoms), ultimately linking behavior to expected outcome. Understanding participants' perceived level of exclusivity can be associated with the perceived behavioral control construct of the TPB. For most participants (who are in monogamous and exclusive relationships), the perceived behavioral control of using condoms can be deemed as nonexistent. Based off the relationship dynamics (i.e., self-esteem, power, and IPV) of participants, the agreements that have been made between partners on sexual practices (i.e., condom use, penetrative sex with sex toys, penetrative sex with body parts, etc.) may be greatly influenced. Using the TPB informed the primary research question by answering for how the dynamics of a relationship may negatively or positively influence sexual practices, potentially increasing the chances of HIV contraction and transmission within the relationship.

Contribution to the Literature

The majority of research on HIV incidence, prevention, and treatment efforts have been focused on MSM. The literature review performed for the study was heavily infused with research related to the MSM population, as there is not a lot of current research being conducted on HIV risk in WSWM. This study contributes new knowledge in HIV prevention and testing interventions for women who have sex with women, by also including interactions with men. More specifically, the study addresses the gap that exits in research in determining sexual behaviors that exist in relation to the health-related risks of young women who have sex with women (WSW) and HIV (Boone et. al., 2015). As a result of this study, the sexual practices that exist within behaviorally bisexual relationships were identified; showcasing that the population being studied (WSWM) may be at increased risk for HIV contraction and transmission.

The results of this study extend knowledge add to the existing body of research in several ways. The most recent literature found connecting WSWM, penetrative sex toys, and HIV risk was cited in 1995. Kennedy, et. al. (1995) mentions that WSW engage in behaviors that put them at risk for HIV infection, such as unprotected sex with men and unprotected sex or sharing of sex toys with women. Insights from this study highlight that the possibility of HIV via female-to-female sex should not be discounted and point to the need of health providers understanding of sexual identity and how it does not always predict sexual behavior (Kennedy et. al., 1995). The results of the current study showcase that participants who have sex with women do not typically use condoms while doing so. This could lend to increased risk of contraction and transmission of HIV as these individuals also do not use condoms with their male partners. As sexual identity does not always predict sexual behavior, this information should be included in provider trainings and educational materials so that they may be aware of this and be able to appropriately provide care to their LGBTQ+ identifying patients. The idea that sexual identity does not have an influence on sexual behavior is identified in the current study in participant responses when asked “What is your hope for the future of health care provided to those in the LGBTQ+ community?” through participant reiteration:

Participant 5 stated: “Because if you look at me, you don't know what I do in my bedroom”.

Participant 4 added: “I don't know it would be just helping me, the person not my, what I identify as or who I sleep with, or making assumptions that I probably walked around with, like fuckin HIV or something”.

Assumptions regarding care surrounding HIV risk should not be based off self-reported nor presumed sexual identity (Kennedy et. al., 1995). Using the results of the previously conducted study as guidance, care being provided to LGBTQ+ populations should include questions to confirm sexual identity and current sexual partner(s), in order to provide both culturally competent care and appropriate healthcare services and resources to patients seeking medical care. As WSWM’s, penetrative sex toys, and HIV risk has not been studied in over 30 years, the current study is revolutionary to improving healthcare in the field of public health of by addressing changes that should be made to improve quality of care within LGBTQ+ populations. Results of this study have the potential to guide new medical and nursing education, new physician/provider trainings, new policies around inclusive healthcare practices, and a better healthcare system that more equitably addresses the healthcare needs of WSWM. Current knowledge in literature is also extended through the execution of this study by identifying the relationship dynamics and sexual practices that exist within WSWM relationships and how they may influence HIV risk, to help answer for which healthcare services participants need access to and the resources the population being study require. Additionally, data from this study extends current knowledge study by representing Black Young Adult WSWM in behavioral research, identifying their lived experiences in relationships that may have influence on HIV risk. Identifying the connections between Black Young Adult WSWM, their lived experiencing influencing HIV risk, and the need for increased access to healthcare services and resources among the study population may aid in decreasing racial and ethnic health disparities in providing culturally competent healthcare.

