Queering LGB+ Women's Sexual Scripts

Mari Tarantino

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Rose Wesche, Chair
Erika L. Grafsky
TeKisha M. Rice

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ACADEMIC ABSTRACT

The invisibility of lesbian, plurisexual, and gay (LGB+) women in sexual health research is of particular concern when it comes to understanding and supporting their safer sex practices. Results of a qualitative secondary analysis of sexual decision-making interviews among 22 LGB+ cisgender women showed that LGB+ women both reify and push against heteronormativity in their sexual partnerships. By queering definitions of "sex" beyond heterosexual intercourse, leaning into trust as a foundation of new sexual partnerships, and promoting accessible and realistic hygienic strategies for STI prevention, LGB+ women queer, or reimagine, new sexual scripts. These results highlight the need for relationship and sexual health scholars to direct focus towards the promotion of holistic sexual and relationship education and research which reflects LGB+ women's various sexual desires, goals and needs.

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GENERAL AUDIENCE ABSTRACT

The way we act in our romantic and sexual relationships is shaped by influences we receive from everything around us, including our families, the government, the media, and how we are educated. These influences also default to "heteronormative" partnerships, or those that are between two straight, monogamous, married individuals. In turn, researchers don't often include lesbian, gay, and bisexual women in their research on sexual risk prevention, even though this group is at certain risk for unintended pregnancy and transmitting sexually transmitted infections. For my thesis, I looked at how the heteronormativity influenced LGB+ women as they discussed preventing pregnancy and STI's. I found that this population is influenced by heteronormativity in that they prioritize pregnancy over STI prevention, and disregard dental dam (used as a barrier like a condom, but for oral sex) use with partners. However, LGB+ women also push against heteronormativity by holding wider definitions of sex with partners, promoting trust, and promoting hygiene during and after sex.

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LGB+ Subsample

Participant ID	Sexual Identity	Age	Racial/Ethnic Identity	Education Level
Leah	Lesbian	23	Asian	Graduate or professional school
Gina	Lesbian	25	White	Graduate or professional school
Izzy	Lesbian	25	White	Bachelor's degree
Leah	Lesbian	22	White	Bachelor's degree
Missy	Lesbian	24	White	Bachelor's degree
Shannon	Gay	23	White	Bachelor's degree
Mona	Bisexual	22	Asian	Bachelor's degree
Tiffany	Bisexual	21	White	Some college
Cheryl	Bisexual	24	Asian	Bachelor's degree
Jenna	Bisexual	22	White	Some college
Barbara	Bisexual	23	White	Bachelor's degree
Terry	Bisexual	26	White	Graduate or professional school
Ali	Bisexual	20	White	Some college
Pam	Bisexual	24	Black/African American, White	Bachelor's degree
Dina	Bisexual	21	Asian	Bachelor's degree
Diane	Pansexual	23	White	Associate's degree
Devin	Pansexual	21	Asian	Some college
Jessie	Pansexual	20	White	Associate's degree
Emmy	Queer	26	White	Bachelor's degree
Sonya	Queer	24	White	Bachelor's degree
Vicky	Queer	25	Asian	Bachelor's degree
Mila	Queer	24	White	Graduate or professional school

Introduction

Lesbian, gay, and bisexual (LGB+) women encompass a diverse group of individuals whose health and relationships are often undervalued and under-researched. The invisibility of this group in sexual health research is of particular concern when it comes to understanding and supporting their safer sex practices. For the purposes of this study and its associated sample, LGB+ women can be defined as cisgender women who are lesbian, gay, or plurisexual (bisexual, pansexual, queer, or who hold other non-monosexual identities).

Heteronormativity describes a set of assumptions that describe "normal" or "right" sexual and romantic relationships (Warner, 1991). Heteronormativity is extremely influential and poses that romantic and sexual relationships default to those which are straight, monogamous, and married (Warner, 1991). These assumptions bleed into sexual health research, where the majority has focused on heterosexual behavior, leaving queer populations, particularly women, outcast from risk prevention work. Subsequently, there is the assumed and misguided notion that LGB+ women are at low risk for sexually transmitted infection (STI) transmission (Workowski et al., 2021) and unintended pregnancy (Tornello et al., 2014). Emphasizing heteronormativity also contributes to the erasure of LGB+ women from sexual prevention work, leaving millions of women (most recent polls estimate that 8% of the United States population self-identifies as LGBT+, U.S. Census Bureau, 2021; Human Rights Campaign, 2021) at heightened risk for negative health outcomes related to STI transmission and unintended pregnancy. Little research has considered the role of partnership communication and queer identity/experience in LGB+ women's safer sex decision-making. To address these issues and ensure that LGB+ women are centered in sexual risk and prevention literature, this study utilized a combination of sexual scripting theory and queer theory to understand how LGB+ women challenge and are influenced

by heteronormativity in their sexual partnerships and safer sex practices. This study highlighted the importance of studying STI and pregnancy prevention in the context of interpersonal relationships and decision making.

Drawing from a subsample of interviews from Dr. Wesche's Sexual Health and Decision-Making Interviews, this secondary analysis addressed the following research question:

How does the presence and absence of heteronormative sexual scripts influence LGB+ women's safer sex practices?

Health Outcomes

STI Risk. A sizeable body of literature concentrates on sexual stigma and risk associated with queer individuals, but the majority of this work is centered around gay men (Mijas et al., 2021). The underlying reality is clear: in the context of both LGBTQ+ and non-sexually minoritized groups, LGB+ women are erased from sexual health and prevention work. The outcomes of erasure leave this population at heightened sexual risk. Semi-structured interviews of women who have sex with women (WSW) showed that limited knowledge, gendered scripts, and an aversion to barrier methods (i.e., dental dam use) contributed to unprotected, riskier sexual activity (Emetu et al., 2022). There is a clear disconnect between popular perceptions of LGB+ women's sexual risk and reported risk for STI transmission in this population. However, the limited, existing work suggests that sexually minoritized women are at heightened risk for contracting and transmitting certain STIs (Workowski et al., 2021; Koh et al., 2005; Morrow & Allsworth, 2000). LGB+ women are at additional risk for transmitting bacterial vaginosis (Evans et al., 2007), HPV (Waterman et al., 2015; McRee et al., 2014), and being diagnosed with cervical cancer (Robinson et al., 2017) compared to heterosexual women. Results from a 2019 review of lesbian STI literature found that the vast majority of articles only considered curable

STIs (Takemoto et al., 2019), although there is some (albeit dated) work that acknowledges the presence and transmission of incurable STIs like Herpes type 2 between partners with vulvas (Marrazzo et al., 2003) and HIV risk for bisexual women (Gangamma et al., 2008).

Pregnancy Risk. Outcomes of sexual risk extend beyond STI transmission. LGB+ women are, unsurprisingly, absent in pregnancy and birth control research and prevention measures (Higgins et al., 2019), even though lesbian and bisexual women report higher rates of unintended pregnancy than their straight counterparts (Tornello et al., 2014; Goldberg et al., 2016). Youth Risk Behavior Survey results from 2005 to 2015 showed that adolescent girls who were unsure about their sexual identity were less likely to report condom use and more likely to report using alcohol/drugs during sex than heterosexual girls (Everett et al., 2019). Further, this study also found that compared to heterosexual girls, bisexual girls were more likely to report unintended pregnancy as teenagers (Everett et al., 2019). Results like this demand a look into the factors contributing to these health outcomes.

Most important for this study is the acknowledgement that heteronormative messaging influences how LGB+ women themselves feel excluded as potential contraceptive users (Higgins et al., 2019). In one study of sexual minority women, heteronormative values created conceptual barriers to accessing contraceptives (Higgins et al., 2019). Examples of conceptual barriers included queer women not thinking of themselves as contraceptive users (Higgins et al., 2019). In other words, participants would intentionally disregard contraceptive use because they were influenced by dominant thinking that only straight women needed to use contraceptives. In reality, contraceptives are used for a variety of reasons (i.e., pregnancy prevention, hormonal regulation, etc.) by LGB+ women including lesbians (Higgins et al., 2019). The authors also referenced tangible, logistical barriers to sexual minority women and contraceptive use, like

needing to consider queer identity, feeling shame/stigma from other queer people, and healthcare barriers due to heteronormative assumptions from providers (Higgins et al., 2019). Authors stressed the influence of heteronormativity on contraceptive use as an important factor in unintended pregnancy rates for LGB+ women (Higgins et al., 2019).

Theoretical Framework

Sexual health matters across contexts, and the empirical work highlights noticeable challenges related to sexual health among LGB+ women. Contextualizing this work within a theoretical framework will aid our understanding of the underlying factors contributing to LGB+ women's sexual health. Further, we need theory to understand why queer women are erased from sexual health narratives and initiatives, and frame how they push back against dominant discourse surrounding sexuality and sexual risk prevention.

