EXPLORING RESILIENCE AMONG BLACK WOMEN AFTER BEING DIAGNOSED WITH A SEXUALLY TRANSMITTED INFECTION

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ABSTRACT

Historical and contemporary social, political, and cultural dynamics of power, classicism, sexism, and racism exacerbate challenges for Black women to attain optimal sexual health outcomes. As such, Black women in the United States continue to be disproportionately affected by sexually transmitted infections (STIs). Despite this obstacle to their health, many Black women adapt and learn how to successfully manage their sexual health despite experiences of adversity. However, how women succeed in managing their sexual health and how their community is a source of strength in doing so is largely unexplored. Instead, much of the prevention research on Black women's sexual health and wellness adopts a deficit orientation. Strengths-based scholarship that highlights assets and capabilities of Black women and their communities to support sexual wellness is needed. Guided by Resilience Theory and Black Feminist Thought, this dissertation study fills this gap and describes Black women's stories of acquiring and rebounding from an STI diagnosis. Among 16 Black women, there was an absence of informative and comprehensive sex education during the participants' early life. Women learned little about their bodies, sex, and healthy sexual relationships. Consequently, many women entered sexual and romantic relationships susceptible to contracting an STI. When women were diagnosed, they experienced a range of negative emotional and psychosocial ramifications following their diagnosis. The results reveal various pathways through which resilience was fostered. Following a period of reflection, women reclaimed control of their sexual lives through strategies that included sexual and relationship boundary-setting, reframing the experience, knowledge seeking, and implementing preventative sexual health practices. Social support from other women was vital to this process, which is consistent with existing literature on socioecological perspectives of resilience. This study underscores the importance of contextual factors in creating vulnerabilities to STIs. The results also suggest the importance of relationship to other Black women in assisting women to reclaim sexual control. The results of this study offer important implications for future sexual and reproductive research and interventions targeting Black women and sexuality education policy.

This dissertation is dedicated to Black women. Your stories and experiences matter. Your voice has the power to radically transform the world. Your unwavering strength and brilliance are the foundation upon which we build a future rooted in equity, justice, and liberation.

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TABLE OF CONTENTS

Introduction

> God didn't bring us across the oceans that divide Africa and America to leave us alone. We embody a spirit, a strength, and a resilience that have allowed us not only to survive but move forward. (Wyatt, 1998, p. 228)

Statement of the Problem

Black women continue to be disproportionately affected by sexually transmitted infections (STIs). In 2019, the rate of chlamydia among Black adolescent females aged 15-24 was five times that of White females and four times that of Latinas. Similarly, rates of gonorrhea among Black female adolescents were nine and ten times higher than White and Hispanic female adolescents respectively (Centers for Disease Control and Prevention [CDC], 2021a). Historical and temporary social, political, and cultural issues of power and racism have contributed to inequities in Black women's sexual and reproductive health. Black communities have adapted to these conditions over time, yet in prevention research how they have done so and what unique resources they have developed remain underexamined, especially around sexual wellbeing.

Prevention research can play an important role in reducing sexual health disparities. However, much of the research in this area fails to explore assets and strengths in favor of documenting deficits and individual risk (Fortenberry, 2013). Prevention research on Black women's sexual and reproductive health is frequently limited to discussions of their individual characteristics and the consequences of risk and risk behavior, failing to explore the resources and factors that help Black women successfully manage their sexual health. Some research has found that factors across multiple levels of analysis can promote positive health behaviors and sexual health outcomes among young Black women (Pilgrim et al., 2011). These factors can include, but are not limited to peer relationships, positive family relationships, age, high levels of religiosity, and the sociohistorical context. Studies on protective factors indicate that there are assets that help Black women to reduce their risk. However, these studies do not capture what assets may help Black women to navigate their sexual health after having a positive STI diagnosis or the ways they may help.

Historically, STIs have been socially stigmatized (Lichtenstein et al., 2005). There are also a number psychosocial and physiological consequences of being diagnosed with an STI (Butler & Eng, 1997; Foster & Byers, 2016; Melville et al., 2003). Given the emotional and psychosocial impact of acquiring a STI that is often driven by non-individual factors (e.g., societal stigma of STIs), the ways that women manage their sexual health after being diagnosed with an STI may be different from those who have not been diagnosed with an STI −and that has been underexplored in the literature. The literature in this area also lacks a strengths-based perspective and attention to the social, cultural, and historical context that shapes Black women's sexual health.

Study Significance

The current study fills a substantial gap in the literature by shifting the narrative on Black women's sexual health. Employing a strengths-based approach can provide prevention researchers with insight on existing cultural and community resources that are protective of Black women's sexual health more broadly. Scholars have acknowledged that employing deficit-based approaches in research contributes to the perpetuation of pathologizing perspectives, potentially inflicting harm upon the individuals under study (Barlow & Johnson, 2021; Bryant et al., 2021; Hammond & Zimmerman, 2012; Kumanyika, 2018; Wilson et al., 2019). A recent review on strengths-based approaches to improving Indigenous health research suggested that strengths-based approaches focus on the positive to reframe and disrupt negative assumptions and beliefs that have been internalized by Indigenous people (Bryant et al., 2021). By highlighting strengths and resilience, the findings of this study may be empowering for other Black women who have been affected by sexual health diseases.

Additionally, the integrated theoretical framing of this dissertation study further enriches the study significance. This study is guided by a fusion of Black Feminist Thought and Resilience Theory. Black Feminist Thought asserts that Black women already have the answers for solving health disparities such as those seen in sexual health in their experiences (Collins, 2002). The current study builds upon this theoretical stance by using narrative inquiry to gather information about the experiences of Black women. This study answers calls for research that privileges Black women's ways of knowing and expands the growing literature that amplifies the experiences of Black women from their perspective.

Lastly, this dissertation study contributes to the scholarly literature on resilience among Black women. The findings illustrate how Black women display resiliency and the processes that support them in doing so. This study offers valuable insights on protective socioecological factors that nurture resilience among Black women. Understanding the drivers of resilience across multiple levels of analysis within the context of an STI diagnosis can aid in the development and improvement of prevention efforts that incorporate resilience and that draw on existing resources rather than only addressing vulnerabilities. The findings of this study can contribute to a foundation for future research endeavors that adopt a strengths-based approach to examining the sexual and reproductive well-being among Black women.

Chapter 1: Review of the Literature

The following sections provide an overview of the foundational literature that informs the dissertation study. I begin with a brief overview of disparities in STIs among Black women with an emphasis on those in emerging adulthood. Next, I review the relevant literature on the consequences of having an STI. In this section, I also argue that traditional prevention approaches have largely been deficit based and that the sexual and reproductive health needs of Black women in emerging adulthood are unmet. Following this, I discuss Resilience Theory as the guiding theoretical framework for understanding what extra individual strengths and resources exist to help emerging adult Black women develop a resilient response (e.g., ability to cope with the consequences of having an STI, avoiding reinfection, implementing protective behaviors) after having an STI diagnosis. The current project specifically draws on a socio-ecological perspective of resilience, which emphasizes the importance of extra individual factors that facilitate well-being under stressful situations (Ungar, 2011b). After this, I discuss resilience theory as it pertains to the sexual and reproductive health literature. Lastly, I identify key socio-ecological contexts that may promote resilience among young Black women after being diagnosed with an STI.

Epidemiology of STIs Among Young Black Women

The United States has experienced a dramatic increase in the rate of sexually transmitted infection (STI) diagnoses in recent years. 2019 marked the sixth year in a row that the number of STI diagnoses in the United States reached a record-breaking high (National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2021). Research suggests that the increasing rate of STI diagnoses cost the United States healthcare system about $16 billion in 2018 (Chesson et al., 2021). Importantly, a significant proportion of STIs in the United States are accounted for by youth and young adults between the ages of 15-24. For example, in 2019, almost half of all new STI diagnoses occurred among young people (CDC, 2021). At the same time, recent budget cuts decreased the availability of state funded sexual and reproductive health services (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2019), intensifying the possibility for increased transmission of STIs among young people in the United States.

STIs are one of many sexual and reproductive health issues that disproportionately affect Black women. Disparities in STI acquisition and diagnosis among Black women have been well-documented for years. For example, in 2003, the largest disparities in HIV and STI diagnoses were among the highest for Black people as compared to other races and this was largely attributable to diagnoses among Black women. (Keppel, 2007). Studies from nearly 20 years ago found that positivity rates of bacterial STIs like gonorrhea and chlamydia were drastically higher among Black girls and women between the ages of 15-24 compared to White women within the same age group (Einwalter et al., 2005). Research also suggests that heterosexual Black women are significantly more likely than women of other racial groups to report having had an STI in their lifetime (Cohn & Harrison, 2022).

Despite an array of public health interventions (see Crepaz et al., 2009; Dorsey, 2022; Kendall et al., 2020; Ware et al., 2019) targeted at reducing STI acquisition among Black women, the disparities among this group persist. According to 2020 census data, Black women between the ages of 15-24 make up less than 1% of the population in the United States, yet in the same year, they accounted for nearly 11.8% of all chlamydia cases and 9.8% of all gonorrhea cases. Other CDC data points to alarming differences in the rate of STI diagnoses among Black women compared to women from other racial and ethnic groups. For example, in 2019 the rate of chlamydia among Black female adolescents was five times higher than White females and four times higher than Hispanic females (CDC, 2021). In the same year, rates of gonorrhea among Black female adolescents were nine and ten times higher than White and Hispanic female adolescents respectively (CDC, 2021).

Consequences of Having an STI

Acquiring a STI can have detrimental psychosocial effects. Many STIs can also have damaging physical effects if left untreated. Given the potential effects of having an STI, learning from Black women who have had this experience is advantageous for optimizing future STI prevention efforts from Black women. Black women may face many trials once diagnosed with an STI. Recognition of these trials is significant for understanding the adversities to which Black women may resiliently respond. The following sections outline the evidence base on the various consequences of being diagnosed with an STI.

STI-Related Stigma

One of the most prominent consequences of being diagnosed with an STI is the experience of STI-related stigma. STI-related stigma occurs when individuals who have an STI are subjected to negative attitudes, beliefs, and/or discrimination because of their STI status (Morris et al., 2014). A 2005 research article by Lichtenstein and colleagues (Lichtenstein et al., 2005) describes how STI-related stigma has permeated western society throughout the history of infections. They also detail how many STIs are associated with sexual immorality and deviance. Stigma is theorized to occur in four different ways: enacted, felt, internalized, and anticipated (Major et al., 2018). Enacted stigma consists of biases, negative feelings, and mistreatment of the stigmatized. Felt stigma is the perception of being devalued and discredited. Felt stigma can occur when one is exposed to enacted stigma. Internalized stigma, also known as self-stigma, occurs when stigmatized people adopt the negative beliefs and devaluation of themselves common in society. Lastly, anticipated stigma occurs when stigmatized people expect to experience bias or discrimination because of their stigmatized identity. Internalized stigma occurs at the intrapersonal level. Enacted stigma, by contrast, can operate across multiple levels of analysis (e.g., interpersonal, structural). STI-related stigma can occur as enacted stigma, ranging from the interpersonal level (stigma from family, peers, or family members) to the community and societal levels where stigma is enacted through media, healthcare, and cultural ideologies. Research scientists have documented the problematic nature of STI-related stigma (Hood & Freidman, 2011; Lichtenstein et al., 2008; Neal et al., 2010; Newton & McCabe, 2008;). For instance, Morris et al., (2014) conducted a study on STI-related stigma among 112 low-income Black men in San Francisco. STI-related stigma was measured by Fortenberry et al's., (2002) STD-related stigma scale. The scale included five items that assessed one's expectation of social mistreatment and judgment associated with STIs (e.g., getting examined for an STD makes people think I have no morals). Findings revealed that increased STI-related stigma was associated with a decreased likelihood of having been tested for an STI, a decreased willingness to notify a non-main partner of their STI diagnosis, and a lower likelihood of bringing STI treatment medication to their partner. In a similar study, Cunningham et al., (2009) explored the relationship between perceived STI-related stigma, STI-related shame, and STI screening among English speaking, sexually active adolescents between the ages of 15-24. The majority of participants in this study were Black. Results indicated that STI-related stigma was negatively associated with being screened for an STI within the past year among this group. Though neither of these studies explicitly focus on Black women, the findings from these studies point to the ways that STI-related stigma can undermine important STI prevention and control efforts, making it difficult to reduce disparities in STI incidence and prevalence.

