

Bisexual Invisibility and the Sexual Health Needs of Adolescent Girls

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Abstract

Purpose: The purpose of this study was to analyze bisexual female youth perspectives on their experiences accessing sexual health information and services provided by a doctor, nurse, or counselor. Specifically, we sought to: (1) understand how youth perceptions of providers' attitudes and behaviors affect their seeking and obtaining sexual health information and services; (2) examine how social stigmas within the family context might be associated with barriers to sexual health information and services; and (3) assess school-based sources of sexual health information.

Method: We utilized a mixed-method study design. Data from bisexual female youth were collected through an online questionnaire and asynchronous online focus groups addressing lesbian, gay, bisexual, and transgender health and HIV prevention. Data were analyzed with descriptive statistics and thematic analysis.

Results: Barriers to sexual healthcare included judgmental attitudes and assumptions of patient heterosexuality among healthcare providers, and missed opportunities for HIV and sexually transmitted infections (STI) testing. Bisexual stigma within families was associated with restricted youth openness with providers, suggesting fear of disclosure to parent or guardian. School-based sexual health education was limited by a restrictive focus on abstinence and condoms and the exclusion of STI risk information relevant to sex between women.

Conclusion: We recommend that practitioners integrate nonjudgmental questions regarding bisexuality into standard contraceptive and sexual health practices involving female youth, including discussion of HIV and STI risk reduction methods. Further support for bisexual health among adolescent girls can come through addressing stigmas of female bisexuality, increasing sensitivity to privacy while engaging parents, and expanding the reach of school-based sexual health education.

Keywords: adolescent health, bisexuality, healthcare, HIV prevention, sexual health, STI prevention.

Introduction

OVER HALF OF physician education programs have no training in lesbian, gay, bisexual, and transgender (LGBT) health, and only 16% of programs address LGBT health in a comprehensive manner.¹ With regard to adolescent medicine, recommendations exist for sexual minority youth and young adults overall,²⁻⁴ but little has been written about the particular needs and experiences of bisexual youth. Improving physician preparation in LGBT health and adolescent medicine will necessitate identifying practices that help youth understand their susceptibility to sexually transmitted infections (STIs) during sexual activity with men and with women.

Bisexual girls have higher pregnancy rates than heterosexual girls^{5,6} and are more likely to be tested for and diagnosed with STIs transmitted through male or female partners.⁷⁻⁹ Compared with their heterosexual peers, bisexual girls have higher rates of many HIV-related risk factors, including

a history of coerced sex, injection drug use, and multiple lifetime and recent sexual partners.¹⁰ Bisexual women are more likely than heterosexual women to report having sex with gay or bisexual men, or with injection drug users.¹¹

Lack of medical attention to the needs of bisexual girls may in part be a consequence of cultural bisexual invisibility, which underlies unconscious inclinations to categorize people as either exclusively same- or other-sex attracted, and includes explicit denial that bisexuality exists.^{12,13} In addition, many girls and women who are bisexually attracted or who have partners of more than one sex may identify as heterosexual or lesbian, or may choose no label for their sexual orientation.¹⁴⁻¹⁷ People who partner with transgender or gender nonconforming individuals may feel the term "bisexual" does not adequately describe the range of their attractions.¹⁸

Lack of attention to the sexual health needs of bisexual girls may be compounded by social stigmas attached to female bisexuality, including the sexual objectification of

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female bisexuality, connotations of promiscuity and infidelity, and the invalidating assumption that bisexuality is a transition to identifying as lesbian.¹⁹ These harmful beliefs often intersect with stigmas associated with female sexuality in general.²⁰ In the healthcare setting, bisexual women are less likely than lesbian women to come out to their provider, to think their provider needs to know about their sexual orientation, and to have their provider ask about their orientation.²¹

The present study

The purpose of this study was to add to the small but growing literature on bisexual women with an analysis of bisexual girls' perspectives on accessing sexual health information and services provided by a doctor, nurse, or counselor. Specifically, we sought to: (1) understand how youth perceptions of providers' attitudes and behaviors affect their seeking and obtaining sexual health information and services; (2) examine how social stigmas within the family context might be associated with barriers to sexual health information and services; and (3) assess school-based sources of sexual health information. We utilized a mixed-method study design, including online survey questions and asynchronous focus groups, to address these aims.