Sexual Scripts. Sexual scripting theory (SST) argues that sexual activity is driven by socially constructed rules, and those rules influence sexual behavior between partners (Simon & Gagnon, 1986). For example, a cultural heteronormative script dictates that sexual activity is centered around male pleasure, which then influences conversations about condom use (i.e., not wanting to use condoms because they "don't feel as good"). SST was created as a response to existing theories of sexual motivation and behavior, which asserted that sexuality was innate and biologically driven (Simon & Gagnon 1986; Beres, 2014). Using the sociological theory of social constructionism (Gergen, 1985), Simon and Gagnon pushed against so-called "natural" behavior models by proposing that sexual behavior between partners is dictated by cultural, interpersonal and intrapsychic scripts. Social processes affect decisions about sexual behavior at each of these three levels, or spheres, of influence.

Cultural Scripts. The first sphere is the presence of cultural scripts, which include initial guidelines about sex and relationships that are given by institutions (Simon & Gagnon, 1986). In my conceptualization of SST, heteronormative assumptions regarding the "normalcy" of sexuality and relationships would fall under the sphere of cultural scripts, where messaging about heteronormativity subsequently influences interpersonal relationships and intrapsychic thought and behavior. Some examples of cultural scripts include gendered expectations that men are dominant sexual initiators and are always ready for sexual activity in heterosexual relationships (Gonzales-Riva &Peterson, 2020). In contrast, women in heterosexual contexts are expected to act submissive and engage in sex for emotional connection yet act as gatekeepers in sexual partnerships (Benoit & Ronis, 2022).

Interpersonal Scripts. The second sphere of influence is interpersonal scripts, which describe sexual roles and expectations between partners (Simon & Gagnon, 1986). This sphere recognizes that each individual is not working alone; rather, they play a part in influencing the sexual scripts of their partners as well. For example, interpersonal scripts could include preferences of sexual behavior of the partners involved. The influence of heteronormativity also plays into interpersonal scripts. An example of heteronormative interpersonal scripts could be partners' decisions to stop or decrease condom use and rely on hormonal birth control once a couple has "officially" started dating, guided by the assumption of monogamy and priority of pregnancy prevention over STI risk.

Intrapsychic Scripts. Finally, intrapsychic sexual scripts describe an individual's personal preference for partners' characteristics (ex. "my type") and their desires and intentions (Whittier & Simon, 2001). Simon and Gagnon (1986) note the importance of intrapsychic scripts as a means for someone to reorganize and interpret their surroundings in ways that are

meaningful for individuals. An example of a heteronormative intrapsychic script could be creating a "type" based on certain gendered stereotypes or characteristics (like only wanting to date men that are tall because shorter men are perceived as less masculine, or men insisting on dating women shorter than them as to not feel emasculated).

The use of SST provides a much-needed perspective to contextualize sexual behavior, motivations, and partnership decisions within the constraints and influence of heteronormativity. The consideration of patriarchal values and power as referenced in the cultural/historical sphere of sexual scripting theory is particularly useful in understanding how women engage sexually with partners.

Heteronormativity

Sexual scripting theory has been criticized for potentially centering heteronormativity (Beres, 2014) by using limited, cisgender, and dualist understandings of gender identity and expression to create and contextualize sexual roles. Heteronormativity is often defined as a set of assumptions, often covert, that describe expectations for engagement in "normal" sexual and romantic relationships (Warner, 1991). Heteronormativity influences each of these levels of scripts; the rules of engaging in sexual behavior are shaped by the cultural beliefs that heterosexual sex is the default condition of sexual interaction. Generally, heteronormativity elicits narrow definitions of sex as penetrative, penile-vaginal intercourse between one cisgender man and one cisgender woman. This concept of "normalcy" also extends to other facets of partnered relationships beyond purely sexual contexts. Under heteronormative thought, "normal" relationships exist solely between cisgender men and women who are married, monogamous, White, and middle class (Warner, 1991). Any sexual or romantic partnerships that exist outside of these lines are considered subversive to what is "normal" or acceptable.

Heteronormativity is more than abstract theory. These assumptions permeate into our social institutions, community and cultural environments, and individual lives. Many United States policies and laws that define consent, sexual harassment, and sexual assault use governing heteronormative language to define sex (van der Toorn et al., 2020), which influences how sex crimes are prosecuted in the justice system. Heteronormativity influences health education. The push for abstinence-only sex education, which is rooted in heteronormative beliefs that condemn premarital sex, directly contributes to increased STI and teen pregnancy rates in some states (Fox et al., 2019; Stranger-Hall & Hall, 2011). Heteronormativity also directly influences interpersonal relationships; a clear example is shown in the existence and study of the orgasm gap (Andrejek et al., 2022; Frederick et al., 2018), where men in heterosexual relationships are much more likely to orgasm during sex than women. The orgasm gap stems from heteronormative viewpoints that regard men's orgasms as expected and natural, where both partners engage in sexual practices aimed at men's pleasure over women's (Andrejek et al., 2022).

Because of heteronormativity's ubiquity in U.S. culture, sexual scripts tend to define sex from a heteronormative perspective. This definition underscores cultural attitudes towards sex and sexuality, which continually frame theory and research regarding this topic. Sexual scripts were created with the assumption of heteronormative sexuality in mind. Research on sexual scripts, like the scripts themselves, tends to center heterosexual partnerships and discussions of power and dominance. To my knowledge, the majority of studies that used sexual scripting theory focused on samples with straight partnerships, and the range of sub-interests was extremely diverse. Some of this literature aimed to understand how relationship gender composition (i.e., same-sex and mixed-sex relationships) contributed to scripts surrounding

sexual initiation. In a study of 60 women in mixed and same-sex partnerships, Gonzales-Rivas and Peterson (2020) found that those in same-sex partnerships were less likely to report direct initiation strategies (categorized by authors as straightforward and clear language) than women in mixed-sex partnerships, complicating stereotypes about women as submissive recipients during sex (Peterson, 2020). Sexual scripts as the prevailing influence over heterosexual sexual behavior was also challenged in a 2013 study, where 44 interviews were conducted with straight young adults (Masters et al., 2013). Researchers identified different levels of adherence to sexual scripts ranging from those conforming to heteronormative scripts, those who found exceptions to scripts, to those who attempted to "transform" or change sexual scripts as they related to their own sexual activity (Masters et al., 2013).

Another extensive body of literature using sexual scripting theory concerned sexual coercion more broadly. Male gender stereotypes have been similarly explored qualitatively. Results from 30 interviews with straight men described pressure that participants felt to exert sexual desire in stereotypically masculine ways (Murray, 2018), and highlighted a disconnect between men's performance of sexual desire and their actual sexual experiences (Murray et al., 2018). Like the study of sexually marginalized individuals, other intersections of experiences and identities make up a smaller body of SST work. For example, researchers developed and tested the sexual scripts scale (SSS) among Black, heterosexual men (Bowleg et al., 2015). For those who had a main partner, participants reported lower condom scripts were associated with higher alcohol and marijuana scripts, and media socialization scripts. (Bowleg et al., 2015). In turn, sexual scripting theory has seen limited applications outside of heteronormative contexts in research, particularly among queer populations.

Queer Theory

Research on sexual scripts is grounded in heteronormative assumptions and therefore centers a narrow segment of heterosexual relationships. It is important to expand and adapt research to be more inclusive of queer people. Therefore, in this study I addressed the gap left by researchers who did not apply sexual scripting theory to queer populations. Using queer theory alongside sexual scripting theory provides a lens from which to apply SST in more inclusive, expansive ways. LGB+ women, by virtue of existing as people who are sexually minoritized, embody queerness. As a result, their communication, sexual experiences, and practices, do not exist solely under a heteronormative umbrella. Adding queer theory to sexual scripting theory will allow me to achieve a more balanced theoretical perspective; the dual use recognizes the importance and usefulness of sexual scripts, and queer theory allows me to center the women who participated in interviews, their voices, and their stories for what they are- without deciding whether they fit into heteronormative sexual scripts (which still center heteronormative experiences).