Study Limitations

There were a few limitations that affected the study, as outline in Chapter 1. The first limitation was access to the study population. This could have been a result of the sensitive nature of the sensitive nature of the research and or the COVID-19 pandemic (having less face-to-face interactions with potential participants). The COVID-19 pandemic limited interactions with individuals and restricted in person recruitment, preventing me from attending community events to actively recruit participants. Although I work in the healthcare field, no longer being in person in my current positions (Public Health Educator, Co-Chair of the Michigan HIV/AIDS council) prevented access to the study population as well. Additionally, the original demographics of the study population were a barrier to recruitment and data collection. As a result, the age range of participants (originally 18 to 30) and the location which they reside was changed (from Michigan to the United States). The incentive for participation was also changed from a $10 gift card to a $25 Amazon gift card as the incentive amount may not have been very intriguing for participants, with the study topic being such a sensitive one. All other predicted limitations to the study (presented in Chapter 1) were not a factor in the recruitment and data collection processes of this study.

Recommendations for Future Research

Existing literature does not address relationship dynamics in the context of adolescent and young women WSWM relationships. Moreover, some literature does account for the effects these relationship dynamics have on adolescent and young women WSWM sexual relationships, in relation to HIV risk (Sabri et. al., 2019, Manning et. al., 2012; Durvasula, 2012). Based off the results of the current study, it is recommended that future research include WSWM populations in HIV prevention and testing interventions to fully understand the needs of this specific LGBTQ+ population in receiving appropriate healthcare services and to further understand the education and resources to be provided to these individuals. Doing so will help healthcare providers understand how to provide culturally competent care to patients who identify as a member of the WSWM population. Additionally, although intimate partner violence was identified as a relationship dynamic earlier on in this dissertation, the existence of IPV in participant relationships was not gauged in the execution of this study. This topic should be explored in future research as knowing the details of how IPV may influence sexual behaviors and decisions may help to deliver better education to both providers, in caring for their patients, and to patients in receiving appropriate healthcare services.

In light of the COVID-19 pandemic and the new normal of a virtual world, online passive recruitment was the most successful tactic in participant recruitment and is recommended to be used in future research that is also conducted virtually. This recommendation is a result of the pandemic barriers experienced related to in person recruitment and attendance at community events. Expanding the age range of the participant population could potentially yield richer data to answer for the research questions. Increasing the study sample size may be helpful in obtaining richer data, achieving saturation sooner, and influencing a more in-depth interpretation of the study results, potentially decreasing limitations in future research. An increase in the dollar amount of the incentive might prove to recruit more participants, in a shorter time period, as well.

Identifying the relationship dynamics and sexual behaviors of the target population hopes to inform future clinical cultural competence interventions which address the problem associated with the phenomena of sexual practices within WSWM relationships, and increased HIV risk within these relationships, resulting from unprotected sex. This study extends knowledge in HIV prevention and testing interventions for WSWM by identifying the sexual practices that exist within behaviorally bisexual relationships, showcasing that these individuals may be at increased risk for HIV contraction and transmission. Thus, needing access to culturally competent and appropriate healthcare services. The study helps to identify what education and resources should be provided to WSWM populations in receiving appropriate healthcare services. Additionally, the type of education that should be given to healthcare providers on how to appropriately deliver culturally competent care to the WSWM community has been identified in conducting this study through participant beliefs that provider education should include education on appropriate pronouns and identifying genders.

Specific to the WSWM population, participants felt the need for increased patient education in the areas of safe same-sex sexual practices and preventive education (i.e., female condoms, using condoms with penetrative sex toys) and health concerns related to the LGBTQ+ community (i.e., risk for STIs and HIV in women, specifically among WSWM). Participants in monogamous and committed relationships showed a pattern of not using condoms (to include non-use of condoms while using penetrative sex toys) with their primary partner(s), though felt it necessary when engaging in sexual activity with a new partner. Based off the attitudes and beliefs of participants surrounding condom use and penetrative sex toys in these relationships, it can be recommended that patient education include safety information, to incorporate recommendations for frequent STI testing (including testing for HIV). It can be determined that the normative beliefs of study participants to not use condoms may be influenced by their dominant partner(s). Having less power and authority in decision-making within the relationship may influence the motivation to, or lack thereof, use condoms. The control beliefs and the potential inability to influence decision-making, specifically related to sexual practices, held by inferior WSWM partners may lend to increased HIV risk, resulting from self-injurious behaviors (i.e., unsafe sex, denial of HIV/AIDS risk) These findings indicate the need for increased safe-sex education for LGBTQ+ patients seeking medical care and reiterate the need for healthcare providers to be educated on ways to appropriately provide culturally competent care to these individuals.