In addition to the impact that STI-related stigma can have on STI prevention, empirical evidence has also documented the impact that STI related-stigma can have on people who have been diagnosed with STIs and their relationships. For example, Newton & McCabe, (2008) used a qualitative research design and thematic analysis to explore how STI-related stigma influences sexuality, relationships, and disclosure. Adult men and women who had been diagnosed with HPV, genital herpes, or no STI at all participated in this study. The authors did not provide information about the race or ethnicity of the sample. Participants explained that STI-related stigma caused them to feel depressed and feel unworthy of sex or romantic relationships. Some participants even reported that STI-related stigma made them feel damaged or unclean. A small number of participants reported that STI-related stigma positively affected them, such that it prompted them to engage in serious and intentional self-reflection. One participant explicitly stated that being diagnosed with an STI "was ultimately an empowering experience. It was the catalyst for me to improve my health and do some work on how I deal with crisis/conflict through therapy. I've used it as a chance to get some real, solid information about 'safer sex.'" (Newton & McCabe, 2008, p. 866). These findings suggest that having an STI can prompt positive behavior change. In a qualitative study of 24 adult men and women, Melville et al., (2003) explored the psychosocial impact of being diagnosed with herpes simplex virus type 2 (HSV 2). They found that participants associated the social implications of having herpes with three themes: 1) being stigmatized, 2) feeling sexually undesirable, and 3) feeling like damaged goods. Some participants attributed the second and third themes to being stigmatized. For example, one woman expressed: "You feel like you're not as good anymore, I guess. And because it's such a, you know, associated with such stigma. It's not just a little black mark, it's like a big black check mark against you" (Melville et al., 2003, p. 282-283).

Foster & Byers (2016) offered an in-depth analysis of the effect of STI-related stigma on the sexual well-being of people who had been diagnosed with STIs. Sexual well-being was comprised of sexual frequency, sexual problem, sexual anxiety, sexual self-schema, sexual esteem, and sexual satisfaction. Using hierarchical multivariate multiple regression, the authors found that those who reported experiences of STI-related stigma also reported poorer sexual well-being. Consistent with these findings, in her qualitative examination of the ways that women managed STI-related stigma, Nack (2002), found that STI-related stigma drastically influenced the sexual self-concept of all except one of the women. Nack also made some important assertions regarding the ways that women are stigmatized with regard to STIs, assertions which may be particularly important within the context of the current study.   argues that STI-related stigma and feminine morality (e.g., being a good woman, practicing piety, adhering to gender norms on sexuality) work together and thus the ways that women perceive, and experience STI-related stigma are unique. Findings from several studies suggest that women are judged more harshly for having an STI than men (Darroch, Myers, & Cassell, 2003; Lichtenstein, 2003; Lichtenstein, Hook, & Sharma, 2005; Smith, Mysak, & Michael, 2008). Stereotypical ideals of femininity such as purity, morality, and being “good” stand in contrast to having an STI, which is often labeled in society as dirty, bad, and impure. Because of the stark contrast between the ideals that women are expected to uphold and societal beliefs about STIs, women may be more drastically impacted by STI-related stigma. Men are not subject to these same ideals, and therefore will not likely experience STI-related stigma in the same ways as women. For Black women, the experience of gendered racism, which is a unique form of oppression at the intersection of gender and race (Prather et al., 2016, 2018; Rosenthal & Lobel, 2020), may further compound this stigma and other consequences of contracting an STI exacerbating disparities.

STI-Related Shame

Much like STI-related stigma, STI-related shame is closely tied to societal beliefs and expectations (Scheinfeld, 2021). The primary difference between STI-related stigma and STI-related shame is that STI-related shame is the internalization of STI-related stigma (Fortenberry et al., 2002). The findings on the impact of STI-related shame on STI prevention and control efforts generally suggest that STI-related shame is not associated with STI screening (Fortenberry et al., 2002; Morris et al., 2014). Despite this, the literature does suggest that people who have not been tested do anticipate feelings of shame about getting tested (Theunissen et al., 2015). On the other hand, there is more consistent evidence of the impact of STI-related shame on one’s sense of self. Results from a study by East et al., (2010) point to the ways that STI-related shame disrupts the sense of self of young women who have been diagnosed with an STI. Young women in this study reported feeling as if they let themselves down and felt dirty or spoiled because of their positive STI status. Blake (2016) also identified STI-related shame from having an STI. In their sample of 10 women who had been diagnosed with an incurable STI, seven reported feelings of shame once they were diagnosed. They elaborated that STI-related shame caused them to feel less confident, more confused, insecure, and even “disposable”. Some women also reported denying their own sexual pleasure because of the STI-related shame they experienced in tandem with their STI diagnosis.

Physical Consequences of STIs

STIs can have a profound impact on one’s physical health. Syphilis, if left untreated, can cause severe damage to the internal organs, ultimately leading to death (CDC, 2022a). Syphilis can also spread to the brain and nervous system, eyes, and ears if left untreated. Once syphilis spreads to the brain, one may experience severe headaches and muscle weakness. The effect of syphilis in the eye can lead to significant changes in vision or even blindness. Similarly, syphilis in the ear can significantly reduce one's hearing ability or lead to complete hearing loss (CDC, 2022a). Women who are pregnant with syphilis may transmit the infection to their unborn baby, which could lead to low-birth weight. It is also possible that having syphilis while pregnant could lead to early delivery or even stillbirth.

Many of the physical consequences of other STIs have a detrimental effect on the sexual and reproductive health of women. Both chlamydia and gonorrhea can lead to pelvic inflammatory disease (PID), which can cause fallopian tube, uterine and upper genital tract damage. The damage associated with PID can lead to infertility (CDC, 2022b). Recent research highlights the challenges of identifying accurate estimates of how many cases of infertility can be attributed to chlamydia and gonorrhea (Horner et al., 2021), however the literature does acknowledge that women who have previously been diagnosed with chlamydia and gonorrhea are significantly less likely to conceive (Steiner et al., 2015) and are at greater risk for ectopic pregnancy (Reekie et al., 2019).

In addition to challenges with conception, STIs can also lead to cervical cancer. The CDC estimates that of about 46,000 new cases of cervical cancer that are diagnosed each year in the United States, 36,500 of these cases can be attributed to HPV (CDC, 2021b.). Recent estimates suggest that 4,290 women in the United States will die each year due to cervical cancer (Siegel et al., 2020). It is also worthwhile to note that among women between the ages of 20-39, cervical cancer is the second leading cause of mortality from cancer (Buskwofie et al., 2020).

In sum, empirical evidence paints an alarming picture of the impact that STIs can have on those who have been diagnosed with them. Beyond this, women, regardless of their STI status, must deal with societal messages and expectations around their sexuality and sexual lives that tend “to create a culture of surveillance and regulation” (Wong et al., 2012, p. 81), compelling them to conform to dominant societal norms and ideologies about sex. These challenges in addition to other systemic issues such as gendered racism that young Black women may face further complicate the opportunity for them to have healthy sexual lives after being diagnosed with an STI. Gendered racism can manifest through stereotyping, objectification and dehumanization of Black women’s bodies, adding additional barriers to their sexual well-being (Cazeau-Bandoo & Ho, 2022) Despite this, many Black women who have been diagnosed with STIs are thriving. From these women, we can learn about strength, resilience, and recovery after being diagnosed with an STI and use this knowledge to inform future health promotion efforts.

The Current Literature on Black Women’s Sexual and Reproductive Health

To date, much of the literature on Black women’s sexual and reproductive health adopts a deficit viewpoint (LoVette et al., 2019; Opara et al., 2021). This orientation focuses principally on the skills, knowledge, and attitudes that Black women are seen to lack — their supposed personal shortcomings, rather than on the structural and other non-individual factors that increase their vulnerability. Scholars note that the deficit lens pathologizes the sexual and reproductive health of Black women and girls by assuming that they are inherently flawed as opposed to acknowledging the social, cultural, and structural factors that contribute to their STI risk (Crooks et al., 2019; Logan, Vamos, et al., 2021). In addition, the deficit orientation ignores the strengths that exist within Black women and their communities that help facilitate their sexual well-being. Consequently, there is a wealth of knowledge on factors across multiple levels of analysis that increase women’s risk and vulnerability for poor sexual health outcomes, such as STI acquisition; however, much less is known about the factors that help Black women to protect their sexual health. This points to a need for research that moves beyond the deficit perspective and begins to consider strengths-based approaches that examine the ways that Black women successfully manage their sexual health. Using a strengths-based orientation focuses on protective factors and processes that support Black women in achieving positive sexual and reproductive outcomes (e.g., STI-negative).

Resilience Theory

One way to foster a strengths-based approach to Black women’s sexual and reproductive health is by focusing on resilience. Resilience Theory offers a strengths-based perspective because it attends to existing resources and capacities within an individual or community to achieve positive outcomes despite challenges or adversity (Brodsky & Cattaneo, 2013). The earliest conceptualizations of Resilience Theory in psychology emerge from the literature on child development (Vernon, 2004). These studies primarily focused on differences in adjustment among children of people living with serious mental illness (Luthar et al., 2000). Researchers observed that although all of the children in these studies were at risk for psychopathology, some of them adapted better than others. Researchers began to make those who were well adjusted the focus of their research (Garmezy, 1974; Garmezy & Streitman, 1974; Masten et al., 1990). Although the term resilience was not used in these studies, they reflect the beginning of empirical efforts to understand differences in how people respond to adversity. Many of these early investigations of resilience tended to focus on internal qualities of children that were considered “resilient” (e.g., self-esteem, autonomy, charisma). Since then, however, many resilience researchers have shifted to conceptualizing resilience as a developmental process that is shaped by the qualities of an individual as well as the individual's environment (McCubbin, 2000; O'Dougherty Wright, 2012; VicHealth, 2015).

Despite the general consensus that resilience is not a static trait, but rather a dynamic process (Fergus & Zimmerman, 2005; Luthar & Cicchetti, 2000; Rutter, 2012; Southwick et al., 2014) there are still substantial variations in theoretical definitions of resilience (Luthar et al., 2000; VicHealth, 2015). For example, Werner (1982), defines resilience as one's ability to cope with internal vulnerability or external stressors, while Ungar (2005), considers resilience to be the structures around an individual that helps them to overcome adversity. Kralik et al., (2006) consider resilience to be a combination of positive self-worth, being able to learn from past experiences, and being adaptable. Researchers have noted that inconsistency in defining the term can make studying resilience difficult (Luthar et al., 2006). Resilience research has followed three distinct lines of inquiry that each stem from the developmental psychology and psychopathology literature (Masten, 2007). The first line examines instances in which an individual develops well despite exposure to risk. This is also termed "beating the odds." The next line includes the study of individuals who maintain their functioning in adverse situations. In other words, this line focuses on things such as how one copes with or manages stress. The last line focuses on the idea of "bouncing back," which involves the examination of recovery or returning to normal functioning after experiencing adversity. The common factor across the different conceptualizations, definitions, and examinations of resilience is that one must experience some difficulty, challenge, or risk that prompts a need for one to adjust in some way in order to respond in a positive manner.

Components of Resilience

Some resilience theorists suggest that the core requirements for resilience are adversity, which is also known as risk, and positive adaptation (Luthar & Cicchetti, 2000). Adversity or risk encompasses negative or challenging life experiences. Positive adaptation refers to maintaining, regaining, or improving functioning after being exposed to adversity (Vella & Pai, 2019). In other words, adversity precipitates or triggers a response, one type of which might be characterized as positive adaptation. This sequence of events indicates resilience unfolds as a process. Resilience is comprised of two major components: vulnerability and protective factors (Luthar & Cicchetti, 2000). Vulnerability factors are those that further enhance the consequences of exposure to risk while protective factors are those that mitigate the effects of risk.