Several theorists have written about queer theory, and all are credited with creating foundational work on the subject (de Laurentis, 1991, Foucault, 1976, Butler, 1990, Warner, 1991). Generally, queer theory is concerned with dismantling dominant thinking (Dilley, 1999). To be queer or engage in queerness is not necessarily related to marginalized sexuality, but is also in reference to being subversive to dominant thinking and practice. In other words, to be queer encompasses much more than sexuality, gender identity or expression (Dilley, 1999). Using queer theory recognizes LGB+ women as resistant to dominant heteronormativity. Queer theory describes how individuals resist these values and assumptions. For example, if to remain abstinent until marriage is heteronormative, having premarital sexual relationships could be

considered queer. If monogamy is the expected, nonmonogamy is an extension of queerness. Of course, if heterosexual partnerships are "normal", queer people and their relationships exist outside of those expectations. Colloquially, the word queer is known to reference anything subversive to what we culturally consider to be "normal"; the word's first definition literally means strange or different. The tension between the assumed, heteronormative sexual scripts and queer existence is where the relevance for this study lies.

Queer Sexual Scripts

Sexual scripts are not the sole determinant of people's behavior in sexual and romantic partnerships, and even heterosexual people adapt dominant scripts to better fit their needs. A 2013 qualitative study aimed to understand how young heterosexual people think about cultural sexual scripts in their relationships (Masters et al., 2013). Authors found that individuals held three styles of engagement with sexual scripts: conforming, where people aligned behavior with traditional sexual scripts, transforming, which was categorized by attempts to confront and reestablish gendered scripts, and changing, where participants had completely redefined and interpreted sexual behavior outside of traditional scripts (Masters et al., 2013). Authors argued that changing sexual scripts could, if widely accepted and utilized, positively impact gender inequity issues and potentially lead to increased sexual satisfaction and safety for women (Masters et al., 2013). This finding, which highlights the importance of changing heteronormative sexual scripts, informed my approach to this analysis; sensitizing questions like how re-establishing sexual scripts influences sexual risk reduction of LGB+ women were considered during coding. I argue that the idea of "changing sexual scripts" aligns with the idea of queering sexual scripts as relevant to this study, and that LGB+ women's rejection of traditional sexual scripts could have implications for real STI and pregnancy risk outcomes.

The idea of joining of queer theory and sexual scripting theory is not new. In the remainder of this section, I will introduce existing LGBTQ+ sexual scripting literature, which primarily focuses on gay men. By discussing the absence of LGB+ women in this work, I will further justify my intention to center this population through this analysis.

Gay Men. Applications of sexual scripting theory among LGBTQ+ individuals are limited in comparison to the seemingly endless use of SST in research on heterosexual partnerships. One aspect of heteronormative sexual scripts is that penetration is deemed as the standard for sexual behavior between partners. A study of cisgender gay men in relationships with men found that penetration occurred less often than in mixed-gender partnerships (Rosenberger et al., 2011). This suggests that queer men may have more diverse definitions of sex with less of a focus on penetration (Rosenberger et al., 2011). Similarly, a study from 2012 which examined masculinity and college sex found that men having sex with men were more likely to engage in oral sex and were more likely to be in noncommitted sexual partnerships than straight men (Barrios & Lundquist, 2012), further supporting the potential for different sexual scripts between gay and straight men.

Bisexual Erasure. There is less literature focused on bisexual individuals' sexual scripts, contributing to the ongoing issue of bi erasure (Feinstein, 2021; Ross et al., 2018). This could be related to the tendency for researchers to only consider an individual's sexuality based on the gender identity of their partner. The authors of a review of sexual communication and scripts for bisexual individuals argued that same gender couples cannot, and should not, be considered in the same way as different gender couples (Gauvin & Pukall, 2018), and considering bisexual individuals only in the context of their partner's gender erases this unique and complex component of bisexual partnerships. The authors also referenced a 2013 paper that examined

how emerging adult women with varied sexual identities ranked sexual activities as to whether they counted as sex (rating different sexual acts on a scale from 'definitely not' to 'definitely') and gave some examples of how heteronormative gendered scripts may not play out in the same way for queer partners (Horowitz & Spicer, 2013; Gauvin & Pukall, 2018). These included differences by sexual identity for the type and timing for sexual activities, differences in who initiated sex and how sex was initiated, and negotiation of receiving and giving of sexual acts, all of which contributed to the absence of gendered scripts (Horowitz & Spicer, 2013).

LGB+ Women and Sexual Scripts.

Little research considers sexual scripts of LGB+ women. In a 2015 study of sexual communication and vaginal pain, Blair et al. found no significant differences in the level of communication between bisexual and monosexual women in relationships; however, they postulated that having same-gender sexual experiences could widen sexual scripts for bi+ women. Gauvin and Pukall's review of sexual scripts and relational characteristics among bisexual individuals found sexual scripting work to be particularly limited in its consideration of bisexual women, where only a handful of studies view this group as separate from lesbian or gay populations and consider them differently in analyses (Gauvin & Pukall, 2018).

More LGB+ women's sexual scripting work has been done in the context of lesbian sex and relationships. I would argue this exists as a response to heteronormative assumptions about the role of penile penetration in sex, and that there is a level of ambiguity surrounding lesbian sexual behavior. This ambiguity alludes to questions of what constitutes sex between two vulva owning people, particularly women. This idea is corroborated by recent sexual scripting work, which notes that LGB+ women have widening definitions of sex (Ekholm et al., 2022; Horowitz & Spicer, 2013) beyond penile-vaginal intercourse, which is commonly associated with

traditional sexual scripts (McPhillips et al., 2001). The absence of sexual scripts for LGB+ women could hold both benefits and drawbacks. A 2021 Swedish study on queer women's experiences with dyspareunia, or vaginal pain during sex, used qualitative interviews to assess sexual scripts' influences on managing this issue and associated sexual contexts (Ekholm et al., 2021). In-depth interviews showed that there are certain advantages of lacking heteronormative sexual scripts, such as developing strong sexual communication skills and understanding partners' anatomy (between two vulva-owning partners) when sexual behavior exists between people who held the same gender identity (Ekholm et al., 2021).

Sexual Scripts and STI Prevention. To my knowledge, only two studies have used sexual scripting theory in direct reference to LGB+ women and safer sex. A 2022 study that utilized online posts by lesbians on sex education websites to understand lesbians' narratives and assessment of sexual risk (Whitlock, 2022). The author concluded that lesbian women lack knowledge about safer sex rooted in the belief that their sexual behavior is low risk (Whitlock, 2022). The author also noted that narratives are noticeably missing from lesbian safer sex research, highlighting the need to consider voices of LGB+ women to understand how heteronormativity and gender roles factor into sexual risk prevention (Whitlock, 2022).

The second article, concerned with lesbian and bisexual narratives regarding safer sex, used self-report surveys and in-depth interviews to explore perceived human papillomavirus (HPV) risk (Power et al., 2009). Authors found similar pervasive narratives to the first article, where lesbians felt that their sexual activity was low-risk for STIs (Power et al., 2009). The authors attributed these attitudes to LGB+ women's exclusion from dominant sexual scripts that overpower conversations about safer sex and STI prevention (Power et al., 2009). Existing work like this acknowledges how sexual scripts and dominant heteronormative assumptions relate

directly to tangible outcomes for LGB+ women, where heteronormative thinking could contribute to engaging in potentially riskier sexual practices. For my study, these findings highlight the need to examine participant meaning-making of sex and consider existing narratives that LGB+ women may consider sex to be less risky if they have female-bodied partners, which could contribute to safer sex practices and decision-making.

Considering Gaps in Sexual Scripts Work. While existing literature that uses SST is interdisciplinary and spans a range of contexts, it often centers heteronormative partnerships while rejecting and dismissing queer populations. Consequently, there is still a lack of knowledge about the role of partnerships in LGB+ women's sexual health and decision-making. Understanding partnerships' health research and outcomes reflect the issue of dominant heteronormative influence, where heterosexual partnerships dominate sexual risk prevention work (Opara et al., 2021). A central tenet of the proposed study is to directly address the erasure of LGB+ women and their sexual partnerships.

Emerging Adulthood

Any conversation about sexual identity among young adults would be incomplete without considering the developmental context. Due to the age range of the interviewed participants and research topic of sexual relationships and identity, Arnett's theory of Emerging Adulthood (2000) provides a useful perspective for understanding this context. The theory of emerging adulthood argues that the period of time in someone's life between adolescence and one's mid-twenties (often stated as 18-25 years) should be considered developmentally separate from adolescence or adulthood (Arnett, 2000). Arnett proposes that this developmental period offers unique opportunities for young people to engage in extensive self-exploration, take risks, gain independence, and interact with their world with more freedom than in other developmental

contexts (2000). With regard to sexual exploration, emerging adulthood brings changes in how young people engage in sexual relationships; notable increases in sexual risk, the deepening of intimacy, and continued individual sexual and romantic identity formation are characteristics of sexual exploration in emerging adulthood (Arnett, 2000) Keeping the developmental context and sexual identity of this study's participants in mind will allow me to consider an intersectional perspective on sexual risk and associated health disparities and outcomes for LGB+ women.