Methods

Participants

Data analyzed for this study were collected as part of a large-scale project on ethical issues in HIV research involving sexual and gender minority youth.^{22,23} Inclusion criteria for the larger study were identification as a sexual or gender minority, negative HIV serostatus, reliable access to a phone and Internet, U.S. residency, and sexual experience or romantic interest in male partners (higher HIV risk across genders). Data reported in this study include cisgender females with attraction to both men and women, prior sexual behavior with both male and female partners, and/or bisexual identity.²⁴ Forty adolescent girls ages 14–17 ($M=15.85$, $SD=1.05$) met this criteria. The overall sample also included cisgender males, transgender males, and youth with nonbinary gender identities, none of whom were included in the present analyses due to the focus on girls. No transgender girls participated.

Procedure

Participants for the larger project were recruited nationally through paid Facebook advertisements targeted to 14–17 year olds who indicated a romantic interest in the same gender or multiple genders and listed interests culturally relevant to the LGBT community. The advertisement linked to an online eligibility survey. Eligible youth were contacted by telephone to confirm eligibility, assess understanding of study procedures and decisional capacity,^{25,26} and obtain verbal informed assent. The Fordham University and Northwestern University Institutional Review Boards approved all procedures, including waiver of guardian permission, for minimal risk research.²⁷ An NIH Certificate of Confidentiality was obtained.

Following verbal consent, youth received through email a consent form and link to a baseline questionnaire. The participants then joined one of six online focus groups conducted from February to April 2015 using a secure website accessed

through pseudonym and unique password. Four groups were stratified by age (ages 14–15 and 16–17) and gender. Two additional groups (ages 14–17) consisted of participants who were not out about their sexual orientation and/or gender identity to their guardians, to ensure data reflected a wider range of participant experiences. Although these two additional groups were mixed gender, the present study addresses only the responses of cisgender girls. The focus groups took place over three consecutive days and were moderated by two members of the research team. Questions were posted each morning, and participants were permitted to answer at their convenience. Participants who posted at least three times were sent a link to a post-focus group survey and received a \$30 USD Visa gift card.

Questionnaire items

All questionnaire items related to this study are provided in Tables 1 and 2.

Bisexuality. Participant bisexuality was determined through bisexual attraction, behavior, or identity: Bisexual attraction involved being “physically attracted” to “mostly males, but some females,” “males and females equally,” or “mostly females, but some males.” Bisexual behavior involved “any sexual contact” with at least one male and at least one female in “your entire life.” Participants who checked “bisexual” in a list of sexual orientation terms were coded as identifying as bisexual.

Identity disclosure. Participants were asked if they were out to their mother or the woman who raised them, and their father or the man who raised them. Participants who were not out to any guardian at the time of baseline survey completion were considered “not out”; those who were out to at least one guardian were considered “out.”

Health service utilization and healthcare experiences. Participants were asked about history of HIV/STI testing and whether they were concerned about HIV infection.²⁸ We adapted nine items assessing perceptions of disparities in healthcare experiences,²⁹ and a series of yes/no items assessed health service utilization in the past year.

TABLE 1. SAMPLE DESCRIPTION, $N=40$

Item	N	Percentage
Bisexual attraction	39	98
Bisexual behavior	27	68
Bisexual identity	31	78
Out to at least 1 parent/guardian	15	38
Any lifetime male partners	33	83
# lifetime male partners: $m=4.2$ ($sd=5.5$) ^a		
Any lifetime female partners	32	80
# lifetime female partners: $m=1.9$ ($sd=1.7$) ^a		
Self-identified race/ethnicity		
White (Non-Hispanic)	28	70
Hispanic or Latina	8	20
Black	1	3
Asian	1	3
Other	2	5

^aMean calculation includes responses of zero.