What constitutes positive adaptation differs based upon the circumstance. For example, in the earlier studies of resilience with children of parents with schizophrenia, positive adaptation was evaluated based on the absence of schizophrenic pathology (Masten et al., 1990). In other studies, positive adaptation was judged by a child's ability to meet developmental milestones (Luthar & Cicchetti, 2000; Wright et al., 2013). Luthar, D'Avanzo, and Hites recommend that positive adaptation be operationalized according to the dimensions that will be most strongly affected by the risk or adversity. Other researchers suggest that positive adaptation is a byproduct of the person-environment interaction and develops over time (Liu et al., 2017) The examples above suggest that some define positive adaptation in terms of certain outcomes attained or avoided, whereas others seem to define it in terms of how people perceive themselves and their circumstances. The diverse nature of positive adaptation underscores the necessity of context, circumstance, and population specific resilience research.

There is a limited knowledge base on what constitutes positive adaptation within the context of having an STI. One might hypothesize that positive adaptation to having an STI could include behaviors that are considered to be safe sex practices (e.g., consistent condom use, regular STI testing, monogamy). In one study, Woollet et al., (2016) researched resilience in 25 South African adolescents living with HIV using a qualitative thematic approach. 15 identified as female and 10 identified as male. The researchers found that the participants displayed positive adaptation by challenging HIV-related stigma and shame, desiring to support others facing similar challenges, increasing their uptake of healthcare services, and pursuing and accessing resources and adult support (Woolett et al., 2016). The findings from this study offer useful insight into how resilience is operationalized within the context of sexual health. However, the findings also show that a narrow focus on sexual behavior fails to capture the other ways in which resilience is demonstrated in the context of an STI.

A Socioecological Perspective of Resilience

Researchers have called for more empirical studies that emphasize resilience as a multilevel process (Luthar et al., 2014; Shaw et al., 2016). They suggest that a socioecological perspective and approach is the best way to fully capture the process of resilience (Masten, 2007; Shaw et al., 2016). These researchers also argue that understanding the processes that underlie resilience at each level of analysis are vital for using resilience research in practical ways (e.g., informing interventions and health programming). The current study is therefore framed by a socioecological perspective on resilience. Ungar (2008) proposed a socioecological definition of resilience that is comprised of two parts: 1) "capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being" and 2) “a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways” (p. 225).

A socioecological approach to resilience recognizes that vulnerability and protective factors exist and interact across multiple levels of analysis (e.g., individual, social, community) (VicHealth, 2015). Examples of vulnerability factors across multiple levels of analysis can include neighborhood violence (community), poor social relationships (interpersonal), and low self-esteem (intrapersonal). Some of the resilience literature has separated the different levels of analysis of protective factors into assets and resources (Beauvais & Oetting, 1999; Fergus & Zimmerman, 2005). Assets are internal individual factors that are protective (e.g., coping, self-efficacy, competency) and that help one to overcome risk. Resources are those that are outside of the individual such as parental support, community engagement, or mentoring. Delineating assets and resources are critical for the current study because it contextualizes resilience and emphasizes the influence of socio-ecological factors on one’s ability to develop resiliency.

Another crucial underpinning of a socioecological perspective on resilience is that the community is a unit of analysis. Shaw et al., (2016), suggest that resilience research should not only examine how the individual overcomes adversity, but also consider how factors at different levels and systems are driving adversity and responses to it. Accordingly, a socioecological resilience framework emphasizes an exploration of how individuals perceive their community to “change the odds” as opposed to traditional resilience frameworks that focus on how individuals “overcome the odds.” Without attention to how communities contribute to changing the odds, researchers run the risk of placing the blame on individuals for failing to overcome adversity (Shaw et al., 2016; Ungar et al., 2013).

Black Feminist Thought

This study was also guided by Black Feminist Thought. Although Ungar's socioecological perspective considers the importance of culture, some resilience researchers suggest that there remains a gap in understanding resilience in Black people because their experiences are understudied (Teti et al., 2012). Black Feminist Thought can be used to address this gap in understanding because, at its core, Black Feminist Thought amplifies the voices of Black women. Black Feminist Thought asserts that Black women possess unique standpoints that are shaped by their marginal social positions (Collins, 1989). This paradigm calls for "ideas produced by Black women that clarify a standpoint of and for Black women" (Collins, 1989 p. 16). It is important to note that Black Feminist Thought stands in direct opposition to knowledge production that excludes or distorts Black women's experiences. Research guided by Black Feminist Thought is informed by methodologies that privilege Black women's ways of knowing and experiences.

There are three major themes in Black Feminist Thought. First is Black women's self-definition and valuation (Collins, 1989). This theme considers how Black women challenge the ways in which they have been historically defined. There is a specific emphasis on rejecting narratives and perspectives of Black womanhood that are driven by stereotypes. Self-valuation is specifically about the content that makes up how Black women authentically redefine themselves. The next theme is attention to how race, gender, and class intersect and create an interlocking system of oppression (Collins, 1989). Within this theme is the recognition that issues of racism, sexism work together in a systematic fashion that creates oppressive conditions and inequality in the lives of Black women. Understanding and acknowledging these systems and the oppressive conditions that they create is key for understanding the standpoint and unique experiences of Black women. The last theme is the importance of Black women's culture. The last theme is the importance of Black women's culture. Within this theme, Collins notes that there is diversity in the Black woman experience. Although there are commonalities among Black women and their experiences, variations in religion, age, geographic location, class, and sexual orientation amid other sociocultural factors demonstrate the different contexts from which Black women can be understood. This theme also captures the importance of social relationships, especially those with other Black women as an integral component of Black women's ability to resist oppression. The significance of this theme within the framing of Black Feminist Thought is that it sheds light on the intricacies of Black women's consciousness and resistance that is woven into their culture and likely obscured from researchers who privilege White male traditional ways of knowing.

Integration of Theoretical Frameworks

Resilience Theory alone is not sufficient for understanding phenomena regarding Black women. An adequate understanding of Black women's ability to "bounce back" from a positive STI diagnosis requires an acknowledgment of the oppressive material conditions driving the high rates of STIs among Black women. Integrating Black Feminist Thought with Resilience Theory will provide an additional layer of social, cultural, and political context for understanding how Black women resiliently respond to having an STI. By applying a socioecological framing of Resilience Theory, this study 1) elucidates how positive adaptation occurs for Black women after they've been diagnosed with an STI; 2) identifies the drivers of Black women's positive adaptation across each level of analysis; and 3) describes community and structural level conditions that facilitate healthy sexual futures for all Black women. Black Feminist Thought was applied in the current study to center and amplify the voices and experiences of Black women. Furthermore, Black Feminist thought was integrated into the current study as a critical research methodology to highlight the value of Black women's lives, knowledge, and identities in academic research. The use of Black Feminist Thought also unearthed vital insight and context regarding Black women's cultural experiences around sex. Including Black Feminist Thought captured how Black women define and value themselves within the context of positively adapting to an STI. This is critical information for future interventions and programs aimed at helping Black women navigate adverse sexual and reproductive health situations.

Socio-Ecological Resiliency Domains for Black Women

Resilience is an interdisciplinary phenomenon of investigation. Despite this, research on resilience and Black women's ability to overcome or adapt to challenges is underdeveloped because the literature tends to focus on Black women's risks and vulnerabilities. Given this, the literature on resilience, Black women, and sexual health is not robust. The following section draws upon studies of resilience in other contexts (e.g., interpersonal violence, substance abuse, reproductive health) as well as research concerning coping and post-traumatic growth among Black women. This section will emphasize the importance of resources (e.g., extra individual factors) and culturally related assets that are protective and help Black women to overcome sexual risk and other challenges related to their sexual health.

Family

A significant portion of the literature on factors that foster resilience among Black women after they have traumatic sexual and/ or reproductive experiences emphasizes the critical importance of family. In general, family plays an important role in one's socialization to sex, sexual values, beliefs, and behaviors (Shtarkshall et al., 2007). For example, in a grounded theory study that examines the process of becoming a sexual Black woman, participants noted that family perceptions significantly influenced the ways that they came to understand themselves as sexual beings (Crooks et al., 2019). Crooks' (2019) described three distinct phases in the process of becoming a sexual Black woman: girl, grown, and woman. During the girl phase, participants described that family members hypersexualized them and did not view them as girls. This contributed to later phases of development where they were naïve and uninformed about sex and had to figure it out without adult support during the grown phase. In the woman phase, participants were aware of their intersectional identities and how they related to challenges. However, women were also extremely confident in their sexuality and bodies during this phase.

Family can also be integral in one's ability to be resilient. Studies that have examined resilience among Black women suggest that social support from their families is integral for their ability to respond in resilient ways across a variety of different circumstances (Brodsky, 1999; Kennedy & Rollins, 2016; Meadows et al., 2005; Todd & Worell, 2000). For example, in a study of resilience among urban Black single mothers, Brodsky, (1999) concluded that family was a facilitator of resilience for some women. Women reported their family provided various sources of support (e.g., economic, emotional, childrearing) that helped them overcome different stressors. Findings from Kennedy & Rollins, (2016) suggest that family members play an important role in the resiliency of Black women who have been diagnosed with breast cancer. Participants in this study were struggling with a life-threatening illness. They cited their family as an important factor for maintaining hopeful and positive while they managed their illness. The role of the family in fostering resilience is especially salient among Black women because of the Black American value of enduring commitment to the family.

There is also evidence of the ways that familial support cultivates resilience among women who experience specific sexual health challenges such as HIV. In a qualitative study of 30 Black women between the ages of 33 and 65 living with HIV and fifteen community stakeholders, Dale & Safren (2018) found that family members were a source of resilience. In this study, resilience was defined according to a socioecological perspective of resilience as the ability to cope or bounce back in the face of adversity by obtaining resources across each level of analysis (social, cultural, psychological, physical) (Ungar et al., 2013). Women reported that their mothers helped them to overcome trauma and substance abuse and provided daily social support. Women also noted that social support from family, their children, and grandchildren helped them to adhere to their HIV medication. In some cases, the social support that women's family members provided gave women the space needed to work through issues and challenges around their HIV status. Subramaniam et al., (2017) highlighted the role of familial support in nurturing and sustaining resilience in a sample of eight Black women between the ages of 32 and 67 living with HIV. This study specifically underscores how support from family members can be crucial for well-being and motivation to live after being diagnosed with a life-altering infection. It remains unclear how family support may be a resilience resource for younger Black women in managing STIs.

Some of the literature in this area names specific familial relationships that are crucial to the development of resilience among Black women. For example, Aronowitz & Morrison-Beedy, (2004), found that among Black women and girls maternal connectedness contributes to increased resilience, such that a well-connected relationship between Black mothers and their daughters helps to foster resilience in the daughters. Daughters were considered to be resilient when they avoided sexual risk behaviors, violence, substance use, and delinquency. Black mothers may help foster resilience in their daughters through the promotion of healthy parent-child communication and broader family connectedness (Everet alt et al., 2016). Notably, there are also a number of studies that highlight the importance of different components of the mother-daughter relationship (e.g., communication, maternal monitoring) in the sexual health behaviors of Black girls and young Black women (Aronowitz & Eche, 2013; Donenberg et al., 2019, 2020; Hutchinson, 2002) There is much less research on the role of the father as a resilience resource for Black girls and women, however, the literature does acknowledge the importance of the father in reducing sexual risk among Black girls and adolescents (Dorsey, 2022; Peterson, 2006)

These empirical studies suggest that familial support and parental relationships can play a role in the development of resilience among Black women, in addition to shaping their sexual health behaviors. Though there is strong evidence that family functions as a resilience resource, the operationalization of resilience amongst these studies varies widely. Despite this, most of the evidence indicates that family operates as a resilience resource in similar ways by either acting as a buffer against vulnerability to risk or helping them to overcome risk through the provision of social support. Although data consistently shows that siblings, fictive kin, and other extended family members are often influential on one’s sexual health beliefs, and behaviors (Boyd et al., 2022; Grossman et al., 2015; Wallace et al., 2014), more research is needed to better understand how family may shape resilience among Black women after they experience an STI infection.