Current Study

Due in part to heteronormative messaging that influences the sexual practices and health of LGB+ women, this population is at risk for unintended pregnancy, as well as certain STIs and cervical cancer. Dominant sexual scripts, which narrow definitions of sex and risk prevention strategies, leave LGB+ women invalidated and excluded in sexual health support and research. While some research has assessed the role of heteronormative sexual scripts on LGB+ women's sexual behavior, the role of partnerships is missing from existing literature.

In this study, I addressed the following research question: How do LGB+ women queer cultural, interpersonal, and intrapsychic sexual scripts related to safer sex? This group must navigate sexual partnerships and communication in the gray, tension-filled area of simultaneously rejecting and reifying heteronormative sexual scripts. This study drew from both queer theory and sexual scripting theory, as well as the important developmental period of emerging adulthood, to analyze the role of cultural, interpersonal, and intrapsychic sexual scripts for LGB+ women's safer sex practices.

I used reflexive thematic analysis (Terry & Hayfield, 2021; Braun & Clarke, 2018) to inform transcript familiarization, coding, and writing for this secondary analysis of interviews about young women's sexual decision-making. Importantly, this study addressed a notable gap in

sexual health and prevention literature that systematically excludes and invalidates the relationships of LGB+ women. This study contributes to literature focused on understanding LGB+ women's partnership contexts, sexual decision making, and navigation of dominant heteronormative influence as it relates to safer sex. This work also aids in supporting LGB+ women's sexual health. Through understanding what influences this population's sexual decision-making, this study positively contributes to more inclusive sexual education programming, policy and gave medical providers more insight into how the lived experiences of LGB+ women influence safer sex decisions. The goals of this study were not only research focused, but ethically focused. As is missing from sexual health literature, I also centered the voices of the women who shared their stories by engaging in a continual reflexive process throughout data analysis.

Methods

Participants and Procedure

This study is a secondary analysis of Dr. Wesche's Sexual Health and Decision-Making Study interviews. Semi-structured interviews were conducted with IRB approval in 2021. Participants were asked questions about defining sex, different methods of STI and pregnancy prevention, and the involvement of present and past sexual partners in those decisions [see Appendix for interview protocols]. Participants were recruited online through social media advertisements on Facebook and Instagram. Online video interviews were conducted by the primary investigator and four graduate research assistants through Zoom (I did not conduct interviews as they were completed before I joined the program). Interviews were then transcribed verbatim and identifying information was removed. Participants were assigned numeric IDs to protect their identities, and were given pseudonyms for reference in the results.

LGB+ Subsample

The total sample included 31 participants who identified as women and had at least one sexual partner in their lifetime. To avoid between-group comparisons that could unintentionally center experiences of heterosexual, cisgender women, only the 22 participants who identified their sexuality as something other than "straight" were included in the subsample. The most common sexual identity was bisexual (n = 9, lesbian = 5, gay = 1, pansexual = 3, queer = 4) and the majority of the sample was White (n = 13, Asian = 7, Black/African American/White = 1, Hispanic/White = 1 [categories were not mutually exclusive]). Their ages ranged from 21 to 26, M = 23.1. All of our participants had college education, representing some college (n = 4), associate degree (n = 2), bachelor's degrees (n = 12), and graduate or professional school (n = 4). Please refer to the demographic table on page 59 for a complete breakdown of participant information. Additionally, one participant had both vagina and penis owning partners (per the language of the interview protocol) but self-identified as straight and is not included in the subsample. In this study, the use of the term "LGB+ women" refers only to cisgender women who hold a sexually minoritized identity. Interviews varied in length, and lasted between 15 and 85 minutes, the average interview being 47 minutes.

My analyses focused on women who reported a minoritized sexual identity. This group suits the sensitizing framework of queer theory and sexual scripting theory, in which sexual and gender identity are important contexts for considering sexual behavior and communication. Participants' acknowledgment of a sexually-minoritized identity is an extension of queerness and an example of resisting heteronormativity through using those labels. Using self-reported sexual identity labels allowed me to consider someone's gender identity and sexual identity in the context of their interpersonal relationships without centering sexual behavior alone.

Secondary Analysis

In order to determine whether it is suitable to use existing qualitative transcripts for use in a secondary analysis, Hinds and colleagues (1997) suggested that one of four approaches be taken. The first is to change the unit of analysis by analyzing transcripts using a different research question and ensuring that the purpose of the potential study differs significantly than the initial analysis. The second approach to deciding whether a secondary qualitative analysis is appropriate is by only using a selected subsample of existing interviews and engaging in a more focused analysis with a similar purpose to the original study. The third approach is to reanalyze data for a present concept that was not outlined in the goals of the original study, and the fourth involves refining existing goals (like asking new questions in future interviews or exploring specific themes found in the original data set). This analysis met more than one of these approaches that validate use for secondary analyses. I did this by only examining a subsample of the existing 31 interviews for a focused analysis of sexually minoritized individuals' lived experiences. Additionally, I considered sexual scripting theory as a concept not originally discussed in the primary study. Sexual scripting theory and queer theory provided a sensitizing framework for use during the analysis process; together, this analysis had substantially different goals than the primary study and was deemed separate enough to warrant a secondary analysis (Hinds et al., 1997).

Positionality Statement

Acknowledging the connection between researcher and the content is important to establish a foundation from which to engage in reflexive thematic analysis (Olmos-Vega et al., 2022). I am a queer, White woman who holds "insider" status related to this subsample of participants, meaning my lived experience would qualify me as part of the population from

which these participants were chosen. As a qualitative researcher, I tend to align with a post-modernist perspective, favoring subjective realities of participants and their stories while rejecting the idea of a single, objective truth (Daly, 2007). My identities and lived experiences, combined with an academic and professional background in sex and health education, queer studies, and family science, surely influenced this thesis in varied ways. Ongoing reflexivity processes were key to remaining aware of my biases, intentions, and perspective on these data. Reflexivity assisted me with the necessary challenge of keeping the women who shared their stories at the center of this work.

Reflexivity

Reflexivity is an integral, ongoing process that is vital to any qualitative analysis. Reflexivity acknowledges that the researcher has their own interpretation of the data, which is based on their own assumptions, biases, morals, and positionality (Terry & Hayfield, 2021). This concept rejects the idea that rigorous research requires the researcher to remain distanced and objective from the data (Terry & Hayfield, 2021). There are several ways that I engaged in reflexive practice during the analysis process. I used reflexive writing throughout coding and writing of this project; this manifested in memo writing, which provided clarity about underlying assumptions of the data and aid in analyses (Olmos-Vega et al., 2022), but likely also included journaling and ongoing written reflection of transcript read-throughs, coding, and theme generation. I also met frequently with my advisor throughout the analysis process. This served two purposes; first, it allowed for opportunities to engage in verbal reflexive praxis by reflecting on reactions, thoughts, and ideas that came up during the coding process. Second, it allowed me to confer with someone who was more intimately connected to the data by virtue of having a forward role in the study and protocol creation, interviewing, and analyses of the primary study.

Analysis Plan

I used reflexive thematic analysis (RTA; Braun & Clarke, 2019; Terry & Hayfield, 2021) as an analytic method to guide the analysis process for this study. Reflexive thematic analysis, opposed to other approaches to qualitative analysis, is branded as a method rather than a methodology; it is stressed that this is a set of tools used to help the researcher generate themes of the data as "multifaceted, conceptual, and meaning-based patterns" (Terry & Hayfield, 2021). A central tenet of reflexive thematic analysis is the acknowledgment and utility of reflexive practice. Reflexivity pushes against a common assumption that in order for research to be rigorous, it needs to be devoid of researcher "subjectivity"; I reject the notion that any research is truly free from researcher bias, and it is my duty as a qualitative researcher to not just acknowledge the connection between researcher and data, but to be actively transparent in this connection through the analysis process. Rigor in reflexive thematic analysis comes from connection and engagement with data, not reliability (Terry & Hayfield, 2021).

Choosing a Method. There are several reasons why reflexive thematic analysis was well suited for this study. A less important point that guided my decision to use RTA is purely practical; certain approaches to qualitative analysis were impossible to sufficiently take on with these data. For example, other methods like narrative analysis and phenomenology require interview protocols and research questions to be created with those analyses in mind from the start, ruling out a few potential methodological candidates.

Reflexivity, while important in all qualitative work, is underscored throughout all six reflexive thematic analysis phases as outlined in Terry and Hayfield's work, which served as my guidebook. As these participant narratives are of a stigmatized and sensitive nature, I needed to engage in a continually reflexive process throughout coding. Reflexive thematic analysis was

well established to aid me in that endeavor. Finally, this is a secondary analysis. Any method used, especially since I was not a part of data collection or interview protocol creation, needed to be flexible. Qualitative data analysis is unforgiving, messy, and time consuming. Reflexive thematic analysis was created with those inevitabilities in mind and was the most suitable tool to use in this situation. RTA was the choice that best fit my intentions and values.