TABLE 2. BISEXUAL FEMALE YOUTH RESPONSES TO BASELINE QUESTIONNAIRE, *N* = 40

Item	n	Percentage
Healthcare experiences		
Comfortable speaking with doctor about sexual health ^a	22	55
My regular doctor assumes I am heterosexual ^a	29	73
Comfortable speaking with doctor about LGBT identity ^a	12	30
Spoken to doctor about LGBT identity	7	18
My doctor is knowledgeable about LGBT health issues ^a	7	18
My doctor has not given me the information I need to protect my sexual health ^a	15	38
I worry my doctor would tell my parents about my LGBT identity, my sexual activity, or if I had an STI ^a	29	73
LGBT identity ^a	14	35
Sexual activity ^a	23	58
If I had an STI ^a	24	60
HIV/STI testing and concerns		
Tested for HIV, past 6 months	3	8
Gut feeling about being likely to be infected with HIV ^b	10	25
Worry about getting infected with HIV ^c	4	10
Ever been tested for STIs	16	40
Health services utilization, past year:		
Received school mental health counseling	15	38
Received psychotherapy through clinic, hospital, or private practice	20	50
Received sexual health services (like getting condoms or birth control pills)	27	68
STI/HIV testing or treatment	12	30
Drug or alcohol counseling or treatment	4	10

^aPercentages include those who answered “Agree” or “Strongly Agree” on a 5-point Likert-type scale. All other items required yes/no responses, unless indicated.

^bPercentages include those who answered “Extremely” or “Somewhat” on a 4-point Likert-type scale.

^cPercentages include those who answered “a moderate amount,” “a lot,” or “all” of the time on a 6-point Likert-type scale. LGBT, lesbian, gay, bisexual, and transgender; STI, sexually transmitted infections.

Focus group questions

The present study used data from two sets of questions posted on the first day of the online focus groups: (1) “Can you describe a time where you felt comfortable with your doctor or counselor asking questions about your sexuality or sexual health? What about a time you felt uncomfortable? What made it feel that way?” and (2) “Has a doctor, nurse, or counselor ever talked to you about HIV prevention? How did it go, and did the healthcare provider consider your sexual or gender identity in this discussion?” Participants spontaneously added information about their experiences with school-based sexual health education.

Data analysis

Survey response items were analyzed using descriptive statistics in SPSS Statistics version 22 (IBM Corporation, Armonk, NY). Focus group transcripts were imported into the Web-based Dedoose qualitative/mixed-methods analysis program³⁰ and analyzed using thematic analysis approaches.³¹ We began with open coding to identify the main ideas arising in the focus groups, then key categories were agreed upon, and excerpts were organized within each of these categories according to axial coding. Thematic differences did not emerge among the focus groups.

Results

Table 1 provides demographic information on bisexual classifications, percent of girls out to at least one parent/guardian, lifetime male and female partners, and race/ethnicity.

Participant responses are presented according to each specific aim of the study. For aim 1, we identified youth perceptions of provider practices. For aim 2, we examined concerns regarding providers’ protection of youth health privacy, and how those relate to the family context. For aim 3, we assessed girls’ access to school-based sexual health information. Youth comments are followed by their age and whether they were out to at least one parent/guardian. Questionnaire items (Table 2) are presented in tandem with related focus group themes (Tables 3–5).

Aim 1: youth perspectives on provider practices

Bisexual female participants indicated three aspects of provider behaviors that most affected their healthcare experiences: (1) negative bias regarding adolescent sexual behavior in general and same-sex attraction in particular, (2) providers assuming they were heterosexual, and (3) providers missing relevant opportunities to screen for HIV and other STIs. Relevant survey responses (in Table 2) are identified below; participant quotes are presented in Table 3.

Judgmental attitudes and bias among healthcare providers. As illustrated in Table 2, only about half of participants reported comfort speaking with their doctor about sexual health. Positive experiences (Table 3) included providers being “helpful and friendly” (17-out) and avoiding judgment. However, other comments reflected a perception that providers were more invested in getting girls to abstain from sex than in helping them to have sex in healthy ways.

