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Souto Pereira, S., Swainston, K., & Becker, S. (2018). The discursive construction of low-risk to sexually transmitted diseases between women who are sexually active with women. *Culture, Health and Sexuality*.

*This is an Accepted Manuscript published by Taylor & Francis in its final form on 11 January 2019 at <https://doi.org/10.1080/13691058.2018.1554188>.*

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## SHORT REPORT

### **The discursive construction of low-risk to sexually transmitted diseases between women who are sexually active with women**

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## **Abstract**

This paper uses discursive analytical method to explore dominant discourses concerning the sexual health of women who have sex with women. In-depth interviews were conducted with a cross-cultural sample of women from England and Brazil. Sex between women was discursively constructed as 'safe' and women who have sex with women were seen as being at low to negligible risk of contracting/transmitting sexually transmitted infections. Analysis identified two discourses underlying these constructions: a binaries discourse which focused on dichotomies of gender, sexuality and risk; and a sexual double-standard discourse, which focused on the positioning of sex between women as safe and the use of barrier methods of protection as indicative of not engaging or fully enjoying the sexual act.

**Keywords:** STI, risk, women who have sex with women, sexual health, discourse analysis

## Introduction

The term 'women who have sex with women' refers to women who engage in sexual activity with other women regardless of sexual orientation (Rowen et al. 2013). The evidence suggests that sex between women provides a viable means of transmission for herpes, trichomoniasis, human papillomavirus and Chlamydia (Fethers et al. 2000; Murrain, Coffey and Bingham 2005). These findings contradict widespread beliefs within the medical community and in the general population, including among some lesbians, that sex between women confers no or low risk for transmission of sexually transmitted infections (STIs) (Fethers et al. 2000).

Central to the representation of what constitutes risk and how women who have sex with women experience sexual health, are the social meanings attributed to women's sexuality and lesbianism (Richardson 1992). During early accounts of the HIV epidemic, AIDS was seen as a 'gay disease', and lesbians were viewed as a 'high-risk' group because they were 'homosexual' (Richardson 2000a). However, when it became clear that HIV is heterosexually transmitted, a process of 'de-gayng AIDS' began (Patton 1994) and biomedical discourse shifted to construe lesbians as a group at low risk of HIV infection (Richardson 2000a).

This shift in the conceptualisation of lesbians as low-risk has had an enduring effect in shaping individual and medical responses to STIs (Murrain 2000). In consequence, women who have sex with women are largely invisible in sexual health discourses and are often neglected in healthcare and research. Lee and Crawford (2007) observed that research focusing on lesbians and bisexual women constituted less than 1% of all psychological research published over a 27-year period (Peel and Thomson 2009). Research from other disciplines is arguably more established through a focus on the prevalence of STIs (Estrich, Gratz and Hotton 2014), perceptions of HIV-related risk (Dolan 2005), sexual risk behaviours (Schick et al. 2015) and use of and access to healthcare (Poteat et al. 2014). There is growing awareness of the health impact of stigma and marginalisation on sexual minority women (Hughes and Sommers 2015; Logie et al. 2014).

Whilst some of the latter research has considered how broader societal ideologies such as heterosexism and homophobia, are linked to the assumption of sex between women as 'low-risk' and its subsequent impact upon the sexual health of women who have sex with women (Formby 2011), the ways in which these assumptions are worked up and attended to in sexual health discourses remains largely ignored. By means of redress, this study aims to 'trace-back' and expose where notions of women-women sexual activities as being low-risk originate in these explanations and accounts of sexual health and safe sex. In doing so, it builds upon observations of the ways in which women's sexualities become 'attached' to specific sexual practices and identities, creating and reinforcing the belief that sex between women is of 'low-risk' and observing how institutionalised exclusion silences discussion of the possibility of STI transmission between women. More specifically, this study explores the ways in which perceptions of sexual health risk mobilise heteronormative notions of women's sexuality. Two research questions are addressed:

- 1: In what ways do women who have sex with women account for sexual health risk in their everyday lives
- 2: In what ways do health care practitioners account for sexual health risk when working with women who have sex with women.

The aim of this study is to illustrate the ways in which constructions of sexual health risk amongst women who have sex with women and health care practitioners may begin to inform understanding of the barriers to engaging in more inclusive and sensitive sexual health promotion work.