Overall, the current study can serve as beneficial in guiding the implementation of future clinical cultural competence interventions for healthcare providers on teachings and training(s) on stigma within the LGBTQ+ community and includes recommendations for future provider education efforts (i.e., appropriate pronouns and identifying genders) and educational resources (i.e., informational pamphlets) for members of the LGBTQ+ community seeking care. These interventions should be aimed at providing education to healthcare providers on awareness and knowledge of the appropriate pronouns and genders. Inclusive to providing culturally appropriate care to members of the LGBTQ+ community is the incorporation of safety education that addresses health concerns related to the LGBTQ+ community (i.e., risk for STIs and HIV in women, specifically among WSWM). Safe-sex education for this population should include information on the female condom and its use, condom use while using penetrative sex toys, and the need to purchase new and or to boil penetrative sex toys between uses, especially with a new partner. Increased education being offered to both healthcare providers and patients intends to increase the knowledge and availability of HIV preventive methods (to include preventive education), helping to ultimately decrease prevalence of the disease.

Implications for Positive Social Change

A methodological implication for positive social change can be made based off the execution of this study, as it relates to virtual data collection. This study provides evidence that rigorous research can be accomplished and executed efficiently using virtual tools and is recommended for future research. This research study is important in effecting positive social change in the field of public health through its identification of the preventive methods and education needed, with the intention to reduce the rates of HIV infections among WSWM. The study is a significant contribution to the field of public health because through its execution, ways to improve provider training, medical and nursing education, and most importantly, improved healthcare outcomes for WSWM, were able to be identified. More specifically, positive social change is affected by informing culturally relevant HIV prevention interventions which include provider education on awareness and knowledge of appropriate pronouns and identifying the appropriate genders within the LGBTQ+ community. It is important that these interventions include education not only on the importance of using the correct pronouns but also highlight the imperativeness in understanding sexual behavior, without assumptions related to sexual identity. Additionally, increased awareness is needed as it relates to the heightened risk of contracting and transmitting HIV in WSWM populations.

Through execution of this study, a new cultural group within the LGBTQ+ community was able to be identified (WSWM). Additionally, there are sexual behaviors and practices specific to this culture (as these individuals have sex with both women and men) that have been identified (i.e., condom use, use of penetrative sex toys). These behaviors and practices, as identified in the results of this study, call for better guided prevention interventions and education being provided to WSWM women. As such, providers should become more educated through trainings on this population as a whole and their sexual experiences and practices, and the challenges they face in receiving healthcare, in order better serve them. Additional social implications of this study relate to understanding the challenges WSWM experience in sexual decision-making and accessing appropriate healthcare services. Challenges WSWM face in accessing healthcare services include the lack of resources and education appropriate to their sexual orientation being provided to them. Historically for the study participants, safe-sex education has only been focused on safe-sex practices related to sexual interactions with men. Understanding these challenges can effect positive social change resulting from the identification of the resources and education needed within the target population (Black Young Adult WSWM) in receiving appropriate healthcare services tailored toward preventing STIs, to include HIV, ultimately decreasing the incidence of AIDS. Clinical cultural competence interventions should be implemented for healthcare providers (which incorporate the importance of culture at all levels of care) that are focused on HIV prevention efforts (i.e., education, resources) to serve the WSWM population. Doing so would prove to educate healthcare providers and increase access to appropriate LGBTQ+ focused healthcare services, to include HIV preventive education and resources for WSWM populations.

Conclusion

The purpose of this interpretative phenomenological qualitative study was to explore the lived experiences of Black WSWM, ages 18 to 35, in the United States and the connection between their relationship dynamics and sexual practices, in relation to HIV risk. This research was conducted to fill the existing gap in literature that exists in HIV prevention and testing interventions for women who have sex with women, to also include interactions with men. I found that WSWM may be at increased risk for HIV contraction and transmission based off the sexual practices that exist within their behaviorally bisexual (having reported sexual experiences with both women and men in the past year) relationships. This finding is a result of the majority of participants reporting unprotected sexual activity and the nonexistent use of condoms, with their primary partner, within their relationship(s). Non-use of condoms with primary partner's stemmed from participants' perceived level of exclusivity with their partner(s), the level of power and authority participants' hold, and the sexual decisions made within their relationship(s). Participants may be at increased risk for HIV contraction and transmission in their same-sex relationships due to the non-use of condoms with their male partners and the non-use of condoms and other protective measures (i.e., female condoms, dental dam) with their female partners. Additionally, the self-injurious behavior of denial of HIV/AIDS risk existed among participants, which may cause them to be more lax in utilizing protective measures to prevent the infection.