Data Analysis. Aligned with Terry and Hayfield's guidelines, I engaged in the authors' six phase process for reflexive thematic analysis. This began with familiarization, which required me to become intimately immersed in the data set. This was of particular importance since this is a secondary analysis and I did not engage in protocol creation, interviewing, or transcription, all of which assist in data familiarization (Terry & Hayfield, 2021). After reading through transcripts, I engaged in open coding, the second phase of reflexive TA. The goals of open coding were to capture meaningful content and engage with the data in more systematic ways (Terry & Hayfield, 2021). Using MAXQDA, an initial 77 codes were generated using a mix of thematic and gerund codes. During open coding, I also reflected on codes with my advisor, engaged in reflexive memo writing after coding each transcript (and sometimes, during coding if a particular initial code stood out as meaningful). In this stage, I viewed coding as a dynamic process that was flexible and open to adjustment. Codes that were more common (i.e., "redefining/queering sex"; "referencing trust as prevention") provided the foundation for initial theme generation. Reflexive memo writing was conducted throughout the coding and analysis process.

In phases three and four, I generated initial themes and developed/refined themes, respectively. Reflexivity was vital during this stage, and it is important to acknowledge that themes were created by the researcher as interpretations of the data (Terry & Hayfield, 2021). By

the end of phases three and four, the goal was to have generated themes- ways of clustering data in ways that may not be immediately obvious, but capture meaning that told a story of the data set (Terry & Hayfield, 2021). Theme generation in reflexive TA is not sole categorization but also relied on my, and my advisor's, interpretation of data that allowed for dimensionality and discussion of the data (Terry & Hayfield, 2021). Engaging reflexively was crucial to the shaping of themes in this stage, and influenced final themes and theme definitions. This nuance and connection to existing sexual scripts would not have been explored without engaging in reflexive and collaborative practices. The last two phases, defining/naming themes and writing the report, concluded the analysis process. Transparency throughout this process, combined with a balance of including both illustrative and analytic examples of themes allowed for dimensionality and context of the data to show in the final narrative (Terry & Hayfield, 2021).

Results

Participants re-imagined heteronormative scripts by re-establishing definitions of sex, queering trust between potential partners (leaning into trust instead of being inherently mistrustful of potential partners' word surrounding testing and sexual history), and enacting creative responses to STI risk. LGB+ women constantly navigated tension between the reification and resistance of heteronormative sexual scripts.

LGB+ women recalled sexual risk prevention efforts that both reified heteronormative values and queered, or reimagined, sexual scripts. Reified heteronormative scripts included ways in which LGB+ women approach sex and sexual risk prevention that promoted heteronormative values, like prioritizing pregnancy prevention over STI prevention. Reimagined scripts subverted heteronormative values and considered sexual risk prevention beyond what is "normal" for heterosexual, monogamous, committed couples.

Redefining Sex

All LGB+ women in our sample held expansive definitions of sex that transcended heteronormative scripts dictating that sex is strictly penile-vaginal intercourse. At face value, this might seem obvious considering that some queer sex may simply not include a cisgender man. However, understanding the desire to promote pleasure individually and with partners differed from feeling that pleasure was transactional or expected, as in the case of heteronormative scripts. In other words, re-defining sex had less to do with the "what" (i.e., behaviors) and more to do with the "why" (motivations). Participants' definitions of sex included many components such as individual pleasure, expansive sexual behaviors, and a focus on altruism and partner pleasure.

Some participants explicitly stated how their definitions of sex rejected heteronormative sexual intercourse:

> Sex means a lot of things to me. Sex to me, is mostly oral, touching underclothes and penetration with a toy. That's my type of sex… [but] the first thing I would think of is penile-vaginal sex; that's the first thing that comes to my head when I use the word *sex.* P7, Bisexual

The acknowledgment of oral sex, touching, and use of sex toys as "my type" of sex reflected awareness of how this participant's definition of sex is different from penile-vaginal sex, but was also something she recognized as her own definition, not necessarily a definition of queer sex or bisexual sex. Instead, this attached meaning to sex reflects something she made and created herself. Similarly, other participants noted that sex was a reflection of individual self-expression: "To me, like being able to have joyful and passionate and communicative sex really feels like a form of like self-expression and liberation that I didn't always think was possible or didn't always

have access to," (Shannon, Gay). Redirected focus towards the self was a concretely queer script in the decentering of men- both as initiators and leaders, but also as those deserving of intentional pleasure and freedom.

Queered definitions of sex also reflected the co-creation of pleasure. This differed from a heteronormative script, which would dictate that pleasure during sex is centered around a cisgender man. Promoting a partner's pleasure acknowledged an intention to co-create sex as something that worked for all parties and removed the gendered nature of centering a cis-man's pleasure. One person discussed the process of learning about someone's desires and dislikes as if "you might learn that your partner hates broccoli or something. But then you might also learn that they really like to be touched a certain way so you can kind of just gather information about that person," (Diane, Pansexual). She goes on to describe the value of sex as a way to connect with a partner. "To me, [sex is] definitely a way to connect with another person, to make each other feel good, and to just kind of like just figure each other out, you know. It's just like a deeper form of intimacy," (Diane, Pansexual). The ability to value sex as a space to co-create connection with a partner stretches across other participant dialogues as part of defining sex. Another participant described some sexual experiences as spaces where she has "been able to feel really free…to be fully present and engage with the person has been just a really positive experience" (Shannon, Gay). Embracing sex as an opportunity to learn and engage with partners reflects the reimagined script of 'co-creating' sex alongside others instead of following the motions of a predetermined heteronormative script.

Another component of redefining sex was the intentional focus on pleasure instead of procreation. One participant commented on how broad this idea could be:

> I would say...when someone is experiencing erotic pleasure specifically. So not just like penetrative penis and vagina, but all forms of eroticism more broadly… I think it's different for everybody, but for example, in BDSM spaces, some of the things that you're involved in wouldn't really be considered sex per se, but there is a sexiness to it and an eroticism to it. It's definitely complicated (Mila, Queer).

Complicating sex encompassed more than listing activities beyond penile-vaginal penetration. This idea also reflects innumerable attitudes, motivations, situations, and behaviors. For example, this participant discussed widening sexual expression to include BDSM and kink.

Leaning into Trust

The risk prevention strategy of relying on honesty and trusting potential sexual partners was a discussion point for most of LGB+ women's narratives about STI and pregnancy risk prevention. A heteronormative interpersonal script portrays women as unable to trust their (often cisgender, male-bodied) partners to keep their best interests. In turn, women often act as gatekeepers in their partnerships, unable to ensure that their male partners are telling the truth about their sexual history and testing. A few participants shared justification for inherently mistrusting partners. One woman noted that, before she started sleeping with women, "a lot of the guys I was with would lie. I mean, not all of them, but I just feel like they would lie… They wouldn't tell you the truth, but you know it already," (Pam, Bisexual). Other participants discussed the consequences of male partners' deception. "I had a male partner once who took the condom off without telling me. And like the next day I was on the phone with the health center. Like, yeah, I need to get an appointment immediately," (Jenna, Bisexual). These strong underpinnings that lead to inherent defensiveness or gatekeeping stirred more comprehensive responses from others, representing a response to the heteronormative script: Do not inherently

trust your (male) partners, and approach new partners with caution. Some women who shared their stories mentioned the use of STI testing to avoid the need to rely on a partner's word:

> I trust [STI testing]. It's trustworthy. I'm in control. I decide when I go to my doctor and when I get tested and it's trustworthy in that I hopefully have a good relationship with my care provider and also that I trust the test results for the most part. Mila, Queer

STI testing was a response to past lying partners and seeking out STI testing allowed her to maintain control over her sexual life. Similarly, another participant recalled the security of STI testing as a "surefire way of validating your habits that should be safe. And if they are not, then you can take prophylactic measures to either treat whatever it may be," (Mona, Bisexual). STI testing could also be a way to follow up with claims made by partners as a response to inherent mistrust. One woman was in a non-monogamous relationship and had a trans-feminine primary partner with a penis. She remarked that her partner "showed up with her most recent STI panel results in hand. And then within that month had another panel done that was more recent and also presented those results to me," (Leah, Lesbian). Establishing a routine of STI testing as way to co-create a foundation of trust was essential given her partner's disinterest in condom use:

> We're in a very blessed position where there is zero pregnancy risk. But my partner has a very strong preference for no condoms. She's very not interested in using them. It kind of ruins the intimacy, that whole 'Babe, I can't feel anything if we wear one' and largely, I just shrugged and said, "OK", and accepted the risks. (Leah, Lesbian)

While some participants noted the inability to rely on trust, a majority of our participants considered establishing trust as an integral part of their sexual lives. Establishing trust bypassed

the drive for some women to be distrustful, inherently queering prevention by promoting a more egalitarian, positive-oriented mindset for women to enact new sexual partnerships. One participant acknowledged the use of honest conversation:

> I guess the conversation itself like doesn't reduce the risk. But in general, being open about stuff is just better. And I think it probably the conversations reduce more anxiety because you can be like,' okay we've talked about this, and this is what we're gonna do'. So I guess it's more peace of mind. Jenna, Bisexual

She recognized that while promoting trust did not directly reduce STI risk, having open conversations did reduce anxiety and apprehension that other participants likened to *needing* to mistrust men. Similarly, another participant noted this ease through her transition to sleeping with cisgender women:

> I don't think I ever had any conversations with men that I was sleeping with about if they had been tested, what their history was or anything. But once I started having sex with women, that was definitely more of a conversation point. And before my current partner, the two women that I had sex with, they were both much more experienced than I was. And I think both of them brought that up before I did. (Gina, Lesbian).

This participant's comment reflects the value of engaging with experienced partners, who modeled trust. This example shows another way in which heteronormative sexual scripts were challenged, where having an experienced woman as a sexual partner was considered valuable and presented an opportunity for growth as a sexual person (juxtaposed with the heteronormative script that women should value chastity and remain virgins to not be "compromised" for their

future husbands). However, our participants represented a diverse group of women who did not solely rely on either STI testing or trust.

While heteronormative scripts of condoms disrupting the pleasure of sex still surfaced, these women leaned into trust, through a combination of open, honest communication with partners and STI testing, as creative, queer ways to establish a strong relational foundation. We initially interpreted "leaning into trust" as a negative way to circumvent more comprehensive approaches to STI prevention (i.e., recalling prevention-centered conversations with potential sexual partners *instead* of getting tested). Upon reflection both individually and with my advisor, the context surrounding this theme actually pointed to trust as something unique to LGB+ participants. The ability to, even after navigating negative and deceitful experiences with partners, build upon trust as a foundation of new partnership speaks to the queered and resistant nature of trust in LGB+ women's sexual partnerships.

Expanding STI Prevention Beyond Barrier Methods and STIs

Sexual risk prevention efforts overwhelmingly favored pregnancy prevention over STI prevention, regardless of actual pregnancy risk. For participants who had penis-owning partners, preventing pregnancy was a priority. One participant stated that she and her partner "use a condom every time, but it's for pregnancy, not for STIs," (Terry, Bisexual). Even for those who were not at risk of pregnancy (e.g., having another vagina-owning partner), pregnancy prevention scripts permeated into their sexual risk prevention habits. The distinction between preventing fluid exchange using dental dams/promoting hygiene versus using condoms for penile/vaginal intercourse is noted:

> If you're kissing and making out, you're exchanging saliva, right? What's the point of cleaning other stuff? You're going to be exchanging fluids no matter

what. So what's the point if there's not the fear of pregnancy to stop the fluids from being exchanged? (Ali, Bisexual)

This rhetoric was the product of a heteronormative cultural script that holds that sex revolves around cisgender people in straight relationships. Participants were left without common, realistic ways to prevent the spread of STIs beyond the use of dental dams. In summary, LGB+ women reified pregnancy prevention scripts by only using barrier methods during penetrative sexual activity.

Reified Script: Dental Dam Aversion. In order to better understand the issues LGB+ women face which prevent the widespread use of dental dams, we must first examine the timing of risk prevention methods in sexual behavior. Primarily, participants discussed having strong intentions to prioritize risk prevention methods like condom use but ended up preoccupied with the progression of sex. Several women alluded to the concept of getting "caught in the heat of the moment" as a justification for forgetting or overlooking condom use or other barrier methods of prevention. As one woman explained about the inconsistency of condom use:

> If [not having a condom] was kind of the holdup then the obvious solution would be to slow things down; but of course, that's not necessarily conducive to everyone's sexual relationship…you know, things kind of happened suddenly and it's [easy to get] caught up in the passion. Sonya, Queer

Stopping sex to weigh risks and mandate condom use halts sexual behavior. The disdain to pause sex to discuss STI risk reifies a sexual script that denotes STI risk prevention as something that is not a part of sexual activity. One woman noted this directly, where even though she was aware that she should use a condom, she remarked that "if it's in the heat of the moment, I know I wouldn't actually change whether or not I have sex with them," (Emmy, Queer). The disconnect

between knowledge of safety and real behavior could come from the heteronormative script to discount sexual risk during sexual activity, along with the need to, as a woman, make those decisions independently without a penis-owning partner mandating condom use. Condom use was consistently promoted by participants to prevent pregnancy for those who have partners capable of getting them pregnant. However, other barrier methods of prevention intended for oral to genital/anal use among vulva-owning people, primarily dental dams, were culturally ignored, joked about, and inaccessible. This stark difference in use, tone, and accessibility described how, in promoting condom use but not dental dam use, the heteronormative script of "avoid pregnancy" was reified. In interviews, participants described disdain for dental dams, indicative of how little they were accessed by people engaging in oral to genital/anal sex. This was so prevalent in interviews that similar commentary regarding the absurdity of dental dams surfaced across participant interviews. First, participants noted accessibility and acceptability issues surrounding dental dams:

> There's culture. I think. If I offer a condom to a guy, they just take it, it's fine. No questions asked. It's just normal. Whereas what I said about dental dams or gloves is, no one uses that…It would be very hard for me to offer a girl some similar type of protection [to a condom]. Emmy, Queer

Dental dams evoked a dual sense of acknowledgment that they existed, followed by an immediate disregard for actual use. Many women recognized their existence but continued with sentiments like, "I just don't think they're often used in real life… I just don't think people actually use them," (Cheryl, Bisexual). Considering dental dams as humorous was also common, where they were often the topic of jokes such as, "I don't know where you get one (laughs)!" (Barbara, bisexual). This also reflected underlying accessibility issues and the failure of public

health and educational campaigns to promote their use. The mystery surrounding dental dam use could also be a product of the emphasis on heteronormative sex in United States sex education:

> Queer sex is already so transgressive against everything that we're taught in school and how we grow up, that there's no space to talk about the intricacies of why it could be helpful to use a dental dam; like why it could be awkward, like how to use it; I've never seen a demonstration of it. I've only seen one because I work in an STI clinic sometimes. And they give them out and I'm like, 'What is this? This is crazy.' But then to the people in the waiting room [I'm] like, 'This is awesome! Look at this!' But really I've never used it, you know." (Mila, Queer)

The contradiction displayed by this participant also clarified the distance between what was recommended and what was reality. Participants naturally discussed dental dams in interviews without prompting, with an awareness that they existed and were there to prevent the spread of STI's during oral sex. However, these participants showed that simply being aware is not akin to changing behavior or expecting that from others.

Re-imagined Script: Prioritizing Hygiene. Though dental dam use has not caught on widely among LGB+ women, this group displayed realistic, accessible, and creative ways to resist heteronormative risk prevention scripts. LGB+ women broadened what it means to promote safe-sex through promotion of cleanliness.

Washing one's hands, washing sex toys, and urinating after sex were included as part of sexual risk prevention strategies. One woman noted hygiene as part of her routine post-sex with her partner where they "usually go straight to the bathroom anyway, just washing up so everything gets cleaned," (Pam, Bisexual). The timing of hygiene—before or after engaging in sexual behavior, not in the middle of a sexual encounter—also circumvented the "heat of the

moment" script described earlier which prevents consistent condom use. Hygiene was particularly relevant for participants who had partners with vulvas, and participants emphasized the desire to not introduce new bacteria to a partner's body:

> I wouldn't put those fingers in my mouth to pull something out of my teeth. So why would I put them in someone else?... I feel like the decent thing to do is make sure that my fingers are clean. And again, it's not necessarily like something that I look at specifically as I'm doing this to prevent STDs, it's more I'm doing this to just be like a clean and [to be], you know, a respectful person" (Leah, Lesbian).