## **Methodology**

### ***Design***

The study employed a qualitative methodology informed by Potter's and Wetherell's (1987) discursive analytical method. According to this approach, language is viewed not an 'expression' of inner thoughts, a window to 'underlying cognitions' or a reflection of an objective 'reality'. Rather, language is best understood as a tool for achieving social action, and as a platform on which meanings are created and negotiated. When people talk, they produce and reproduce 'shared knowledge' rather than engage with pre-existent meanings which precede culturally available ways of talking (Wetherell and Potter 1992). Discourses are seen as embedded within wider ideologies and the social, cultural and historical conditions that give rise to their emergence (Parker 1992). In this way, language creates, reflects and reinforces power relations, sociocultural dynamics and political practices (Potter and Wetherell 1987).

### ***Participants***

The study sample comprised 17 women. Ten women were drawn from within the first author's friendship network and were recruited on the basis of having previous or ongoing sexual experience with women. Seven other women were healthcare professionals (HCPs) who were recruited via snowball sampling initiated from the first author's personal contact with a health care practitioner, who in turn asked their professional colleagues if they would be willing to participate. Ten participants were recruited in England and seven participants in Brazil. No financial incentive was provided.

*Women who had sexual experience with women.* Of the ten women who said they had had sex with women, five participants described themselves as lesbians, 3 as bisexual, 1 as heterosexual, and 1 as pansexual. Their ages varied from 20-58 (mean age of 35). Three stated they had acquired HPV and trichomoniasis when having sex with women only.

*Health care professionals.* The seven health care practitioners included nurses (4), GPs (2) and gynaecologists (1) who had experience delivering sexual healthcare to women. Three self-identified as heterosexual, 3 as lesbian, and 1 as bisexual. Their ages varied from 29-47 (mean age of 42).

### ***Data collection***

Data was collected via telephone (n=10) or face to face (n=7) interviews. Seven participants were interviewed in Portuguese. The remaining participants were interviewed in English. Interviews lasted approximately 30-60 minutes and were audio-recorded.

A semi-structured interview schedule was used as a guide for discussion, as it encourages participants to talk more 'freely' and attend to topics that are especially relevant to them (Holloway 1997). According to Potter and Wetherell (1987), a semi-structured interview schedule can aid in the production of lengthier explanations and descriptions, leading to the emergence of unanticipated categories of meaning, and allowing the researcher to gain access to the discursive patterns produced when respondents provide their answers.

The schedules developed for interviewing health care practitioners and non-health care practitioners were broadly similar in content. Both covered topics such as knowledge of STI transmission between women and prevention methods, and the contextual evaluation of sexual risk (i.e. in what circumstances would you think 'it is not safe to have sex with another woman'? ). Health care practitioners were asked additional questions relating to their experience of delivering sexual healthcare to women (e.g. how important it is to know about the sex/gender of a patient's sexual partners).

### ***Data Analysis***

Data was generated in English and Portuguese. Material in English was transcribed in its entirety. Material in Portuguese was first translated into English. To preserve the original meanings of participants' responses, the following translation strategy was adopted: firstly, a word-by-word search of equivalence of words from Portuguese into English was attempted; if words or expressions did not exist in English language or if they presented lexical meaning incompatibility, then the researcher 'borrowed' a word in English that offered the same conceptual equivalence (Filep 2009). This process was facilitated by the fact that the researcher who undertook the translation speaks Portuguese as a first language and had lived in Brazil for over 20 years. She also self identifies as a woman who has sex with women and was therefore familiar with many of the insider formulations used to construct these experiences.

Data was decontextualised by first grouping concepts into 'categories'; at this point all elements of text referring to safe/unsafe sex, use/non-use of protection, including implicit constructions of gender and sexuality, were included (MacNaghten 1993). Protection was considered to involve the use of barrier methods such as dental dams, latex gloves and female condoms as well as the cleaning of sex toys (Schick, Dodge and van der Pol et al. 2015). Data were then re-contextualised as the researcher 'reassembled' them back into context (Willing 1995). As advocated by Wetherell (1998), data analysis involved an amalgamation of two analytical foci consisting of participants' discursive practices as well as the discursive resources they drew upon. While a focus on discursive practices enables an understanding of how participants construct and negotiate meaning through language, attending to discursive resources enables an understanding of why they may have utilised certain repertoires and not others (Willig 2013).