Participants felt that increased education, awareness, and knowledge of appropriate pronouns and identifying appropriate genders should be the focus of provider trainings. Additionally, participants felt that more information, education, and resources (potentially a pamphlet of sorts) should be provided to LGBTQ+ patients seeking services, with an increase in LGBTQ+ centered healthcare facilities being implemented across the nation. Identifying the perceived lack of provider and patient education, the need for appropriate healthcare services, and the need for healthcare resources that currently exist within a specific LGBTQ+ community helps to inform future culturally competent LGBTQ+ interventions that will provide education to health care providers on delivering culturally competent services to all LGBGTQ+ populations. Data collected from this study fills the current gap in existing literature by representing Black Young Adult WSWM in behavioral research, identifying how their lived experiences in their relationships may have influence on HIV risk. It is recommended that future research include WSWM populations in HIV prevention and testing interventions. This should be done to fully understand the needs of this specific LGBTQ+ population in receiving appropriate healthcare services and to further understand the education and resources to be provided to these individuals and how to provide culturally competent care to patients who identify as a member of said population.

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Appendix: Interview Transcript

I am going to begin by asking you questions related to HIV infection. As a reminder, your responses will be kept anonymous.

Let us begin with what you know about HIV infection.

Can you tell me what HIV stands for?

What do you know about the difference between HIV and AIDS?

Can you tell me what you know about the ways an individual can get or pass along HIV from or to their partner?

Now I will begin to ask questions to get to know you a little better and assess areas where resources may be needed.

Demographic Information:

Are you a person living with HIV or AIDS?

Are you a partner of someone living with HIV or AIDS?

What sexual orientation (i.e., gay, lesbian, bisexual) do you identify as?

If you identify as lesbian, what are some reasons behind choosing this classification?

For the purpose of this interview, what would you like for me to call you?

Interview Questions:

Now, I am going to ask you questions about your relationship. As a reminder, your responses will be kept anonymous.

How long have you and your partner been in a relationship?

Can you tell me a little bit about your relationship? Is it exclusive? Are you both only dating one another?

Would you say that you and your partner are committed and monogamous (having only one partner), or uncommitted and polygamous (having multiple partners)?

Would you consider yourself to have more, or less, authority in your relationship?

Who would you say has the most power in decision-making in your relationship?

When did you feel it was important to have a discussion with your partner about sex?

How did that conversation go?

Can you provide a description of what was discussed when you and your partner talked about sex?

What was your experience in having this conversation with your partner about sex?

Now, I am going to ask you questions related to your usage of male condoms, female, condoms and/or dental dams, and penetrative sex toys. As a reminder, your responses will be kept anonymous.

What do you think about using male or female condoms and dental dam?

How do you think using male or female condoms and dental dam would affect your sex life?

What would happen if you asked your partner to use a male or female condom?

How do you feel about using male or female condoms when having sex with a new partner in or outside of your relationship?

What items (i.e., body parts, sex toys) do you and your partner use when engaging in sexual activity?

Do you use any penetrative sex toys, such as a dildo or anal products? Which ones?

Do you use a condom when using penetrative sex toys? How often?

Do you have concerns about having sex without the use of a male or female condom or dental dam? What are they?

Do you feel that using any of these items could increase risk of contracting and transmitting HIV? Which ones?

Now, I will ask you questions related to the decisions you and your partner have made regarding sex. As a reminder, your responses will be kept anonymous.

How did you come to decide how you would engage in sexual encounters, knowing that there may be a potential for HIV risk?

What decisions did you and your partner ultimately make?

Now, I am going to ask you questions related to your healthcare experiences. As a reminder, your responses will be kept anonymous.

Tell me about your previous healthcare experiences. What were your experiences like as you accessed the healthcare system?

Do you feel that you have received appropriate and competent care by those you have encountered in the healthcare system? Why or why not?

Are you comfortable disclosing sensitive information to healthcare providers? Why or why not?

What have been the responses of healthcare providers when you disclose sensitive information? How did those responses make you feel?

Can you describe a time when you may have felt the need to educate a healthcare provider on your healthcare needs?

Did you feel the provider was negligent? Why or why not?

What do you feel could help healthcare providers provide better care to their patients who identify as a member of the LGBTQ community?

What is your hope for the future of healthcare provided to those in the LGBTQ community?