Peers or Friends

The resilience literature emphasizes the importance of social support from friends and peers in fostering resilience (Cameranesi et al., 2021; Donnellan et al., 2017; Shilo et al., 2015; Werner, 2013). In a study of 2,389 adolescents between the ages of 14-24 years, researchers examined the role of family and friendship support on resilient functioning (Harmelen et al., 2017). Resilient functioning was defined as “the degree to which an individual functions better or worse than expected given their self-reported childhood family experiences” (Harmelen et al., 2017 p. 2312). Harmelen and colleagues measured resilient functioning across several domains including psychiatric symptomatology, personality traits, and mental well-being. The researchers found that friendship support was the strongest predictor of resilient functioning. Friendship support was measured with a self-report scale that assessed the participants’ perceived quality of friendships. Example items include “Do you feel that your friends understand you?” “Are you happy with the number of friends that you’ve got at the moment?” This data points to the ways that quality friendships are perceived as supportive and its importance in relation to the development and maintenance of resilience. Dale & Safren (2018) suggest that social support from friends is a resilience resource for Black women living with HIV.

In addition to support from friends, having positive peers can be protective against risk and play an integral in the development of resilience. In one study, researchers reported that having a positive peer microsystem (e.g., friend support and peer engagement in prosocial activities) fostered resilience among Black youth who were on average about 15 years old (Elkington et al., 2011). Using hierarchical linear modeling, Elkington et al., (2011), found that the positive peer microsystem had a compensatory resilience effect on Black youth such that having positive peers compensated for risk factors such as substance use and positively predicted condom use. They also found that there was no longer a relationship between family risk factors and condom use once the positive peer indicator was entered into the model. These findings point to the ways that peers can foster resilience by acting as a neutralizing effect against risk.

It is important for people who hold marginalized identities and are faced with unique vulnerabilities to have peer support from those in similar situations. Individuals with similar experiences can offer first-hand knowledge and insight on navigating identity-specific vulnerabilities. For example, in Dale & Safren's (2018) study of resilience resources for Black women living with HIV, the participants emphasized their bonds with other women living with HIV. They noted that these unique relationships fostered their resilience by helping them learn to live with HIV when they were newly diagnosed. Participants also explained that social support from other women living with HIV helped buffer some of the effects of HIV stigma, racism, and heal from trauma. Research grounded in Black Feminist theory has highlighted the importance of shared bonds with other Black women as a means of coping, healing, and resilience for Black women (Anyikwa, 2015). Collins (2002) aptly states "African American women as sisters and friends affirm one another's humanity, specialness, and right to exist" (p. 102). This perspective offers critical insight on the significance of Black women's reliance on each other for support. Furthermore, literature in this area illuminates the ways in which Black women's unique relationships with one another foster resilience. For example, in a qualitative study of the ways that Black women college students cope with racial and gendered microaggressions, Lewis et al., (2013), reported that participants emphasized the importance of having support from other Black women because they would be able to validate and normalize their experiences.

Research has identified the role that supportive friends and peer relationships play in fostering resilience. For Black women specifically, relationships with other Black women appear to be integral in the development of resilience. The literature also provides evidence of the ways that peer relationships can affect sexual risk and behaviors. Although there are studies that provide evidence of peers and friends fostering resilience among people living with HIV, little is known about the ways that friendship and supportive peers contribute to resilience among Black women who have had other STIs.

Partners or Significant Others

When considering factors that contribute to one’s ability to be resilient, scientists have noted the role of romantic partners or significant others (Harper et al., 2014; Joly & Connolly, 2019; Masten, 2018). Healthy and secure relationships with romantic partners can be protective against a variety of risks. For example, Notter et al., (2008) describe the role that healthy romantic relationships has on the development of resilience in rural White women. These relationships, particularly those where their spouse did not use substance abuse, have a criminal record or engage in violent behavior, provided stability and support which helped them to overcome adversities they’d experienced throughout their life (e.g., intimate partner violence, intergenerational risks). Although some literature identifies the problems that Black women, especially heterosexual Black women have with finding suitable partners (Andrasik et al., 2014; B. Boyd et al., 2021; Dauria et al., 2015), healthy romantic relationships play an important role in their ability to be resilient. In Haight et al.'s, (2009) qualitative study of three resilient adolescent mothers in the Illinois foster care system, each participant reported that their male partner provided substantial emotional and financial support which strengthened their resiliency. Bowleg (2008) illustrates the importance that one’s romantic partner can have on resilience among Black lesbians who experience multiple forms of minority stress. In this study, 21% of participants expressed that the emotional support they received from their romantic partners was essential to their ability to overcome stressful situations.

Current research within the context of sexual and reproductive health also suggests that romantic partners or significant others also play a significant role in fostering resilience (Dale & Safren, 2018). Quantitative research has shown that women who are resilient during pregnancy are more likely to have high paternal support (e.g., positive relationship with the biological father of their pregnancy), compared to women who have low paternal support (Maxson et al., 2016). Lack of support from the paternal partner was associated with an increased risk of an adverse outcome, such as preterm birth. In a recent mixed-methods study of perinatal risk and resilience during COVID-19, a sample of primarily White perinatal women between the ages 24-45 years identified emotional support from their partners as a source of resilience (Farewell et al., 2020). Partner support was the primary factor that enhanced their ability to cope and be resilient to the toll COVID-19 was having on their pregnancy. While this evidence points to the importance of romantic partners or significant others in fostering resilience, few studies identify how these factors promote resilience in Black women, especially those who have experienced a socially stigmatizing condition like an STI. Romantic partners and significant others is also of particular interest within this context given the possibility that it is one's main sexual partner who exposed the individual to the STI or, if one has more than one partner, that having an STI is a potential violation of the terms of one’s primary romantic relationship (if a woman has a primary romantic relationship). In some cases, STIs can violate relationship norms and that may change whether and how partners support women’s resilience in this situation.

Formal Systems

Although a recent literature review of the literature on resilience suggests Black women are more likely to rely on informal and communal support systems rather than formal support systems (Woods-Giscombe et al., 2023), some researchers have noted that in contexts such as HIV treatment adherence (Subramaniam et al., 2017) Black women do rely on formal support systems, which helps them to develop resiliency. Formal systems of support include any services that are provided by a paid professional (e.g., nurses, social workers, law enforcement, lawyers) (Mushonga et al., 2021). For example, in their study of resilience among low-income Black women living with HIV, Subramaniam explored how women overcame health challenges and the factors that helped them to remain resilient. They defined resilience as the ability of an adult to maintain healthy levels of psychological and social functioning after experiencing an isolating or disrupting event (e.g., a positive HIV diagnosis). Participants expressed that formal organizational support was instrumental in their ability to live with HIV and remain resilient. Organizations provided social services and a setting to find camaraderie with other women living with HIV. Formal support was also found to contribute to resilience in a qualitative study of 20 Black women living with HIV in the Southern United States (Qiao et al., 2019). Participants were between the ages of 22 and 67 years. The researchers conducted semi-structured in-depth interviews and analyzed the interview transcripts using thematic analysis. Women in the study identified health facilities as impactful to their resilience. They explained that health facilities provided them with resources such as HIV education and the space to develop supportive relationships with other women living with HIV. In addition, they described that HIV education they received from the health facilities helped them to view their diagnosis, and their ability to live in a more positive light. Participants also reported that HIV education from the health facilities acted as a buffer against stress. Lastly, women described good relationships with their medical providers, which helped them to have positive healthcare encounters and more safe when receiving care. Women's positive experiences with their healthcare providers played an important role in women's ability to be resilient because women received affirming care that encouraged them to continue along a positive trajectory in spite of their diagnosis. It is also possible that the experiences these women had mitigated barriers to care that are commonly experienced by Black people (e.g., medical mistrust). The examples from this study provide evidence of health facilities as an asset and a resource. Viewing one's situation differently and the capability to live in a more positive light is an internal asset that is facilitated by the resources that the health facility provides. Dale & Safren (2018) found similar results about medical providers as a resilience resource. The participants reported that providers offered them emotional support, connected them with resources, and advocated for them.

Watkins-Hayes et al. (2012) conducted a study on the coping processes of Black women living with HIV. They conducted semi-structured interviews with 30 Black women living with HIV in Chicago, Illinois using a grounded-theoretical approach. Watkins-Hayes (2012) suggests that " 'framing institutions' in these women's lives were critical to explaining how and why members of socially marginalized groups adopt healthy behaviors to fight HIV" (p. 2028). Framing institutions are institutions that "generate language, adaptive skills, and practical knowledge that shape how individuals interpret a new life condition and whether they ultimately see it as a platform for growth. They operate as intermediaries between micro-level perceptions and actions and macro-structural forces and systems, positioned between one's personal response to a new circumstance and the larger set of privileges and disadvantages that she experiences due to her social location." (Watkins-Hayes, 2012 p. 2029). Prisons, traditional hospitals, health clinics, HIV housing complexes, drug, and alcohol rehabilitation programs, and AIDS social service organizations were all identified as framing institutions in this study. Each of these framing institutions helped women to cope with their diagnosis. Women also demonstrated resilience by reshaping their beliefs about their diagnosis. Watkins-Hayes reported that framing institutions pushed women on a coping trajectory where they went from feeling like their HIV diagnosis was a death sentence to being able to thrive while living with HIV.

Although these studies illustrate the importance of formal systems in fostering resilience among Black women living with HIV, there is a lack of evidence that clearly explains if and how formal institutions may foster resilience within the context of STIs. Understanding resilience as it relates to HIV differs from other STIs because people living with HIV experience slightly different adversities. Living with a chronic illness is different than something not chronic and curable. Black women who have been diagnosed with an STI may be faced with social disadvantages such as STI-related stigma, shame, and gendered racism. Consider the small differences in HIV specific stigma versus general STI-related stigma. Some HIV stigma stems from fear of the life threatening nature of HIV/AIDS leading to death and misinformation about how HIV is spread. There is also a unique social construction of HIV/AIDS (see Crystal & Jackson, 1989; Polgar, 1996) that illuminates how HIV-related resilience may differ from resilience in relation to STIs. The social construction of HIV/AIDS is intricately tied to the experience of the disease which includes things like initial responses to the disease on behalf of the U.S. government as well as the ways that people once deemed HIV as a punishment for sexuality or substance use.

Given that the literature generally suggests that Black women tend to rely on informal support, it may be possible that they do not rely on formal systems of support for STIs because they do not have the life threatening implications that HIV has. On the other hand, if they do rely on formal systems after being diagnosed with an STI, formal systems may shape resiliency directly by providing them with STI education and prevention resources as a buffer against STI risk for example.

Culturally Specific Assets

The literature previously discussed focuses specifically on resources that may help foster resilience among young Black women. Each of those factors exist outside of the individual and are largely relational and rooted in social support. For Black people in the United States, the literature points to two other factors that are critical for their resilience and coping: spirituality/religion (Utsey et al., 2007) and racial and ethnic socialization (Miller & MacIntosh, 1999). These factors are considered assets rather than resources because while they are shaped by family and community, they come from within the individual.

Spirituality and Religion

There is consistency among researchers that spirituality and religion contribute to resilience among Black women across a variety of contexts (Banerjee & Pyles, 2004; Blakey, 2016; Bryant-Davis et al., 2011; Holder et al., 2015; Howell et al., 2018; Mattis, 2002; Mushonga et al., 2021; Singh et al., 2013; Spates & Slatton, 2021; Taylor, 2004). Spirituality and religion have also been reported as resilience resources after Black women experience adverse sexual and reproductive health outcomes, particularly after they have been diagnosed with HIV. Amongst a sample of 225 Black women living with HIV in Chicago, IL and Birmingham, AL, Lipira and colleagues (2019) explored religiosity, social support, and ethnic identity as resilience resources for these women. Researchers found that religiosity, as defined by the Religious Beliefs and Behaviors survey, moderated the association between HIV stigma and depression. The authors noted that religiosity buffered the effect of HIV stigma on depression, and thus reflects the protective model of resilience.