To ensure trustworthiness, an independent researcher analysed the transcripts ensuring that themes were credible. All participants were provided with the opportunity (4 accepted) to read their own transcripts as a way of gaining feedback regarding the accuracy of their data (Liamputtong 2008).

### ***Ethical considerations***

The study was approved by the Ethics Committee of School of Social Sciences, Humanities and Law at Teesside University and was conducted in accordance with the ethical guidelines of the British Psychological Society. In accordance with BPS Code of Human Research Ethics (2016), all participants were provided with an information sheet before the study outlining their rights as participants as well as information on what the study would require of them and why they had been approached. The consent and debrief forms provided to participants provided summaries of their rights including the right to anonymity and to withdraw from the study. In addition, the debrief form provided participants with contact information for local organisations who could provide further information or support. Care was taken to manage conversations in a sensitive, supportive and non-judgemental manner. Information regarding appropriate risk-reduction strategies was discussed after the interviews.

## **Findings**

Two discourses were identified during our analysis of interview transcripts. The first illustrates the ways in which women who have sex with women draw on and take ownership of traditional heteronormative accounts of resisting safe sex practices to gain pleasure and authenticity in their sexual relationships. The second discourse illustrates the ways in which HPCs also draw on heteronormative notions of gender and sexuality to construct women to have sex with women as being at lower risk than men.

### ***The sexual double standard discourse***

All of those who made mention of the sexual double standard discourse were non-health care practitioner women. Although each participant acknowledged the possibility of STI transmission from woman-to-woman, they drew from the sexual double-standards discourse not only to construct sex between women as relatively 'safe' but also to construct the use of protection as unnecessary and possibly even as 'unsafe', as the following interchange makes clear.

Nicola (29 years old, lesbian, Brazil): I think the ones from direct contact with vaginal fluids can be transmissible herpes, HPV ... I don't think about that when I want to have sex with girls because I think that sex between women is safe (. .) for me sex is about the energy you share with that girl, so I don't just jump into bed with anyone.

Researcher: What do you mean by anyone, who's 'anyone'?

Nicola: '...what I mean is like if I met a girl today and she said let's have sex I wouldn't. My last relationship was an open relationship and my circle of friends, we are a lot of girls and we all have the same opinion you know (. .), of free love, so if we are out together getting drunk normally we have sex with each other. My ex and I used to have sex together with other people, sometimes another couple but these were people we knew...'

This account begins by demonstrating knowledge of STI transmissibility from woman-to-woman but stresses there is little need to think about the risks of having sex with women because 'sex between women is safe'. Sex is constructed as the energy shared between

women rather than a physiological process. A discourse of romanticism or spiritual connection lies beneath the notion of 'shared energy'. Shared energy is the perception of genuinely knowing the person, ultimately qualifying them as 'trusted' and 'safe' enough to have unprotected sex with. While the category of 'anyone' is applied to women encountered in situations offering opportunities a one-night stand, it does not apply to having sex with 'a lot of girls', with 'other people' and 'sometimes another couple' because these are people the participant knows. By highlighting that she is not having sex with 'anyone' Nicola suggests she is having rather fewer partners than she could potentially have, thus the meaning of 'promiscuity' is renegotiated. It seems that for this participant, at least, safe sex is which happens in the context of romance, fewer partners and friends.

In the next quotation, Claudia calls upon a double standard discourse to justify the reasons for not using protection when having sex with women. However, this time rhetoric of 'sexual equality' is utilised to contest the 'rules' that define what women cannot do as compared to men. Within this explanation, it is not the sex between women which is constructed as 'safe', but rather women who have sex with women drawing on heteronormative and traditional notions of masculinity and sexual reputation:

Claudia (24 years old, bisexual, UK): ...obviously it's [STD transmission between women] got to be possible ... I think it would be weird and boys don't do that when they have sex with girls so why would it be different... nobody says like oh you messed your reputation by doing oral with girls and there is anything for that, you never heard of that before and that's the norm apparently... so I would be like why is this any different?.