TABLE 3. FOCUS GROUP COMMENTS ON PROVIDER PRACTICES, *N* = 40

Positive provider practices

“The councilor [sic] at my school asks me about my sexuality (I talk to her often) and she’s curious about it and she’s a wonderful lady so I’m very comfortable talking about something like that with her because she makes you feel welcome and she doesn’t judge you” (16-out).^a

“I feel most comfortable with the doctor at my school. She was very helpful and friendly, not as robotic as the normal doctors. And made me feel very safe and like I was talking to her in confidence” (17-out).

Judgmental attitudes and bias among healthcare providers

“It feels like they’re judging you based on your past experiences or previous mistakes, like your sexual history makes you immoral, and that can make it discouraging to talk about” (17-not).

“My doctor just told me not to have sex before marriage” (15-out).

“My doctor... complained about me getting implanon [contraceptive implant] put in [by saying] ‘I’m a pediatrician and not trained to do that seeing as my clients really should not need it’” (17-not).

“Since I’m young, they tend to judge and shame more instead of trying to make you aware of the safety concerns of it” (15-not).

“The last time I was at the doctor she asked if I was active, and I told her I am gay. She [the doctor] just sat in stunned silence for a few minutes then left the room... I’m not a fan of doctors anymore” (17-not).

Assumptions of patient heterosexuality

“They usually just assume that you’re straight” (17-not).

“Most of them assume I’m straight and therefore don’t bother asking and educating me about it” (17-not).

“Generally adults will assume you’re straight unless you tell them otherwise, or a significant stereotype applies to you” (17-not).

“They would ask if I was sexually active and I would say no, but I was with women so I didn’t know if I should tell them” (15-out).

“She didn’t ask about sexuality, I guess she just assumed I was straight because I was going for birth control” (16-not).

“The nurse and doctor I talked to did not ask my sexuality at all, I’m guessing because I was sexually active with a guy at the time and I told them that, and instead [they] were more worried [about]... birth control options” (16-not).

“I did not tell my doctor about my sexuality yet, but talking to her about birth control was fine” (17-not).

“I was required to take a pregnancy test... she’s never asked about my sexual orientation, but I would be comfortable talking to her about it” (17-out).

“A doctor has only ever mentioned HIV protection by saying that condoms can be used for prevention. The doctor does not know my sexual orientation” (16-not).

Missed clinical opportunities for HIV and STI testing

“[I have] had pregnancy tests... but I don’t believe I’ve ever been tested for HIV or STDs” (17-not)

“[Doctors] talked to me about HPV, but not HIV” (17-not)

“The only time I can think of [speaking with a provider about HIV]... [was] when my doctor wanted to give me a shot preventing genital warts and explained it wouldn’t prevent HIV” (17-out)

^aComments followed by age and whether out to at least one parent/guardian.

Girls also perceived physicians to be biased against same-sex attraction and behaviors.

Physician assumptions of patient heterosexuality. Almost three quarters of participants endorsed the survey item “my regular doctor assumes I am heterosexual” (Table 2). Few reported speaking with their doctor about their sexual identity, or felt comfortable doing so. Thus, although over two-thirds of participants had received sexual health services, over one-third indicated not having the sexual health information they needed. Focus group comments (Table 3) further reflected girls’ experience that providers assumed them to be heterosexual. Failure of providers to explore patient sexuality was compounded by some participants’ confusion about which behaviors constitute “sex” or whether to tell providers about sex with women. Participants reported seeking services related to heterosexual activity, such as pregnancy prevention, without being asked about a broader range of sexual partners and activities. Many youth expressed willingness to share if prompted, but would not bring up the topic of sexual orientation themselves. Comments also included providers’ focus on condoms for HIV/

STI prevention, omitting information about STI risk and safer sex between women.

Missed clinical opportunities for HIV and STI testing. Survey items (Table 2) indicated limited access to HIV/STI testing and treatment, and low frequency of concern regarding HIV infection. Focus group comments (Table 3) described missed opportunities for HIV/STI testing and counseling, such as pregnancy tests and HPV vaccinations.