In Qiao and colleagues (2019) examination of resilience resources for Black women living with HIV, the majority of participants reported that religious and spiritual practices helped them to overcome challenges. As one participant eloquently stated, “The same God that brought me through is going to take care of them. And that's how I get through the day. That's how I get through the day. I got to have faith. You know, he brought me through. He still looks out for me.” (Qiao et al., 2019 p. s39). Similar findings were reflected in (Subramaniam et als., (2017) exploration of resilience in low-income Black women living with HIV. In this study, most of the participants attributed their religion and spirituality as something from which they drew strength.

The literature has consistently acknowledged the role of religion and spirituality in helping Black people to overcome challenges and protect against poor health outcomes. The findings presented from the studies in this section suggest that religion and spirituality may also foster resilience among Black women after they have been diagnosed with an STI.

Ethnic and Racial Identity

The ways a person is socialized around their ethnic and racial identy/ies, can contribute to the development of resilience. In 2008, Brown published a study on racial socialization, social support, and resilience among a sample of Black young adults in college. Racial socialization was defined as "a set of behaviors, communications, and interactions between parents and children that address how African Americans ought to feel about their cultural heritage and how they should respond to the racial hostility or confusion in American society" (Brown et al., 2008 p. 33; Stevenson, Cameron, Herrero-Taylor, & Davis, 2002). Resilience was assessed according to the CD-RISC (Connor & Davidson, 2003). Findings revealed that receiving racial socialization messages was significantly associated with self-reported resilience, such that higher scores on racial socialization predicted greater levels of self-reported resilience. Racial socialization has also been found to be a resilience resource that buffers against racial discrimination for young Black adults (Brown & Tylka, 2011). Brown & Tylka, 2011 examined racial socialization as a moderator of the association between racial discrimination and resilience. Data from a survey with 290 young Black people in college indicated that racial socialization messages as defined by the Teenager Experience of Racial Socialization Scale (TERS; Stevenson et al., 2002). For participants who received a high number of racial socialization messages, the negative association between racial discrimination and resilience no longer existed, indicating that racial socialization acted as a buffer against the effects of racial discrimination. Butler-Barnes et al., (2018) explored racial identity beliefs and resilience among a sample of Black girls. They found that racial identity beliefs, particularly feeling good about being Black, mitigating the negative effects of school climate on academic attitudes and beliefs. Other studies have found that racial identity beliefs act as a buffer against mental health challenges (Jones et al., 2007; Settles et al., 2010). Findings from Settles et al., (2010) revealed that racial identity beliefs such as race centrality (e.g., how central race is to one's identity), acted as a buffer against depression.

Although none of the studies above are within the context of sexual and reproductive health, some sexual and reproductive health literature implicates that there is an association between racial and ethnic identity and sexual health behaviors and outcomes. The results of this literature is mixed. Some of this literature stands in exact opposition to the resilience research that regards racial and ethnic identity as an asset for Black women's resilience. These studies find that Black women's racial and gendered socialization may increase their risk for STI acquisition (Brown et al., 2014; Crooks et al., 2020). This is because when Black women receive negative racial and gendered messages (e.g., exposure to negative images of Black women in the media, being encouraged to be silent), they are less likely to engage in preventative sexual health practices. Townsend et al., (2010) found that racial identity did not buffer against the negative effects of societal and stereotypical messages on sexual risk among Black girls between the ages of 10 and 15. They suggest that strong racial ties might have made participants in their sample more susceptible to negative cultural messages (e.g., colorism). Beadnell and colleagues (2003), also explored racial identity and sexual risk taking among Black women. Participants in this exploratory quantitative study were 28 years of age on average. Their findings point to racial identity as a protective factor. Specifically, the results revealed that having a stronger racial identity was negatively associated with participation in sexual risk behaviors. Belgrave et al. (2000) reported similar findings. More recently, Opara et al. (2022) concluded that for Black female adolescents, racial identity has a negative relationship with sexual risk behaviors. As some of these studies demonstrate, having a positive and strong racialidentity can have a positive effect on Black women's sexual risk behaviors and thus may help Black women to develop a resilient response to having an STI. Others show the opposite, suggesting this is an important area for future investigation.

Summary

This literature review provides insight on Resilience Theory, the consequences of having an STI, and factors that may contribute to resilience among Black women during emerging adulthood. Resilience Theory provides a strengths-based approach to understanding Black women's sexual health. Although the resilience literature provides evidence that family, peers and friends, romantic partners, formal systems of support, spirituality and/or religion, and ethnic-racial identity each can foster resilience among Black women, no research to date has attempted to understand how these assets and resources contribute to resilience among Black women in emerging adulthood who have experienced an STI. As a result, there is a gap in our understanding on how Black women successfully manage their sexual and reproductive health in the face of an adverse event. In times where the sexual and reproductive rights of women are being threatened daily, it is critical for researchers to identify, explore, and amplify resources that can help Black women to have healthy sexual futures.

The Current Study

The purpose of the current study is to explore trajectories of resilient responses to being diagnosed with an STI. This is important because through examining processes of resilience, we learn how Black women have successfully managed their sexual health. Black women in the United States have experienced centuries of oppression that has affected their sexual and reproductive health outcomes in very specific ways (Prather et al., 2018). Given this, Black women have had the challenge of not only navigating oppression but also their sexual and reproductive health as a function of their oppressive experiences. Improving the sexual health of Black women necessitates that Black women resist the dominant deficit narrative surrounding their sexual health. Wyatt, (1998) contends that a major challenge to the sexual health of Black women is for Black women to see themselves "as we [they] are, as we [they] were, and as we [they] want to be" (p. 4), rather than the ways that others see them. To this end, it is important to examine the experiences of Black women through their own voices and stories.

Research on Black women's sexual health has primarily adopted a deficit point of view. Much of the research in this area focuses on Black women's risk and vulnerability to sexual health infections and diseases. In addition, numerous studies have documented the disparities in the acquisition of STIs, HIV, and other sexual health diseases among Black women (Bradley, 2019; Cohn & Harrison, 2022; Newman & Berman, 2008; Tillerson, 2008). Literature in this area has left out Black women's perspectives, resilience, recovery, and healing. Capturing and understanding these perspectives offers a much-needed strengths-based approach that emphasizes the existing capacities and capabilities of Black women and their communities.

There is some extant literature that examines healing, coping, and recovery among Black women in other contexts such as sexual assault (Bryant-Davis et al., 2011; Singh et al., 2013), intimate partner violence (St. Vil et al., 2017; Taylor, 2000, 2004), substance abuse (Blakey, 2016) and incarceration (Williams et al., 2021). The literature in this area emphasizes the importance of community and social support for Black women's healing. However, there is little known about how Black women bounce back after being diagnosed with an STI. Researchers must begin to further explore assets that help Black women to successfully manage their health. This study will provide stories of healing, strength, and recovery to offer an enhanced understanding of resilience among Black women in a context that has not been previously considered, which is important because resilience is contextually specific.

In the current study, I collected interview data from Black women who have been diagnosed with an STI at any time during their life to understand how they develop a resilient response to their diagnosis. Findings from the study disrupt and dismantle the dominant narrative about Black women's sexuality and sexual health that has been derived from deficit-based research. This study expands the existing literature on resilience among Black women and contributes to Black women's sexual health literature.

Research Questions

Guided by Resilience Theory and Black Feminist Thought, the overarching goal of the current study was to explore Black women's resilience process after being diagnosed with an STI. More specifically, the study documented how Black women define resilience after contracting an STI and investigated the processes and resources that facilitated their resilient response. The research questions for the study are as follows:

1) How is resilience defined in the narratives of Black women who have been diagnosed with an STI?

2) How do Black women demonstrate positive adaptation after being diagnosed with an STI?
3) What do women describe as drivers of their resilience across the intrapersonal, interpersonal, and community levels of analysis?

The answers to these questions were obtained through a series of narrative interviews conducted during the spring of 2023 with Black women who had a history of infection.

Chapter 2: Methods

A dearth of empirical literature explores Black women's sexual health from a strengths-based perspective. This dissertation addresses this gap in the literature by eliciting counter narratives to those that problematize Black women's sexual health. Given this, the current study employs qualitative research methods that engaged Black women in conversation about their sexual health and resilience.

Few culturally specific theoretical models provide a framework for understanding what happens to Black women after they have been diagnosed with an STI or for understanding resilience after experiencing adverse sexual and reproductive health outcomes. However, there are models that provide a framework for understanding resilience in the context of illness and disease. In lieu of a definition of resilience within the context of sexual health illness specifically, resilience in this study is operationalized according to Kralik and colleagues' (2006) definition of resilience within the experience of chronic illness. Resilience in the context of illness is defined by "having a strong sense of self-worth, the ability to learn from experiences and to develop the capacity to be adaptable" (Kralik et al., 2006, p. 193). Central to this operationalization of resilience is the reconciliation and reconstruction of one's sense of self which leads to having a strong sense of self-worth. Scientific evidence highlights similar negative experiences of fear, shame, physical illness, and stigmatization among individuals with chronic illness and those with infectious diseases such as STIs (Person et al., 2004; Rai et al., 2020; P. S. Rao, 2010). For this reason, it is appropriate to apply Kralik's definition to the study.

Qualitative Research and Black Feminist Thought

This dissertation study was guided by Black Feminist Thought; qualitative research methods were best suited for approaching the aims of this study. According to Yin (2015), there are five distinguishing features of qualitative research: studying the meaning of people’s lives in real world conditions; representing the perspective and views of research participants; accounting for contextual considerations; attempting to explain social conditions; collecting and integrating data from several sources as evidence. Each of these features are well aligned with Black Feminist Thought, which emphasizes the creation of knowledge based on truths, wisdom, and experiences of Black women, particularly those within the unique social, political, and historical context of the United States (Collins, 1989, 2002).

Qualitative research, like all research, is rooted in philosophical belief systems; therefore, it is also important to consider the philosophical underpinnings of the specified approach (Leavy, 2017). Broadly speaking, qualitative research is based upon an assumption of relativism which asserts that there are multiple socially constructed realities that are confined by space, time, and context (Creswell & Poth, 2018). The ontological assumptions of qualitative research reject the notion of one objective reality and truth, which allows for the exploration of socially constructed realities. Epistemologically, qualitative research allows for knowledge to be constructed in a way that generates a deep understanding of people’s subjective experiences, and how people make meanings of their experiences (Leavy, 2017). Both assumptions are necessary for undertaking research that is informed by Black Feminist Thought.

Examination of Narrative Inquiry and Rationale for Use in the Current Study

This study employed narrative inquiry as the methodology to better understand the processes that contribute to Black women’s ability to respond resiliently to having an STI. One of the main objectives of narrative inquiry is to describe and understand the meaning-making process attached to an experience through storytelling (Esin et al., 2014; Kim, 2016). Employing the use of dialogue and storytelling through narrative inquiry allows Black women and girls to create their own self-definitions and valuations as outlined in Black Feminist Thought. Lindsay-Dennis, (2015) further suggests that engaging Black women and girls in research that uses storytelling and dialoguing may provide a space for healing because they are able to share their knowledge, wisdom, and experiences, whereas in other places their knowledge, wisdom, and values may not be explored or may be devalued. Importantly, inviting Black women to share their stories as a part of research communicates the message that Black women's experiences are valid forms of knowledge (Lindsay-Dennis, 2015), which is another integral principle of Black Feminist Thought.