Here, Claudia highlights how men's reputation is not compromised when they have unprotected oral sex with women. Since 'that's the norm' it should be no different for women, for to do otherwise might imply a 'damaged' reputation and the absence of a 'pristine' morality. Drawing from a discourse of sexual-equality here allows Claudia's account to do two things: first, to use the 'norm' of the gendered double-standard as a way to justify the non-use of protection; and second, to advocate for the sexual freedom to behave 'just like men' so as to justify the act of not doing so. The reasoning here seems to be that if men are 'safe' against defamation when performing unprotected oral sex on women, it ought to be 'safe' for women to do so as well.

In the next extract, a sexual evolutionary rhetoric reinforces the sexual double standard discourse. When reflecting on how she would feel if a woman suggested protection during sex, Olivia constructs a hyper-sexualised identity and sexual desire as an inherently biological need. However, the symbolic meanings of protection surface as a 'threat' to this construction.

Olivia (40 years old, heterosexual, Brazil): I think it's [STD transmission between women] possible because you have just as much contact, you are in direct contact with their fluids ... I'd have a feeling that (. .) she's feeling like disgusted and if she's feeling disgusted does she really like it that much? 'coz I think that when you like it you want to get messy, you want it in your mouth (. .) at least me, I'm quite visceral and I don't think I can control myself (. .) if a person had like loads of doubts deep inside I'd be thinking she doesn't really like it (. .) she's too frigid, why is she like that?



Olivia starts by highlighting that she would interpret a partner's suggestion for the use of protection as indicating a lack of sexual interest in women; because if she in fact 'likes it', they should be eager to 'get messy' and have it 'in their mouth'. Noticeable within this explanation is Olivia discursively working on the construction of her own and her partner's sexual identity. Whereas Olivia depicts her partner's request for protection as the act of someone who is 'too frigid' and does not really like sex with women 'that much', in contrast, she presents herself as someone who is very sexually-oriented, who enjoys sex with women enough to consciously 'choose' to decline the use of protective barriers. Olivia also describes her libido as 'visceral' which connotes sexual desire as an 'innate urge' or 'natural impulse'. Protection is constructed as a barrier to sexual pleasure and the choice not to engage in unprotected oral sex as a sign of feelings of insecurity with regards to sexuality and partner choice. In this discourse the decision to be 'natural' and engage in 'messy' unprotected oral sex is equated not only with 'real' pleasure but also with an authentic form of sexual desire.

### ***Binaries Discourse***

Discourses that construct a binary opposition between gender and sexuality underpinned health care practitioners accounts of delivering sexual healthcare to women. Through such discourses, women's sexual desires are limited to, and tightly bound to, a dichotomous division between gender and sexuality, and to its underlying assumptions. In a first example, the autonomy of female sexuality is denied, as it is 'reorganised' to fit with heteronormative notions of sexual behaviour.

Sarah (GP, 46 years old, lesbian, Brazil): '...if I thought a woman had an STI, we wouldn't ask who she had been sleeping with because it is understood that regardless if her sexual partners are males or females you are going to treat her, so I don't necessarily ask...'

Researcher: ... and how do you educate women about preventive measures without knowing the gender/sex of their sexual partner?

Sarah: '...prevention, generally, is like I said, it's either abstinence or condoms, and there are male and female condoms so...'

In the above example Sarah downplays the relevance of a woman's sexuality at the point of treatment. Interestingly, the invisibility of sexuality in this context is not constructed in terms of a 'medical model' of symptom diagnosis and treatment but rather in terms of warranting treatment. The use of 'regardless if' makes relevant notion of the worthiness of relative categories of patients and in everyday language serves to account for and justify decisions to exclude and include particular groups and individuals.

When accounting for sexual health prevention work, Sarah again renders women who have sex with women invisible. Through her description of safe sex practices for penetrative sex and in particular her focus on condoms, Sarah ignores woman-to-woman sexual acts and inadvertently reinforces phallogentric notions of the sex act. Both of these constructions serve one overarching function: namely, to re-categorise women's sexual desire and render invisible woman to woman sexual acts in relation to sexual health care practice.