Aim 2: family factors influencing healthcare utilization

Only 38% of participants reported being out to their parents about their sexual orientation. Responses to survey items indicated concern that doctors would tell their parents about their LGBT identity (35%), their sexual activity (58%), and if they had an STI (60%). In focus groups, participants described incidents in which their private health information was shared with their parents/guardians in ways that made them uncomfortable, and many youth would remain uncomfortable sharing information even if their parents were not in the room during the medical appointment (Table 4). Several participants identified

TABLE 4. FOCUS GROUP COMMENTS ON FAMILY FACTORS IN HEALTHCARE UTILIZATION, *N*=40

Youth privacy concerns

“My parent was always in the [examination] room with me and there’s a lot of pressure to answer ‘correctly’ as to not upset your parents with truth” (17-out).^a

“I mostly feel comfortable talking to healthcare providers about my sexual health or sexuality, as long as my mom isn’t in the room” (15-not).

“I would fear he [the doctor] would want to tell my mom I’m bisexual and I don’t want that to happen” (17-not).

Private information shared with parents/guardians

“It was supposed to be confidential, but the receptionist went ahead and called my mom to confirm the appointment. She [my mom] confronted me about it, but I denied everything until about 2 years later when I told her the truth” (17-not).

“A school counselor ... told her [my mom] a bunch of my personal business, and it made it very awkward for us to be around each other after that” (15-not).

Family stigma

“I am not comfortable with coming out to them anytime soon” (17-not).

“I’m not out to them yet and don’t plan on coming out to them unless I absolutely have to (e.g., if I were in a very serious relationship with someone of the same sex)” (15-not).

“I don’t see how them finding out about my sexuality could result in any positive outcome” (16-not).

“When my cousin came out as gay ... my parents flipped out” (16-not).

“My parents have already told me they would stop my social life if I was anything other than straight ... any experience I’ve had with them from just talking about gay people has been negative” (14-not).

“I’m not out to her and I’m not sure if I ever will be seeing as she doesn’t think being bisexual is possible. She sees it more as someone straight seeking attention, or someone gay lying to themselves and everyone else” (17-not).

“One of my parents thinks me being queer is an act” (16-out).

“My guardians are very religious and feel that my sexuality is just a phase that I have been going through” (17-out).

“I don’t want to tell my parents I’m bisexual because I’ll get that you’re just confused and don’t know” (14-not).

“It kind of sucks because I have to hide my life from them, but they’re too close-minded and bigoted to be open to me” (17-not).

^aComments followed by age and whether out to at least one parent/guardian.

evidence of bisexual stigma within their families. These comments regarding family biases were not directly related to healthcare experiences, but suggest fear of being outed to parents may be a significant barrier to bisexual girls seeking and receiving adequate sexual health services.

Aim 3: school-based sources of sexual health information

Participant responses indicated a general lack of sexual health information even beyond the healthcare setting. For example, several participants indicated that HIV prevention “was never brought up in conversation” (15-out), confusion over whether there exist STI prevention practices for sexual activity between women, and a wish that “it was more talked about so I can understand it better” (17-not). Although one participant reported having learned “most of what I know... from looking up information online” (17-not), there were no details about what she may have learned from those sources. The messages they reported receiving from school-based health education

classes often reflected a focus on abstinence, condoms as the only available barrier method, and failure to address variations in sexual orientation (Table 5). Participants emphasized that “only teaching abstinence and neglecting to teach safe sex is where it gets dangerous, along with the blatant heteronormativity within the sex-ed environment” (17-not). Overall, participants expressed a frustration with a lack of information in schools addressing them as bisexual and sexually active youth.

Discussion

Recent studies attending to differences among bisexual youth and their heterosexual and gay/lesbian peers have identified distinct patterns of sexual health risk, including HIV/STIs and unintended pregnancy.^{7,32} Although more girls report bisexuality than report exclusive attraction to and partnership with other girls,^{12,14,17,33} little attention has been paid to supporting bisexual girls’ sexual health. Our mixed-method approach considered survey items on

TABLE 5. FOCUS GROUP COMMENTS ON SOURCES OF SEXUAL HEALTH INFORMATION, *N*=40

Messages received from school-based sexual health education classes

“Just don’t have sex” (16-out).^a

“If you absolutely must have sex, [then] you need to use a condom” (17-not).

“They didn’t really talk about gay people” (14-not).

“Most of what I know I have learned from looking up information online... in any sex ed class I’ve had at school, they didn’t talk at all about sexuality” (17-not).