Employing culturally relevant research methods is required for research that engages Black feminist traditions (Lindsay-Dennis, 2015). While it is outlined in Collins' chapter as a feature of Black feminist epistemology (2002), the use of dialogue is identified as an important method within Black Feminist traditions (Lindsay-Dennis, 2015). In addition, storytelling practices are deeply engrained in Black American culture (Amoah, 1997). Historically, storytelling in Black American culture has been used to educate, share wisdom, and history (Amoah, 1997). Narrative creates an opportunity for Black women to disrupt dominant and inaccurate narratives of who they are by sharing their stories and experiences from their standpoint.

I used narrative inquiry to gather the stories of Black women to provide insight on the development of a resilient response to having an STI. In the words of Connelly and Clandinin (1990), narrative inquiry is "the study of experience as a story" (p.2). This study used the stories of Black women to demonstrate how specific events and experiences enabled them to be resilient. Haydon & van der Riet, (2017) emphasize the appropriateness for narrative inquiry for gaining insight to people's experiences of health and illness. They argue that understanding people's experiences through their individual narratives can provide useful information for prevention and care.

Positionality

Considering the nature and context of this study, it is important to situate myself and discuss my positionality as it shapes my interest and approach to answering the research question. It is imperative that I bring to the forefront my social position, identity, and personal experiences because each of these uniquely contributed to the development of this study. I am a young Black woman who was raised in the southeastern region of the United States, also known as the "Bible Belt." This part of the United States earned its name because Protestant Christian conservative values are deeply ingrained into all we do. One of the main ways that these values disadvantage the population living in this area of the country is via abstinence-only sex education. During middle and high school, I learned very little about protective sexual behaviors besides "mutual lifelong monogamy" or in other words, waiting to have sex until marriage. Luckily for me, I had a mother who was very open with me about sex and was willing to answer the questions that remained after we were merely shown graphic images of STIs in my middle school physical education class. It was these early experiences that piqued my interest in the ways that people learned and talked about sex. I remember the way people spoke down about girls who had acquired STIs during high school and college. Because my social circles primarily consist of Black girls and women, more often than not, I heard Black girls and women being degraded and shamed by people in their social circles because they had acquired an STI. I knew then, as I know now, that having an STI is nothing to be ashamed of and that they are, unfortunately, far too common.

In graduate school, I began to fully lean into becoming a sexual and reproductive health researcher. During this time, I noticed that the literature overwhelmingly discussed the disparities in Black women's sexual and reproductive health outcomes. Though these issues are important to uplift because many of them highlight the structural issues that make Black women vulnerable to adverse sexual and reproductive health outcomes, I found myself drained from constantly engaging with material that focused attention on losses for and deficiencies in Black women. My decision to pursue the current study is driven by my desire to highlight the ways that Black women thrive despite illness and loss.

Although I am the same age group as some of my participants and share a Black racial identity with them, I acknowledge that I still hold an outsider status within the context of this dissertation study because I am a researcher and they are being researched, so we held different statuses. Consistent with the principles of Black Feminist Thought, I must acknowledge the power I hold as a researcher, as many researcher and participant relationships can be hierarchical (Beoku-Betts, 1994; Campbell & Wasco, 2000; Collins, 2002; Few et al., 2003; Oakley, 1981; Zinn, 1979), and how this may influence the way I am perceived by the participants. This also means that I have power over how their stories are presented. To decrease power imbalances and distance between myself and the participants, I was transparent and vulnerable about who I am and how I came to this work in all my interactions. When I introduced myself, I told participants where I was from (Birmingham, AL), shared my background (how I ended up at Michigan State), and why I was interested in Black women's sexual health. Sometimes participants followed up with questions after I introduced myself and at the end of the interview when I asked participants if they had questions for me. I answered them even if they were personal. For the interviews, I dressed in a casual fashion because I wanted to decrease the sense of formality in the interviews. I wanted participants to share their stories with me as if I was one of their homegirls. I did not have prior relationships with any of the participants. I do believe my transparency and casual demeanor helped me to establish trust and a more balanced power dynamic because participants expressed how comfortable they were talking with me. I also kept detailed memos in a journal to reflect on the role of my values, assumptions, and beliefs throughout the duration of the project. This journal was helpful for me to evaluate my relationships with the participants and to make modifications to how I engaged with them, if needed.

Participants

I intended to study 12 to 15 participants. However, the pace at which women screened into the study was rapid and I did not want to close the Qualtrics screener before I completed interviews with the desired number of participants. I recruited a total of 18 participants. Two participants were ultimately excluded from the analytic sample due to the poor quality of their interviews. The information they provided me in these interviews was not sufficiently detailed for meaningful analysis. Table 1 summarizes the demographic characteristics of the analytic sample and provides short details on key aspects of their stories. More detailed participant profiles are at the beginning of the next chapter. Several of the women reported having had multiple STIs. For the purposes of the interview, I asked that they select their first diagnosis. One participant preferred to discuss her most recent diagnosis because she felt she had more to share about that experience.

Table 1

Participant Demographics and Brief Story Summary

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Naomi	37	19	Black	Grew up in a strict Christian household with limited discussion of sex. Learned of STI diagnosis when confirming pregnancy at age 20.	Chlamydia diagnosis prompted her to prioritize her sexual health. She is now a mother and wife and wants her daughters to be able to communicate with her about sex.
Kathleen	62	19	Black	Loss of father led her down a path of promiscuity. Her mother provided minimal guidance on relationships, dating and sex. She contracted an STI from her high school sweetheart.	Her lack of education on sex and experiences with STIs motivated her to do things differently with her children and grandchildren. She has open and honest conversations with them about sex and provides space for them to come to her with questions and concerns.
Kasey	36	24	Black	Very curious as a child but family did not teach her much about sex. She learned about sex from peers, but wanted to wait until she was married to have sex. Once she had sex, she felt disadvantaged because of her lack of knowledge.	She is committed to providing her daughters with knowledge and tools to counter influences that may pressure them to have sex. She is a women’s health worker and also educates other women on making informed decisions about sex and their sexual health.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Diamond	37	19	Black	Born to a team mom who had strict rules about dating and sex. She learned about sex from her peers. Once she began dating, she had a series of relationships she perceived to be monogamous. However, her partner was unfaithful, and she contracted an STI.	She continued the relationship although her partner had been unfaithful. Participating in the Vagina Monologues was pivotal in helping her move past the diagnosis and relationship. Her now husband also played a critical role as she rebuilt trust.
Madison	26	21	Biracial	Struggled with her body from a young age. Had a Catholic upbringing so she embraced the idea of chastity. When she got to college, she felt prepared to have sex. She was assaulted and tried to cope by becoming hypersexual, which she believes led to her to contract HSV 2.	Experienced severe depression but coped through meditation and Yoruba spiritual practices. Is more intentional about prioritizing her sexual and reproductive health.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Taylor	43	22	Biracial	Struggled with her body from a young age. Had a young mother who gave her negative messages about men and sex which deterred her from having sex until college. She quickly married this person but got divorced. Following her divorce, she engaged in a series of casual sexual encounters. She believes she contracted chlamydia and gonorrhea in one of these encounters.	The infection made her hyperaware of her sexual health. She implemented a range of preventative sexual health practices. Tries to provide her daughters with information about sex that she did not receive.
Kennedy	28	27	Black	Her mom had her as a teen, and did not talk to her about sex, but put her on birth control at a young age. Peer pressured into sex in high school. In college she wanted her sexual experiences to reflect what she saw in pornography. Contracted chlamydia and gonorrhea just last year from her boyfriend.	Hurt and embarrassed by the infection. Left the relationship and established new boundaries such as consistent condom use for future sexual encounters. Wants to ensure her children are educated on sexuality.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Jazmine	25	18	Biracial	Lacked guidance and education on sex growing up. Curiosity and peer pressure influenced her to have sex with her boyfriend in high school. After high school, she started a new relationship and contracted chlamydia and gonorrhea.	Went through a period of self-reflection in which she prioritized her sexual. Expressed a desire for an adult to have open communication with and receive education from about sex.
Candace	26	18	Black	Knew early on that she was not straight. Learned about sex from friends, not parents. Was urged to have sex with boys in high school and obliged. Embraced sexuality in college and contracted STIs several times.	Experienced a range of negative emotions after the first diagnosis, which taught her how to handle subsequent infections. Is now learning how to explore sexual fantasies while also prioritizing her sexual health.
LaShawn	48	21	Black	Had a strict mother who did not provide the guidance and attention needed. Observed sex in her surroundings, mirrored what she saw and became sexually active at 13. Later contracted an STI while she was pregnant from her child's father who died before she was diagnosed.	Hurt by diagnosis, also worried about the health of her child. Moved forward and established boundaries like monogamy and implemented preventative behaviors such as condom use and birth control.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Kese	47	18	Black	Mom informed her about sex, but experienced sexual assault which was detrimental to her sexuality. Decided to have sex at age 17 and had a cryptic pregnancy. Upon learning of her pregnancy, she also learned she had trichomoniasis.	The diagnosis, childbirth, and mistreatment from her child's father took a toll on her mental health. Her mom and a group of single mothers supported her during this time. She is still working through the pain of the diagnosis. She uses her story to help other women.
Monique	25	21	Black	Mom had her at a young age and tried to shield her from anything related to sex, including socializing with boys. Explored her sexuality with girls and only dated women for most of her life. Shortly after she began dating men at age 20, she contracted gonorrhea.	Experienced a loss of trust and damaged self-confidence. Implemented boundaries for new dating relationships, and instead on condom use. Dating her now husband was instrumental in helping her rebuild trust, but she still struggles with the emotional impact of the diagnosis. Views the experience as a valuable lesson and wants to teach her son to prevent him from having the same experience.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Bou	22	19	Black	Only gained a thorough understanding of sex once she was in college because it was not discussed in her strict and religious African household and her sex education in school was not efficient. Frequently tested for STIs and used condoms almost always, but still acquired an STI from her college boyfriend.	Felt dirty and embarrassed by diagnosis. Became obsessive about her sexual health. Eventually found solace about her diagnosis and was able to move forward by talking about the experience with other Black women. Established boundaries for future sexual and romantic relationships.
Leslie	35	19	Black	Absence of conversations related to sex in her household. Her sexual experiences were initiated by sexual assault, as she tried to learn more on her own. In her first long term relationship after high school, she was repeatedly diagnosed with infections. Her most recent infection from her child's father motivated her to navigate her sexual experiences differently.	Is now practicing abstinence in hopes of making better decisions in life and in dating and relationships.

Table 1 (cont'd)

Pseudonym	Current age	Age at first STI diagnosis	Race	Key elements of story before infection	Key elements of story after infection
Destiny	23	19	Black	Despite her mother's lessons that her body was sacred, she struggled with low self-esteem for a majority of her life. She felt abandoned by her father which led her to allow men to use her. One of these encounters led to her pregnancy. She learned of her infection after she gave birth and was discharged from the hospital.	Remained abstinent for some time after her daughter's birth because she wanted to be a good example. Sought knowledge on how to protect herself. She is now engaged, and her fiancé has been pivotal in building her self-esteem.
NikAsia	37	35	Black	Hypersexualized from a young age. Delayed sex because her parents warned her it would hurt. Began having sex adamant about condom use, then relaxed boundaries. Was diagnosed with HSV 2 years ago.	Takes responsibility for diagnosis. Initially experienced embarrassment about the infection but confided in a friend and cousin who supported her. Currently practicing abstinence and plans to continue educating herself on managing HSV 2.