As part of re-imagining a heteronormative script, participants explained the dual purpose of promoting hygiene as something to prevent STI's and promote general health, like avoiding yeast infections. Although handwashing seems to be lacking in sexual risk prevention literature, LGB+ women displayed creativity by widening prevention to include a more holistic sense of well-being and cleanliness. In this way, their safer sex scripts identified new methods of prevention that were relevant to the needs of themselves and their partners. The intentionality of considering a partner in risk prevention also comes across in this discussion of hygiene, where one woman with a same-sex partner noted, "I'll wash my hands for sure… It just seems like the smart thing to do. Like if you're going to be touching someone in a private area, you should probably have clean hands, right?" (Barbara, Bisexual). Where dental dams were expensive, unappealing, and rejected by LGB+ women, washing hands and sex toys was habitual, accessible, and normalized.

Discussion

LGB+ women navigated heteronormative sexual scripts in diverse ways, representing a mix of reifying heteronormativity and reimagining, or queering, sexual scripts. This mixed bag reflects how LGB+ women must deal with public health efforts, medical providers, and sexual

education that overwhelmingly defaults to heterosexual partnerships (Arbeit et al., 2016; Harris & Farrington, 2014). However, they also exist in a time of motivated socio-political change and increased public visibility, where queer people are more easily able to reject and resist dominant scripts.

These results align with the limited prior research suggesting that LGB+ women are not free from heteronormative influence (Power et al., 2009), shown through the ways in which pregnancy prevention, both consciously and subconsciously, is still prioritized. The rejection of barrier methods for anything other than penile-vaginal intercourse also reflects an inherent propensity to promote barrier methods for pregnancy prevention over STI risk incurred through oral sex. From these women's stories, we further understand and underline the role of heteronormativity in *all* relationships, regardless of sexual identity or partner gender. More importantly, these results highlight the creative and resistive ways that LGB+ women reject heteronormative scripts and create sexual risk prevention efforts that reflect their own needs and goals.

Reimagined Scripts

Participants navigated sexual risk prevention in ways transcending heteronormativity, seen in the results through the diverse definitions of sex, the promotion of trust, and the emphasis on individual and partner hygiene. First, expansive definitions of sexual behavior reflect the incredibly large world of sexuality that exists beyond penile-vaginal intercourse. We found that some participants included the promotion and co-creation of pleasure with their partners as part of their definitions. This aligns with newer research on queer hookups, where researchers found that LGBTQ+ young adults prioritized pleasure of their partners as part of their hookup motivations (Snapp et al., 2023). Expansive definitions of sex could drastically shape research on

sexual health and education, paving the way to decenter heteronormative experiences and lift up the role of interpersonal connection and intimacy.

Second, many of our participants, regardless of the sex or gender identity of their partners, acknowledged trusting partners as an important component of sexual relationships. While a heteronormative script tells women that their male partners cannot be trusted, and to enter sexual activity as gatekeepers with an inherent defensiveness and distrust (Benoit & Ronis, 2022), this reimagined script flips this idea completely. Instead, our participants regarded trust, through conversations about previous risk and sexual history, as an integral part of forming sexual partnerships. Relying on trust is a queer sexual script because it allows LGB+ women to establish new sexual partnerships that are built using mutual respect and honesty instead of inherent deceit and defensiveness. Trusting partners goes against the heteronormative script that dictates total avoidance of honest conversation or being initially skeptical of a partner's word.

LGB+ women found accessible, realistic ways to promote hygiene while acknowledging the limitations of dental dams. Interestingly, there is little research on how effective dental dams actually are in preventing the spread of STI's (Gutierrez et al., 2022), even though they are promoted across trusted health sources like the Centers for Disease Control (2016) and Planned Parenthood (2019) and our participants were introduced to dental dams by educators. However, our participants, particularly those partnered with cis-women or those with vulvas, often referenced washing their hands and sex toys preceding or following sex. The emphasis on washing toys and hands served two purposes.

First, hygiene circumvented the idea that sexual risk prevention occurs *during* sex and disrupts sexual activity. Participants discussed how risk prevention behaviors that occur during a sexual experience (i.e., condom use) interfered with the flow of sexual activity. Staying in the

flow was more important than preventing STI risk and pregnancy. Reversely, hand and sex toy hygiene primarily occur before or after sex, making them more desirable risk prevention options. Some participants described hygiene as habitual, indicating that these methods are built into LGB+ women's sexual practices.

Second, hygiene methods of prevention also reorient prevention towards what is realistic and accessible. People are much more likely to have soap and water on hand than dental dams which are difficult to access, expensive, and unpleasurable. The promotion of hygiene is a clear example of how LGB+ women extend prevention beyond STI contraction. Though they often referenced cleanliness in response to a question about STI risk prevention, participants also noted wanting to avoid yeast infections or introduce germs to their partners' vulvas. Existing work supports these results, where LGB+ individuals were more likely to use sex toys as part of their sexual activity and reported washing toys regularly (Wood et al., 2017). A survey of Japanese lesbians also found that around half (of 102 participants) reported hygiene (showering, brushing teeth, washing hands) as part of their STI prevention strategies (Fujii, 2018). Our participants' stories about cleanliness reflect creative responses to ineffective approaches toward same-sex risk prevention.

Limitations

The results of this study should be interpreted with regard to the limitations. This sample was predominantly made up of White, cisgender women who were college-educated. It is likely that sexual scripts, whether reified or reconstructed, differ by sex and gender identity, stressing the need to consider transgender and gender-expansive voices in risk prevention literature. There will also be a need to consider diverse, intersectional perspectives regarding sexual risk prevention in future research, as socio-cultural expectations likely impact romantic and sexual

partnerships. Many participants commented on college contexts as opportunities for more comprehensive, or initial sexual education. This group also considered the influence of college hook-up culture which likely impacts the prevalence of heteronormative sexual scripts (Lamont et al., 2018). Additionally, this study consisted of a second analysis where the interview protocol did not provide questions directly about sexual scripts. In turn, this could have affected the depth of participant responses associated with this study's research question and goals. Future work would benefit from a more focused study design and analysis that intends to pull apart LGB+ women's sexual scripts surrounding STI and pregnancy prevention.

Future Directions

Research. This study highlights key possibilities for future research. Scholars should address the aforementioned limitations of this study and first re-focus their attention on queer people of color, transgender and gender-expansive individuals, and nonbinary perspectives, and young adults who represent a wide range of professional and educational backgrounds. Similar research that examines intersectional perspectives among diverse populations could highlight much-needed nuance in how these groups navigate heteronormativity which could inform more directed public health efforts.

A majority of participants pointed out the inadequacy of barrier methods (i.e., dental dams) as a prevention measure, instead prioritizing individual hygiene to prevent not just STIs, but also yeast infections and to promote general cleanliness. Researchers should take this finding seriously and should study the effectiveness of hygiene, targeting prevention research that reflects how women engage with sexual partners. Although some literature acknowledges the role of general hygiene in sexual risk reduction, particularly in the context of the COVID-19 pandemic (Banerjee & Rao, 2020) and among those experiencing homelessness (Tucker et al.,

2020), the intersection between sex toy and hand hygiene and LGB+ women's safer sex practices has yet to be comprehensively studied. Addressing this literature gap, and applying that research to comprehensive education programs, will also allow women to grow a set of tools that relates to the outcomes they deem important, not the outcomes that those unfamiliar with LGB+ women's partnerships and lives deem important.

Education. Sexual scripts, both reified and reimagined, should be integrated into education for both LGB+ women and those supporting LGB+ women with STI and pregnancy prevention, like medical providers and relationship educators. Reimagined scripts also speak to an implication for health educators more broadly; LGB+ women in our sample promoted trust in their partners, choosing to lean into conversations about sexual history and STI exposure/testing alongside actual STI testing and other concrete methods of STI prevention. Our participants highlighted the value of establishing honesty and communication between sexual partners, and showed that for LGB+ women, establishing trust was a focal point of their sexual risk prevention approach. There is also a need for sexual education to center relationship education; situating sex education within relationships (valuing communication, honesty, and respect) could assist young people in establishing trust with their partners beyond a simple definition of consent. A small body of recent literature acknowledged a similar need for inclusive sex and relationship education (Meadows, 2018), mostly focused from a health perspective. Emphasizing relational support could also positively change heteronormative scripts regarding STI and pregnancy for everyone regardless of gender or sexual identity. Another trust-focused educational direction could include teaching LGB+ women about situations in which a barrier method of prevention may not be applicable if partners are in committed, closed partnerships (Agnew et al., 2017) and other contraceptives are used, although peer-reviewed literature on how partners decide to stop

using condoms is still limited (Mullinax et al., 2017). A small but existing literature on fluid bonding, when partners intentionally decide not to use barrier methods of prevention during sex as a way to signify commitment and increase intimacy (Wosick-Correa, 2010), has been studied in polyamorous communities (Wosick-Correa, 2010; Sheff, 2011) and among transgender individuals (Kosenko, 2011). Education about fluid bonding and barrier-free sex could be more realistic ways to approach relationship and sex education that promotes trust and teaches young people about how to engage in common behaviors (like forgoing condom use after a certain point in a relationship) safely instead of avoiding the topic altogether.