“Most of the people I speak to on sex and sex education all promote abstinence and how to say no. There’s nothing wrong with abstaining from sex, but I think only teaching abstinence and neglecting to teach safe sex is where it gets dangerous, along with the blatant heteronormativity within the sex-ed environment. When people assume everyone is straight and everyone is abstaining from sex, you neglect the other half of people who are not straight and don’t wish to abstain for sex. And for those people, they need—no, we all need—proper education on sex and STI/STDs” (17-not).

^aComments followed by age and whether out to at least one parent/guardian.

healthcare utilization in tandem with girls' narratives about accessing health information and services.

Provider attitudes and practices

Consistent with prior studies focusing on sexual minority youth healthcare perspectives,² girls in our study wanted their providers to be open and nonjudgmental. Many described negative provider attitudes toward adolescent sexual activity in general and minority sexual orientations in particular. Similar to reports by bisexual adult women, participants were willing to speak with providers about sexual orientation, but unlikely to initiate coming out.²¹ These findings emphasize the importance of providers asking about sexual attraction, behavior, and identity during primary care and sexual health procedures to adequately identify and respond to the treatment and prevention needs of bisexual girls.²⁴ Standard sexual healthcare, such as contraceptives, condom counseling, and HPV vaccinations, provide opportunities for delivery of information and services relevant to bisexual health.³⁴

Youth privacy

Our findings reinforce the importance of provider attention to the privacy needs of bisexual girls,² including speaking with adolescent patients individually and explaining the confidentiality policy regarding what information will or will not be shared with parents/guardians.³⁵ However, we do not interpret these findings to signify that guardians should be

entirely excluded from healthcare for bisexual youth. Understanding the specific stigmas attached to female bisexuality and the factors that affect girls' choices around coming out, can help inform ways in which providers facilitate conversations with adolescent patients and their families.^{36,37}

Sexual health education

Comments highlighted an abstinence focus and heteronormativity within school-based sexual health education. Health class silence surrounding sexual orientation and same-sex activity played a significant role in bisexual girls' lack of sexual health literacy.²² Pregnancy rates suggest that in the absence of school-based attention to their bisexuality, heterosexual safer sex instruction may be alienating and ineffective. School-based sexual health education has the potential to reach young people at different stages in sexuality development, such as early adolescence before they initiate sexual activity, or as they begin exploring their sexual desires and identity.³⁸

Limitations and future directions

The need to keep group membership small to facilitate discussion, and the interactive nature of focus group designs, means that the extent to which findings would generalize to populations not included needs to be considered. Participants represented youth on Facebook interested in finding out more about an LGBT-related study, willing to be contacted by phone, and comfortable responding in writing.

TABLE 6. RECOMMENDATIONS FOR PRACTITIONERS

For all adolescent girls

- Start with a clear privacy and confidentiality policy. Tell parent/guardian it is important to speak with adolescents individually. Tell the adolescent what kinds of information will be kept confidential (e.g., sexual orientation, sexual activity), and what kinds of information will need to be disclosed (i.e., consider state and local laws).
- Use a positive, open, and welcoming approach for discussing sexual behavior. Use language that normalizes both having sex and not having sex. "Many adolescent girls choose to have sex and many choose not to. Both of these choices can be positive, if a person feels good and is getting good healthcare. Can I tell you more about the sexual health resources available here?"
- Make contraception available to girls who want it, without shaming or judgment.
- Discuss HIV. Normalize HIV/STI testing by telling girls that it is recommended for anyone who is sexually active, regardless of partner gender.
- Ask questions regarding sexual attraction, behavior, and identity. For example:
 - "What have you noticed about your sexual attraction, if anything? Do you experience sexual attraction to men, women, or both?"
 - "When I ask about sexual activity that includes any gender partner. Have you been sexually involved with men, women, or both?"
 - "How do you identify your sexual orientation right now, if at all?" (Some may be in a process of questioning, or they may choose no label.)
- Do not assume that attraction, behavior, and identity will be consistent with each other. Allow for these answers to change over time.
- Provide counseling in risk management. The highest HIV/STI risks are in penile–vaginal and penile–anal sex.
- Acknowledge HSV and HPV risks in any genital contact, and offer to discuss risk management strategies relevant to sex between women.