Recruitment

Once the study received approval from the Michigan State University Institutional Review Board (Study 00008700; a copy of the approval letter can be found in Appendix A) on February 3, 2023, I began the recruitment process. Participants were recruited through facility-based and word-of-mouth sampling strategies. Facility-based sampling is a strategy in which participants are recruited from a variety of facilities that may be frequented by members of the target population (Magnani et al., 2005). According to Coker et al., (2009), one of the major challenges with recruiting Black Americans is inadequate recruiting efforts by researchers. They argue the importance of recruiting in places where Black Americans congregate. Similarly, Abrams et al., (2020) suggest that marginalized groups like Black women often face difficulties accessing healthcare, therefore researchers interested in recruiting participants for health-related research should not focus all of their recruitment efforts at traditional health sites and consider expanding recruitment to religious centers, hair and nail salons, restaurants, and public service organizations. In the past, health promotion interventions and programs have relied upon Black churches (Berkley-Patton et al., 2010; Bryant-Davis et al., 2016; Lightfoot et al., 2012; Williams et al., 2014; Woods-Jaeger et al., 2015), Black led and Black serving organizations (Austin et al., 2014; J. Jones et al., 2019; Williams & Anderson, 2021), and hair stylists/salons (Belgrave et al., 2016; Linnan et al., 2014; Mbilishaka, 2018; Sadler et al., 2011) as conduits for implementation and effective delivery to Black people. Researchers have relied on these spaces for recruitment and program implementation because they are spaces where Black people have established relationships and routine interactions (Palmer et al., 2022).

I placed recruitment flyers (see Appendix B) at beauty supply stores, hair, and nail salons frequented by Black women, which reflects the idea of “communities in motion” (Campbell et al., 2004). Other facility-based recruitment strategies included distributing flyers to health clinics, physician offices, Black churches, Black owned businesses, mental health counseling practices, and throughout Michigan State University's campus. Flyers were distributed at health clinics and physician offices because STIs are a health-related issue. In addition, flyers were distributed at counseling practices because of the potential psychological consequences that may be associated with STI acquisition. To gain access to these sites, I leveraged my existing relationships with community partners at the Ingham County Health Department Women's Health Clinic & STI/STD Clinic, Alliance Obstetrics and Gynecology, and Therapy in Color Counseling and Consulting. I gained entry to Planned Parenthood locations in Jackson and Lansing, MI, by connecting with the research coordinator for Planned Parenthood of Michigan via email. To distribute flyers for mental health counseling practices with which I did not have a pre-established relationship, I reached out via phone call to inquire about the possibility of distributing flyers.

Researchers have cited word-of-mouth as an effective recruitment strategy for minorities and other hard to reach populations because potential participants learn about the study from a trusted source (Jones et al., 2009; Rodríguez et al., 2006; Sankaré et al., 2015). The study was also introduced by word-of-mouth by women who had learned about the study through flyers, including at a Michigan State University Black Alumni meeting, to North Star Doulas, and at Socialight Society. Several women were enthusiastic about their participation in the study and shared the opportunity with other women they knew. From what I can discern, some women also circulated information to their peers about the study on social media platforms.

The recruitment flyers asked participants to complete an online screener or call the number listed to determine their eligibility for participation. Once eligibility was confirmed, I scheduled each woman for an interview anywhere between 1 day and 3 weeks following the screening phone call. During the screening phone call, I encouraged participants to complete the interview in person. However, 7 women requested to complete the first interview online via Zoom. I accommodated these requests.

My initial recruitment strategy focused on facility-based recruitment of women in emerging adulthood (ages 20-29 years). However, after about 3 weeks, the initial recruitment strategy had not yielded any participants. Therefore, I amended the study eligibility criterion to include any Black woman over the age of 20 years who had ever been diagnosed with a STI at any point in their life. I also discovered that an error in the Qualtrics form prevented eligible participants from leaving their phone numbers to be contacted to schedule an interview. I modified the online screener to ensure I could call women to confirm their eligibility for participation and to schedule interviews. These changes were approved by the IRB. In the end, eligible participants had to meet the following criteria: being Black, assigned female sex at birth, currently identifying as a woman, being 20 years of age or older, and having received a positive diagnosis for any STI (excluding HIV) at least once in their lifetime. Other eligibility criteria included having received treatment for the infection and the ability to communicate in English.

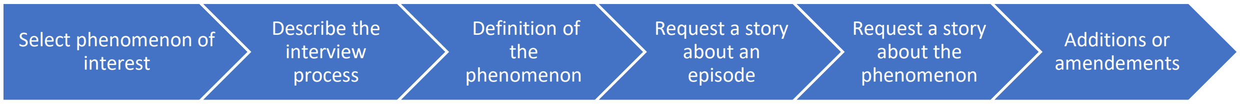
Data Collection

I collected my data using episodic narrative interviewing (Mueller, 2019). Episodic narrative interviewing is a fusion of several different qualitative data collection approaches and draws upon narrative inquiry, episodic interviewing, and semi-structured interviewing. Mueller (2019) defines the episodic narrative interview as an “approach that is used to encourage research participants to convey bounded stories about their experiences of particular phenomena” (p. 2). The episodic narrative interview is structured according to the experience-centered narrative style. These are narratives that are sequential and human, display change or transformation, and re-present and express experiences (Squire, 2013). The episodic narrative interview retains foundational elements of narrative inquiry such as collecting stories to understand and make meaning of individual experiences. However, rather than situating the story as the unit of study, episodic narrative interviewing is designed to elicit stories about a particular phenomenon of interest. The central focus in an episodic narrative interview is a specific experience in a person's life. Consistent with this hybrid approach, I asked participants to share stories focused on their experience of being diagnosed with a STI.

The protocol for conducting an episodic narrative interview took place in six phases shown in Figure 1 and as suggested by Mueller (2019), with minor modifications. Prior to finalizing the interview protocol, I completed one pilot cognitive interview as suggested by Mueller (2019). There were no significant revisions to the interview protocol following the pilot interview.

Figure 1

Episodic Narrative Interview Process



The first step for conducting an episodic narrative interview is identifying a phenomenon of interest. The phenomenon of interest for the current study was Black women's experiences of resiliency after being diagnosed with an STI. Following the identification of the phenomenon of interest is the development of the interview protocol (see Appendix E). According to Mueller (2019), the interview protocol for the episodic narrative interview should start with a description of the interview process. Once participants were briefed on the style of the interview, I asked three opening questions to set the climate, help me learn more about the participant, and to help the participant practice telling stories. I asked the following questions: When do you feel you feel you are at your best holistically, meaning spiritually, mentally, physically, and emotionally? What do you love the most about your body and why? Please tell me a story about why you decided to participate in this study. This can include how you found out about the study and any particular reasons you wanted to participate.

Next, Mueller suggests the researcher provide an invitation for the participant to provide insight on the phenomenon of interest by defining it or describing it. Participants were asked to define what resilience meant to them. After this, Mueller recommends the researcher to solicit a story of an episode which is a specific incidence or occurrence related to the phenomenon of interest. This solicitation should be a broad request that creates space and freedom for the participant to locate a story that they feel is the most pertinent. At this point in the interview, I asked participants to tell me a story about messages they received about their body, sex, or sexuality when they were growing up.

The interview then proceeds like a funnel in which participants are invited to share another story about their individual experiences of the phenomenon within the context of the episode they just described. In this phase of the interview, I asked participants to tell the story about when they were diagnosed with an STI and the events and experiences that followed their diagnosis. To conclude the interview, participants were provided an opportunity to revise or add to any of the stories they had shared. I also revisited their definition of resilience and provided space for the participants to reflect on what it meant for them to be resilient following the infection.

In many of the interviews, I deviated from the interview protocol to be consistent with the participants' style of storytelling. For example, when responding to the opening prompt: "Tell me a story about why you decided to participate in this study?", some participants immediately told the story of the episode when they were diagnosed with an STI. When conducting the episodic narrative interview, there should be minimal interjection from the researcher (Meuller, 2019), so as participants narrated their stories, there was minimal interruption from me. I intermittently posed prompts and probed for additional information during natural pauses in the stories, particularly when participants encountered challenges in sharing their experiences or when more information was needed. If they started in the "middle" of the story, as in the example above, I still made sure that I asked the women to tell me stories about the "beginning".

A key component in retelling participant stories and as suggested by the analytic approach is inviting collaboration with participants (Mishler, 1986; Nasheeda et al., 2019). To do this, I held a second interview with each woman, again at a time and place of her choice. This interview focused on reviewing my assembling of their information into a chronological story (examples of these are in Appendix I). I also presented them with a visual version of the restoried narrative in the form of a journey map. Examples can be found in Appendix H.

Data Collection Procedures

Interviews were either completed in person at the Psychology Building on the campus of Michigan State University (n=7), online via zoom (n =7), or in-person at the Michigan State University Detroit Center (n =2). Upon arrival at the interview location, participants were greeted, taken to the private space, and then the consenting process began. Online participants were provided with a copy of the consent form via email prior to the start of their interview. During the consenting process for both interview formats, I verbally went over the form emphasizing the confidentiality of the interview. I also reminded the participants that they could take a break at any time, decline to answer any questions, and decide to stop the interview at any point. Once the participants indicated that they understood the information in the consent form, I asked them to sign the consent form. Participants who completed the interview via Zoom provided verbal consent as well as an e-signed copy of the consent form. I also asked each participant to provide written and verbal consent for the interview to be audio recorded. Participants were asked to adhere to the COVID-19 safety and masking protocols of the interview location.

The interviews conducted in person were recorded using a hand recorder. The interviews completed via Zoom were recorded using the integrated recording software on that platform. The Zoom interviews were recorded with audio and video, but the video recordings were immediately deleted. At the end of the interview, each participant was compensated $50 in cash or in an e-gift card for their participation and scheduled for a follow up interview. Follow-up cocreation interviews were part of the data analytic process and completed no more than 30 days after the first interview. Participants were also compensated $50 for their participation in the second interview. All interview audio recordings were saved on a secure server and uploaded to Rev for transcription. On average, the episodic interviews were about 1 hour and 12 minutes long. The longest interview was 1 hour and 31 minutes. The average length of the cocreation interviews was 34 minutes.

Ethical Considerations

Ethical considerations informed by the sensitive nature of the research topic guided the research. As with any research study, ethical concerns associated with privacy, confidentiality, anonymity, harm, risk, honesty, and trust, as well as the costs and benefits for participants were all important considerations. The information shared in the participant narratives revealed sensitive information about the participants' lives and also personal information about the people they discussed in their stories. All identifiable information was removed from the transcripts. Pseudonyms are used to present the results. The consent form (see Appendix C) details additional information about how privacy, anonymity, and confidentiality were upheld for the participants.

Some participants had strong emotional reactions during the interviews. When this happened, my priority was ensuring that I responded in a way that minimized harm. I paused the interviews, offered tissue (when in person), and consoled the participant. I encouraged them to resume the interview whenever they felt emotionally ready to proceed. I also offered participants a guide with a list of local resources that could support the participants in continuing to have healthy sexual futures and holistic well-being (e.g., therapy, fitness centers). When women made incorrect assertions regarding different sexual health matters during the interviews (e.g., how HSV 2 is transmitted), I provided them with accurate information and provided references to facilitate further learning. I also followed up with some women via email to provide additional resources.

Data Analysis

Research situated within the narrative inquiry paradigm follows one of two approaches: analysis of narratives or narrative analysis (Kim, 2016). The current study integrated both approaches. Narrative analysis is focused on analyzing the story and the way it is told or put together (Kim, 2016). On the other hand, the analysis of narratives places emphasis on the content of the story (Kim, 2016). Using an integration of both approaches allowed me to answer the research questions by analyzing data within and across each participant's story. The data were analyzed using a multimethod approach that included the analysis of narratives and structural narrative analysis. Traditionally, narrative research focuses on within-case analyses, with little emphasis on how to analyze narratives across cases (Ayres et al., 2003). Ollerenshaw & Creswell (2002), posit the approach to data analysis in narrative inquiry depends upon the goals of the study as well as the preference of the researcher. The aims of the study required a multimethod analytic approach that made sense of each women's individual story as well as compared across stories to outline commonalities in the mechanisms that facilitated the participants' resilience.

The analytic sequence used in this study entails within and across case analysis. The within case analysis relied on restorying and cocreating the story with each participant. Cross-case analysis was performed using structural analysis. Restorying is a narrative data analytic process that focuses on retelling a story based upon data that is presented in the interview transcripts (Ollerenshaw & Creswell, 2002). Although there are many advantages to restorying, within the context of a Black Feminist study restorying helps to retain Black women's core experiences in a way that cannot be done by segmenting the story (Iyengar, 2014). Restorying preserves Black women's narratives and situates Black women as co-researchers and knowledge producers. The restorying component of data analysis was informed by Nasheeda et al's (2019) multimethod restorying framework. This framework is comprised of elements from structural analysis, holistic content reading and elements of the story. There are four phases in this framework: 1) familiarizing with the transcripts, 2) storying the transcript 3) cocreating and 4) meaning making. Table 2 details that analytic process.