Public Health Efforts. This study also provides clear next steps for public health professionals and medical providers. Our participants clearly pointed out the inadequacies of dental dams, supporting the idea that promoting dental dam use may not be an effective intervention to support LGB+ women with STI prevention. Public health efforts should redirect oral sex-oriented prevention towards methods that this group will *actually* consider seriously; both researchers and practitioners could benefit from meeting LGB+ women where they are instead of pushing expensive, difficult-to-find, and underused methods like dental dams. The lack of dental dam use noted by out participants is consistent with recent findings noting low dental dam use (around 5% for those engaging in oral/oral and oral/anal sex) among Spanish lesbians (Gil-Llario et al., 2022).

Finally, this study points out an existing limitation of public health research that centers disease models (i.e., Janz & Becker, 1984) of sexual risk reduction. Even though our participants demonstrated engagement in prevention which extended far beyond disease prevention, public health and current sex education efforts disregard the creative, expansive ways that LGB+ women engage in sexual behavior and prevention. Subsequently, I would stress the need to

center a more holistic approach to sexual risk prevention that addresses vaginal health more broadly than preventing often treatable and curable STI's.

This approach, stemming from the foundation set by our participants' queered definitions of sex which emphasized pleasure and expansive sexual behaviors, could center pleasure and sex positivity in research and education. This recommendation aligns with a newer push to consider pleasure in the context of sexual health (Ford et al., 2019), and to situate pleasure as a core component of sexual rights and health as opposed to an afterthought. Even early literature on sexual health acknowledged the role of sex-positivity as a component of sexual health research and education (Edwards & Coleman, 2004). Sex-positivity generally captures approaches to sexuality are open minded, free of judgement, and inclusive of individual autonomy (Ivansky & Kohut, 2017). Older research acknowledged the desire for young women to incorporate pleasure and relationship equity into relationship education (Hirst, 2013). Including positive approaches is likely conducive to supporting relationship development and normative sexual development (Harden, 2014). Understanding LGB+ women's complicated and contextually situated sexual roles and health outcomes will ensure that this population continues to be lifted up, validated, and supported by clinicians, researchers and educators.

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Appendix A

Interview Protocols

Vagina-owning partners only

Interview Questions

1. **Let's start by thinking about sex and sexuality more broadly. What does sex mean to you?**

   Note: Can prompt with additional aspects of sexuality besides behaviors. Sexuality, sexual health, and how people protect their sexual health are all valid topics of conversation. The purpose of this question is to start a conversation about sex and ease into further questions about specific sexual experiences.

   Follow up by noting that for the purposes of the interview, we define sexual behaviors as touching someone's genitals without/under clothes, oral sex, vaginal sex, anal sex, or penetration with a sex toy.

2. **In your lifetime, when you have been sexually active, what have you done to reduce your risk of sexually transmitted infections (STIs)?**

   Note: Can prompt with a list of STI prevention methods (condoms, dental dams, STI testing, avoiding certain sexual behaviors). Can also prompt by asking what methods they use for different sexual behaviors (e.g., oral sex vs penetrative sex).

3. **When was the last time you engaged in sexual behaviors with a partner? Remember, by sexual behaviors, I mean touching someone's genitals without/under clothes, oral sex, vaginal sex, anal sex, or penetration with a sex toy.**

4. **Describe your most recent sexual partner's sex and gender.**

   Note: For future questions, mirror the language that participant uses to describe their partner's sex and/or gender.

5. **How would you describe your relationship to this person?**

   Note: This question can address a range of relationship characteristics—length, relationship labels, relationship dynamics, etc. You may ask about how the participant would negotiate safer sex with this person, or other questions to better understand dynamics like power, commitment, communication, and satisfaction. The purpose of this question is to get participants to reflect on their relationship, setting the stage for future discussion of how relationship characteristics may have influenced sexual decision-making.

6. **Is this someone you are currently seeing in a sexual or romantic way?**

   Note: If they are not currently together, can prompt to find out when they stopped seeing each other sexually/romantically.

7. **With your most recent partner, describe how you typically reduce(d) your risk of STIs, if anything.**

Note: Can prompt with a list of STI prevention methods (condoms, dental dams, STI testing, avoiding certain sexual behaviors). Can also prompt by asking what methods they use for different sexual behaviors (e.g., oral sex vs penetrative sex). If someone says they had used a method in their lifetime, but didn't mention it with this partner, you can clarify that this they didn't use the method with this partner. Can also discuss personal and relationship negotiation (or lack of negotiation) around method choice. For example, you may discuss how they communicated with their partner about method choice.

8. For **<u>each</u>** STI risk reduction strategy identified, ask the following six questions:
   A. Why did you choose this method to reduce your risk?
   Note: You may discuss how medical, environmental, situational, or relationship considerations influenced their choice. You may also discuss cognitive influences on decision-making, such as knowledge, risk assessment, self-efficacy, negotiation skills, and attitudes. The purpose of this question is to understand all of the factors participants considered when they made the decision to use a certain method. If participants report not thinking about their decision, prompt about this too. Why didn't they think about their method?

   B. Describe a time, if there was one, when you didn't use this method.

   C. What was going on for you?
   Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

   D. What do you think was going on for your partner?
   Note: Can prompt about partner's life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

   E. Was there anything about the situation or environment that you think led to this?

F. If you could go back, would you like to have used [method] in this situation?

a. Follow-up if yes: What could have gone differently?
Note: Can prompt about barriers and facilitators from cognitive, situational, relationship, and environmental levels.

b. Follow-up if no: Tell me more about why this situation worked for you.

9. Recall a past sexual partner other than the one we just discussed. What was your relationship to this person the last time you engaged in sexual behaviors?

Note: This question can address a range of relationship characteristics—length, relationship labels, relationship dynamics, etc. You may ask about how the participant would negotiate safer sex with this person, or other questions to better understand dynamics like power, commitment, communication, and satisfaction. The purpose of this question is to get participants to reflect on their relationship, setting the stage for future discussion of how relationship characteristics may have influenced sexual decision-making.

10. How are the decisions that you made about STI prevention different with this partner than with other partners?

11. How have your decisions about STI prevention changed over time?

Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

12. Imagine that your next sexual partner is male. What kinds of things would you consider when it comes to reducing risk of pregnancy and/or STIs?

Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

End of interview:

That was my last question. Thank you again for your time today. I really appreciate your willingness to speak with me about your experiences.

Both penis and vagina-owning partners

Additional Questions:

1. **With your most recent partner, describe how you typically reduce(d) your risk of pregnancy, if anything.**

   Note: Can prompt with a list of pregnancy prevention methods (condoms, hormonal birth control, sterilization)

2. For **each** STI and pregnancy risk reduction strategy identified, ask the following six questions:

   G. Why did you choose this method to reduce your risk?
   Note: You may discuss how medical, environmental, situational, or relationship considerations influenced their choice. You may also discuss cognitive influences on decision-making, such as knowledge, risk assessment, self-efficacy, negotiation skills, and attitudes. The purpose of this question is to understand all of the factors participants considered when they made the decision to use a certain method. If participants report not thinking about their decision, prompt about this too. Why didn't they think about their method?

   H. Describe a time, if there was one, when you didn't use this method.

   I. What was going on for you?
   Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

   J. What do you think was going on for your partner?
   Note: Can prompt about partner's life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

   K. What do you think led to you not using this method?

L. If you could go back, would you like to have used [method] in this situation?

c. Follow-up if yes: What could have gone differently?
Note: Can prompt about barriers and facilitators from cognitive, situational, relationship, and environmental levels.

d. Follow-up if no: Tell me more about why this situation worked for you.

3. The partner we just discussed was [male/female]. Next, I would like you to think about the last sexual partner you had who was [female/male—a different sex than the partner we just discussed]. What was your relationship to this person the last time you engaged in sexual behaviors?

Note: This question can address a range of relationship characteristics—length, relationship labels, relationship dynamics, etc. You may ask about how the participant would negotiate safer sex with this person, or other questions to better understand dynamics like power, commitment, communication, and satisfaction. The purpose of this question is to get participants to reflect on their relationship, setting the stage for future discussion of how relationship characteristics may have influenced sexual decision-making.

4. How are the decisions that you made about STI and/or pregnancy prevention different with this partner than with other partners?

5. How does the sex of your partner influence your decisions about safer sex?

6. How have your decisions about STI prevention changed over time?

Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.

7. How have your decisions about pregnancy prevention changed over time?

Note: Can prompt about life circumstances, relationship factors, and thought processes that might have influenced behavior and decision-making.