For bisexual adolescent girls

- Offer support for communicating with parents/guardians: "Have you talked to your parent/guardian about your sexual orientation?"
- If so: "How did they respond?"
- If not: "Do you want to? Do you have any concerns?"

For everyone: "Would you like resources or support for talking to your parent/guardian about your sexual orientation?"

- Discuss condom use on penises and sex toys. Explain options for risk management during sex between women: "While many choose not to use gloves or dental dams, others find these to be useful methods for reducing concern about HPV and HSV."
- Ask where else they are getting their sexual health information (e.g., school, Internet) and whether it is LGBT inclusive.
- Note the potential for bisexual invisibility and bisexual stigma to influence girls' personal relationships, mental health, and choices around whether and when to be open about their sexual orientation.

Additional in-person research is needed to determine the extent to which our participants' views reflect those of youth not connected to the LGBT community online, without Internet access, with telephone and Internet privacy concerns,³⁹ or not comfortable expressing themselves in writing.

However, this study can inform current ways of thinking and point to new directions of scientific inquiry.⁴⁰ Future research should make greater efforts to include adequate samples of transgender youth, and also to provide participants with the option of indicating transgender and nonbinary sexual partners.¹³ Our team has begun to explore these issues through the design of a large-scale quantitative study that will build on the perspectives of our focus group participants and utilize outreach methods more inclusive of ethnic and gender minority youth.

Finally, additional research on provider knowledge about, attitudes toward, and treatment competencies regarding sexual health needs of bisexual female youth is required to inform best practices. Such research can identify key characteristics of the provider (e.g., general practitioner or specialist) and of the healthcare context (e.g., clinic focus, urban/rural differences) that contribute to girls' comfort. Parent/guardian perspectives on bisexual stigma and youth privacy needs could inform interventions to improve communication and collaboration between providers and families.^{36,37} Research with school health education programs could examine strategies for addressing bisexual health and for reducing young people's exposure to biphobia and bisexual invisibility. Each of these directions could deepen the understanding of bisexual-specific health needs outside a "gay" or "straight" binary.

Recommendations for practitioners

Given that only 18% of participants had told providers about their bisexuality, we offer recommendations for practitioners (Table 6) regarding adolescent girls who may or may not provide information regarding bisexual attractions or sexual history. Delivering sexual healthcare in a nonjudgmental manner and integrating questions and information about bisexual attraction into standard contraceptive care, condom counseling, and HPV vaccination can increase opportunities for bisexual girls to learn about ways they can best protect their health. Furthermore, there were participants in this study who were either unaware of STI risks involved in sex between women, or who did not know of any available protection methods. It is beyond the scope of this article to assess clinical indication for and acceptability of barrier methods such as gloves and dental dams for sex between women. However, sharing the extent of the risks and options for risk reduction is an important part of supporting girls' personal sexual health decision making.⁴¹ These provider practices can strengthen bisexual girls' engagement in healthcare, and should be implemented alongside HIV/STI testing for sexually active youth.³⁴

Conclusion

This study examined bisexual girls' experiences accessing sexual health information and services. A lack of communication with providers regarding sexual orientation and sexual activity between women was identified as a barrier to adequate healthcare. Girls faced bisexual-specific stigmas as

well as distinct stigmas related to being sexually active young women having sex with men and with respect to being interested in or having sex with other women. Their discomfort in healthcare was exacerbated by their perception of provider biases toward abstinence, assumptions of heterosexuality, and by privacy concerns. Sexual health education in schools focused on abstinence and condoms also failed to address concerns related to bisexual health. Next steps include developing and implementing ways for providers to ask questions regarding sexual attraction, identity, and behavior and to offer relevant HIV/STI screening and risk reduction counseling. Furthermore, working to strengthen sexual health resources in schools can increase access to inclusive and affirming sexual health knowledge, which is the cornerstone for reducing the transmission of HIV/STIs and promoting bisexual girls' sexual health throughout adolescence and into adulthood.

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