The next example reveals the binary division of genders (women/men) and sexualities (homo/hetero) and their relevance to sexual health risk (high/low). A discursive tie is created which associates gender 'categories' with particular sexual orientations and sexual acts. Gender thereby becomes a marker of risk/non-risk status and sexuality an indicator of the degree of risk. The account reveals the discursive construction of women's sexuality as irrelevant to relative risk of STIs, while men's risk statuses are determined on the basis of their sexuality.

Charlotte (Gynaecologist, 37 years old, heterosexual, Brazil) '...sexual orientation, hetero or homo, for women patients doesn't make much of a difference, but I believe that professional specialities specifically directed to male patients... I think that it's very important to include an anamnesis and to know the sexuality of the patient...'

A key feature here lies in the participant's suggestion that providing sexual healthcare for women entails a different approach to that for men. Two kinds of binary constructions can be observed: a gender division (women/ men) and sexual orientation division (homo/hetero). Although Charlotte identifies the importance of taking sexual histories, she frames this within a clear differentiation between the need for specialist approaches for men and the lack of relevance of a woman's sexuality at the point of assessment. Charlotte's assertion that 'hetero or homo for women patients doesn't make much of a difference' renders invisible the particular concerns of women who have sex with women and downgrades the importance of women's sexuality in relation to sexual health risk.

The final account illustrates how the binary distinctions and associations outlined in the above analysis above influence health care practitioners' perceptions of risk. In it, Olivia attempts to explain why gay men are perceived as high-risk, while gay women are viewed as being at 'low-risk'.

Olivia (GP, 40 years old, heterosexual, Brazil): ... we have prejudices, don't we? for example a homosexual couple, two men, we tend to think that he's too exposed because of this idea that gay men are more promiscuous. But with women I wouldn't think that (. .) I'd think they are more (. .) theoretically safer. It's a misjudgement I know (. .) when a woman came into the clinic with some kind of STI, it didn't even cross my mind if she was having sex with women or not ....

Here, the evaluation of high-risk/low-risk appears not to be assessed via the patient's gender but in terms of the perceived 'risk' which their sexuality represents. For example, note how the sexuality of gay men is construed as 'promiscuous'; it is because they are 'too exposed' that they are also assumed to be high-risk. Because the participant 'wouldn't think that' women who are lesbian are either 'promiscuous' or 'too exposed', they are presumed to be low-risk.

## **Discussion**

Our aim in this study was to assess how discursive constructions of gender and sexuality inform the discourse of sexual health in a manner that legitimates sex between women as 'safe'. Findings point to two dominant discourses present in two rather different cultural contexts: the binaries discourse as it applies to polarised genders (women/men), sexualities

(homo/hetero) and risks (high/low); and the sexual double-standard discourse which positions sex between women as safe and the use of protection as unsafe.

Importantly, when health care practitioners engaged in the process of meaning-making with respect to 'risk', they positioned women patients as 'low-risk' whereas men as 'high-risk'. As Wilton (1997) noted, to speak about sex, the erotic and the sexual body is to speak about what men do and women are. Hence, it is possible that this positioning women as being at 'low-risk' was informed by a range of pre-existing discursive assumptions which differentiate the different genders' sexual roles.

Despite conceptualising men and women's sexuality differently, it seems that the leading 'logic' within evaluations of risk was achieved through an interaction between the patient's gender and their sexuality: hence men + gay = high-risk; and women + lesbian = low-risk. Thus, the evaluation of sex between women as low-risk is produced and maintained by social representations which desexualise relationships between and draw on heteronormative constructions of women as non-agentic in sexual behaviours (Richardson 1992). Previous study has shown that health care practitioners may not even regard patients who identify as lesbians as sexually active (Baldwin, Dodge, Schick et al. 2017). From this perspective it is not difficult to see how notions of gender and sexuality connect to construct sex between women as 'safe'.

