Sexual Minority Identity and Sexual Health Among Lesbian and Bisexual Black Women who Have Sex with Men

Aaliyah Gray, M.A. and Celia B. Fisher, Ph.D.
Fordham University, Bronx, NY

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BACKGROUND

• Black Lesbian Gay and Bisexual Women (BLGB) are an invisible population in health care settings.
• BLGB face greater sexual health risk including earlier sexual experiences, higher risk for HIV and STI, and unplanned pregnancy.
• Positive sexual minority identity, family support, community with other lesbian and bisexual women, and lower sexuality-religious conflict may be protective against sexual health risk.
• On the other hand, negative health care beliefs and experiences and low contraceptive self-efficacy (the ability of an individual to control the use of contraception in sexual situations) may increase sexual health risk.
• However, there is little research on the relationship between race, sexual minority identity, and sexual health risk.

STUDY AIMS

To examine the relationships between LGB identity, psychosocial factors, health care experiences, and sexual health outcomes among a sample of Black women who have sex with men and women.

METHODS

• Black sexual minority women (n = 320) were recruited using advertisements on Facebook.com (n = 271) and direct recruitment from the Community Marketing Insights LGBT panel (n = 49).
• Participants completed an anonymous online survey including demographics, sexual history, LGB identity, perceived support from family and lesbian/bisexual community, and experience and trust in healthcare providers.
• Sexual health risk score computed as a sum of number of lifetime male partners and whether the participant had ever had STI, emergency contraception, unplanned pregnancy, and abortion.

PARTICIPANTS

• Participants were between the ages 18 and 35 years old (M = 25.47, SD = 4.12).
• Among our sample of sexual minority women, 65.3% (n = 209) of participants identified as bisexual and 9.1% (n = 29) identified as lesbian.
• 52.2% (n = 167) of the sample reported an annual income of $20,000 to $50,999 and 83.4% (n = 267) indicated they were employed part- or full-time.
• 40.3% (n = 129) reported completing some college and 26.6% (n = 85) reported receiving an undergraduate degree.
• 57.5% (n = 184) reported visiting a health care provider for sexual health reasons in the past 6 months.

HYPOTHESES

1. Stronger LGB identity is related to higher levels of family support, community support, and patient-provider communication; and, lower levels of religious conflict and heterosexist and racist health care beliefs.
2. Lower contraceptive self-efficacy is related to higher levels of religious conflict and heterosexist and racist healthcare beliefs and lower levels of LGB identity, family and community support, and patient-provider communication.
3. Greater sexual health risk is related to higher levels of religious conflict and heterosexist and racist healthcare beliefs and lower levels of contraceptive self-efficacy, LGB identity, family and community support, and patient-provider communication.

RESULTS

• See Table 1 for correlations between psychosocial and health care factors and sexual health outcomes.
• Stronger LGB identity was related to greater family support and greater community support, greater patient-provider communication, and negative beliefs about about how doctors treat lesbian and bisexual women and Black women.
• Lower contraceptive self-efficacy was related to weaker LGB identity, less family support, greater religious conflict, and poorer patient-provider communication.
• Greater sexual health risk was related to stronger LGB identity, greater family support, higher contraceptive self-efficacy, greater patient-provider communication, less community support, and negative beliefs about how doctors treat lesbian and bisexual women and Black women.

CONCLUSIONS

• Family, community, and patient-provider communication can play a positive role in LGB identity.
• LGB identity can lead to greater contraceptive self-efficacy among BLGB who have sex with men.
• However, LGB identity may not play a protective role against sexual risk and also may increase anticipated sexual and racial stigma in healthcare settings.
• Further, contraceptive self-efficacy may be perceived rather than actualized for BLGB with strong LGB identities.

Table 1. Correlations between Psychosocial and Health Care Factors and Sexual Health Outcomes

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<th>Variable</th>
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<td>2. Family support</td>
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<td>3. Community support</td>
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<td>4. Sexuality-religious conflict</td>
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<td>5. Contraceptive self-efficacy with men</td>
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<td>.03</td>
<td>.36***</td>
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<td>.03</td>
<td>.36***</td>
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<td>7. Beliefs about how doctors treat Black women</td>
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<td>23***</td>
<td>.14*</td>
<td>.05</td>
<td>.20**</td>
<td>.22***</td>
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<td>9. Sexual health risk composite score</td>
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<td>23***</td>
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<td>.22***</td>
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*p < .05  **p < .01  ***p < .001