In this study, health care practitioners found it unnecessary to ask women patients about their gender identity, sexual orientation and/or the gender/sex of their sexual partners. These findings align with those in previous research suggesting that most clinicians neither initiate nor engage in such dialogue (Kitts 2010; Parameshwaran et al. 2017). Our study also identified an health care practitioner acknowledging not even considering whether patients might be sexually active with women; suggesting that for this health care practitioner there is only one way to be, heterosexual. More generally, information about the gender/sexual identity/behaviour of women and their sexual partners is seen as irrelevant because the assumption that all patients are cisgender and heterosexual (Hinchliff, Gott and Galena 2005). Baker and Beagan (2014) reported that one reason why physicians do not ask such questions is because they believe all patients are treated equally and making such enquiries can be insulting to heterosexual women. Health care practitioners also fear that these questions may be perceived as questioning the 'essentiality' of protected characteristics and, as a result, potentially offensive (Munson and Cook 2016). Simkin (1991) highlighted, however, that when health professionals fail to engage with a woman's homosexual identity/behaviour they categorically miss the point; women who have sex with women have unique sexual-health needs and healthcare problems that require immediate and exclusive attention (McNair 2005).

Those health care practitioners who participated in the study also 'tailored' women's sexual behaviour in ways which resisted directly addressing relevance of women's object choices and rendering WSW invisible whilst highlighting the need for specificity in working with men. Several authors have noted that normative thinking divides (and limits) sexuality into a binary classificatory system, erasing the existence of any sexuality falling within the polarised 'homo-hetero' spectrum (Pereira, Becker and Gardiner 2016). However, such associations are problematic since they lead to erroneous assumptions about the relationship between sexual identity and sexual behaviours. It follows that if health providers make such suppositions, they cannot accurately determine the necessity to screen patients for STIs, recommend appropriate preventative healthcare services and provide relevant risk-reduction strategies (Diamant et al. 1999).

There was greater variability among the women who have sex with women interviewed in terms of the way in which they called upon the sexual double-standard discourse to construct sex between women as 'safe' and protection as 'unsafe'. Although not mutually exclusive, some of these constructions were based on moral preconceptions and others on notions of natural and spontaneous behaviour. Constructing sex between women as 'safe' was achieved by organising talk in a way that reproduced the social 'rules' that determine the conditions under which it is 'acceptable' for women to have sex. For example, social norms dictate that sex for women should happen in the context of romantic and committed relationships (Fasula, Carry and Miller 2014). Women who adopt a different stance to sex are often construed as 'promiscuous' or 'deviant' (Crawford and Popp 2003). Seen from this perspective, constructing sex between women as 'safe' allowed the participant to fulfil moral expectations, to be congruent with the 'good-girl' image and neutralise the possible negative consequences of behaviours seen as different (Lees 1994).

For women who have sex with women in this study, the use of protection represented a threat to their reputation and a challenge to the 'naturalness' of their sexuality and sexual desire for women. The participant challenged men's 'privilege' of not being defamed by performing unprotected oral sex on women and reclaimed the 'right' to the same, 'safety' was associated with avoidance of stigmatisation rather than avoidance of infection. This is in line with previous studies of women who have sex with women who declined use of protection due to perceptions that only 'promiscuous', 'dirty' or unfaithful women would use protective barriers when having sex with another women (Marrazzo, Coffe and Bingham, 2005; Champion et al. 2005).

Findings from this study provide some insight into what should be included in future health promotion programmes directed towards women who have sex with women. Firstly, such interventions need to move beyond individually-centred approaches towards strategies that engage with the broader aspects of women's social worlds, including gender socialisation, sexual stigma and heterosexism. Secondly, programmes should be designed to promote the 'protective strategies' that women who have sex with women employ through discourses of 'love', 'romance', 'morality' and 'reputation' in order to align health promotion messages to ways in which women account for not engaging in safe sex practices. Thirdly, future programmes and interventions should be attentive to women's health beliefs as well as what they want to achieve, so that other methods of safer sex can be introduced and negotiated (e.g. Logie et al. 2014).

Health care practitioners are not immune to the influence of heteronormative and heterosexist ideologies that permeate Western societies and are susceptible to actions and beliefs that contribute to inequality and discrimination (Daley and Macdonnell 2011). Although cultural competence may be part of some health care professionals' training, greater attention should be given to topic related to issues of sexuality (Hinchliff, Gott and Galena 2005). Future educational training programmes should address, for example, increasing awareness about all dimensions of women who have sex with women's sexual health needs, including sexual behaviours, STI transmission and methods of prevention. Training should also be directed towards greater recognition of diversity and fluidity of sexual expression and the dangers of relying on stereotypes for decision-making.

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