Table 2

Outline of Analytic Process

Phase	Method
1. Familiarization with the transcript	• Holistic content reading
2. Storying the transcript	• Sequence the narrative by placing events in chronological order • Develop the chronological plot by identifying main characters, when and where the sequenced events took place, and how the participant positions themselves in the story • Develop a rough draft of the story using the information sequenced and the chronological plot
3. Cocreation	• Follow-up interview • Present draft story to the participant • Revise transcript
4. Structural analysis	• Theorization across narratives • Identify the six elements of a narrative in each transcript. • Place examples of each element in the matrix for display • Identify recurrences examples and similarities within elements

Although data analysis was informed by Nasheeda et al's. (2019) framework, the analytic process unfolded iteratively. During the transcript familiarization phase, I cleaned the transcripts by checking them against the interview audio. I also engaged in holistic content reading. While in this phase, my goal was to gain a comprehensive understanding of the content in each participant's interview. I made note of key elements in each story such as the individuals involved (who), the events and experiences described (what), and the contexts in which these took place (where) (Beal, 2013) in a separate word document and excel spreadsheet.

Documenting these elements early on was useful for the subsequent structural analysis that occurred in the meaning making phase.

Next, I proceeded to the third phase of analysis and restoried the transcript. I began the restorying process by sequencing narratives from the transcript. Sequencing chronicles the participant's story and lists the events of the story in chronological order. After this, I used the information I sequenced to create a chronological plot which is "a thematic thread to lay out happenings as parts of an unfolding movement that culminates in an outcome" (Polkinghorne, 1995 p. 5). From here, I used the sequenced information and chronological plot to create a cohesive narrative based upon the different stories and episodes women shared during the interview. I played an important role in ensuring each participant narrative had a well-defined structure with a clear start and end point. The stories and episodes shared during the interview were restoried to develop a narrative reflective of each person's trajectory of resilience. Once drafts of the narratives were completed, I proceeded with the cocreation phase of the analytic process.

Each participant was emailed a copy of their story prior to the start of their second interview. Some participants provided feedback on the story via email while others waited until the meeting to share their comments. The cocreation interviews served several purposes. First, they were implemented to ensure the story accurately reflected the participant's voice and experience. They were also used to probe for additional information to fill gaps in the stories. As I was reflexively journaling about the second cocreation interview, I realized this approach was not generating any new substantive information for the stories or engaging participants as active collaborators in the storying process as I intended. I believe this was because the questions on the initial cocreation interview protocol were related to accuracy of the story and did not get deep enough into reflective evaluations of the story. So, I revised the cocreation interview protocol to gain deeper insights into the participants' self-perception of resilience within their narratives. I also presented participants with journey maps to draw upon and provide insight. My training in community psychology coupled with the Black Feminist framing guiding the study heightened my awareness to my responsibility to ensure that I considered the power imbalance that exists between me and the participants. I actively encouraged participants to engage in a collaborative process, inviting them to select a pseudonym, and co-write the introduction and subtitles for their respective stories.

I repeated the cocreation process for each participant. After each cocreation interview, I created the final version of the story by integrating the new information gleaned from the cocreation interview. The stories presented in Appendix I represent the outcome of the restorying analysis and are also an essential component of the subsequent analytic process. The creative and flexible nature of narrative inquiry provides a variety of options for presenting participant narratives (McAlpine, 2016). To honor the Black Feminist Thought principle of Black women having a "self-defined voice" (Collins, 1998), the narratives are told in first person from the perspective of the participant to remain as close to their voices as possible. The narratives also include a significant amount of the participants' verbatim words from the interview transcripts. Using verbatim language from the interviews was also done to preserve and privilege each participant's voice.

The final component of the analytic process was a structural analysis. The goal of the structural analysis is to attend to the structural makeup of the story. More specifically, structural analysis delves into how a story is told and organized. In other words, it places a greater emphasis on the telling rather than what is being told. Another benefit of structural analysis is that it allows for theorization across narratives (Garcia Rodriguez, 2016), which is its primary use in the current study. The following example employed in Riessman (2008), reflects the utility of using structural analysis to compare across interviews:

> "In a case comparison, I contrasted the structure of Gloria's account with two others in the divorce sample, who also lived with a spouse's long-term infidelity. For these participants (both men), the spouse's long-term infidelity did not seem to be a source of suffering; other events appeared to be more important. Case comparison here shows how close attention to story structure can yield different findings than a thematic analysis would. Although each of the three storytellers mentioned infidelity as a "reason," and used a similar set of narrative structures to develop their accounts (orientation, complicating action, evaluation, etc.) they combined the elements in different ways because they had very different points to make. I analyzed linguistic choices— *how* the speakers composed their tales not, simply what they said about the relationship between infidelity and divorce. If I had relied only on thematic coding of the stories, and ignored sequence and narrative structure, I would have missed important differences and the meaning of the "same" event for different participants. Thematic narrative analysis assumes that the accounts of individuals in a group resemble each other because the accounts are organized around the same theme. By combining the thematic and structural analysis of divorce stories, I was able to describe broad patterns (thematic similarities across the sample) but also variation in meanings for individuals. Infidelity was not an objective event but if phenomenologically different experience." (p. 89-90)

Initially, I intended to complete the structural narrative analysis by identifying the six elements that fully form a narrative across each transcript. The six elements, as described by Riessman (2008), include the abstract (story summary or objective); orientation (setting, characters, time place); complicating action (turning point); evaluation (storyteller shares deeper meaning or comments on the story); resolution (outcome); and coda (story ending and return to present) (Riessman, 2008). I began coding the transcripts in NVivo by assigning the elements of narrative to the corresponding components in the interview transcripts. As I started to notice other important parts of the participant narratives that did not align with any of the elements that fully form a narrative, I began questioning whether the participants' stories conformed to the standard narrative structure. I began to search for other forms of narrative analysis and drew upon Daiute's (2014) plot analysis approach. In contrast to Labovian analysis, which primarily emphasizes the linear progression of the six elements of narrative (Patterson, 2013), plot analysis takes into account the diverse ways in which a story may unfold.

Plot analysis is a form of structural analysis that examines characters, initiating action (first event or action that drives the story plot), complicating action (action that develops from the initiating action), the highpoint or climax (the arc of the story where the main character experiences a major conflict), resolution strategies (attempts to resolve the conflict from the high point), and coda (story ending and a reflection on the story) (Daiute, 2014). Plot analysis does not account for the storyteller's explicit commentary or reflection throughout the storytelling. Therefore, I retained an examination of evaluation as a part of the structural analysis to better account for the subjective and reflective aspects that contribute to a more comprehensive understanding of the narrative. This combination of approaches to structural analysis seemed to fit the data well, so I continued to identify and label the narrative elements in each interview transcript accordingly. As I coded each transcript, I also made note of similarities and differences within the narrative elements across participant interviews.

This part of the analysis facilitated a rich understanding of where and how women's stories converged and diverged. Moreover, this approach provided valuable insight into the various events and experiences that shaped women's sexuality and contributed to vulnerabilities to which they ultimately were resilient. The structural analysis yielded a deeper understanding of how women displayed resilience and identifies the influential factors that helped them to do so. Overall, this final phase of data analysis shed light on the complex dynamics that impacted women's journeys, both negatively and positively. It also illuminated how women adapted and navigated some of the challenges they experienced. The results of the structural analysis are presented in the next chapter.

Data Quality

Miles, Huberman, and Saladaña (2020) suggest that qualitative research usually lends itself to quality checks of the data rather than confirming and verifying the data. They outline 13 tactics for increasing confidence in the data. I relied on two tactics suggested by Miles, Huberman and Saladaña (2020), to assess the data quality: checking for researcher effects and getting feedback from participants. As noted earlier in this section, researcher subjectivity is an inherent aspect of qualitative research, making it impossible to remove my influence from the study. However, Maxwell (2013), indicated that it is important to explain possible biases and identify techniques to address them. To minimize researcher effects, I made my intentions about the study clear for participants to mitigate any biases or assumptions that my position as a researcher may have imposed on the participant (e.g., social desirability bias). Another strategy was to allow the participant to choose the location for the interview which may have reduced my "threat quotient and exoticism" (Miles, Huberman & Saladaña, 2020 p. 292) as a researcher. The cocreation interview was a form of member checking, which can be described as "a process of systematically soliciting feedback about your data and conclusions from the people you are studying" (Maxwell, 2013 p. 126). Member checking was ongoing throughout the duration of the study. Participants reviewed and revised a rough draft of their story during the cocreation interview. They reviewed the final drafts of their story, and I welcomed their feedback. I understand that receiving the entire dissertation can be overwhelming, yet I offered to send final drafts of the dissertation if they were interested. At the time of this writing, I have not received any requests for a full draft of the dissertation.

Quality of Results

Another important step in the analytic process was to consider how to establish quality of the conclusions. This involves issues of confirmability and dependability. In the following section, I explain the precautions I took to account for each of these issues.

Confirmability

Confirmability is concerned with the general neutrality of the study and acknowledgement of any potential biases that may exist on the part of the researcher (Miles et al., 2018). To meet this requirement, I presented a positionality statement at the beginning of this chapter which explicitly details my personal assumptions, values, and beliefs and how they may impact the study. Through this statement, I brought attention to any potential researcher bias, such as my socialization to sexuality, that might have affected the confirmability of the study. Furthermore, I explicitly detailed the study methods and procedures, such that readers can follow them. I also kept a detailed journal to keep track and reflect on any potential biases or other concerns that arose throughout the data collection and analytic process (Meyer & Willis, 2019). These journal entries captured my raw thoughts and feelings after each interview, as well as any other thoughts, questions, and reflections that arose throughout the dissertation process. As I analyzed the data, I often returned to my journal to reflect on my perspective and ensure that the findings I presented in the structural analysis were the meanings participants attached to their stories, not my own (Morrow, 2005; Ortlipp, 2008). I developed an iterative process in which I used my journal entry as a guide to look for places in the data where my biases or expectations were likely to shape my interpretation of the data because of my personal experiences or beliefs. As I cycled back and forth between what I wrote in my journal and preliminary interpretations of the data, I was able to identify and address areas in the analysis where my assumptions may have more heavily impacted the analysis.

Dependability

I established dependability through consistency in my data collection procedures and coding strategies. I kept detailed notes on the analytic process to keep track of my thoughts and decisions as I analyzed the data. I also had a specific journal to bring awareness to any biases, concerns, and uncertainties that arose during the data collection process. I wrote detailed journal entries to capture my initial thoughts, emotions, and reactions following each participant interview. I found the notes on the analytic process as well as my after-interview journal helpful for drafting the participant narratives and theorizing across stories. In addition, both of these practices facilitated ongoing reflexivity throughout the duration of the study which helped me to better interpret the data (Meyer & Willis, 2019; Riessman, 2008).

Chapter 3: Results

The results of this dissertation are divided into two major parts. In the first part, I briefly present each of the women who were in the study. A full version of their stories is in Appendix I. Then I present the results of the structural analysis.

Part I: Participant Profiles

As previously noted, there is great variation in the analysis and presentation of narrative findings (Beal, 2013; McAlpine, 2016). Since the complete participant stories are presented in the Appendix, it is important to include information to contextualize each participant before presenting the findings of the structural narrative analysis. Doing this facilitates a deeper understanding of the findings presented in the next chapter. In addition, these participant profiles are presented to remain consistent with narrative inquiry methods that emphasize the importance of representing the participant in social and historical context (Josselson & Hammack, 2021). The profiles are presented in the order that the interviews were completed, which may also permit the reader to see my growth as an interviewer across the data collection process. It may be helpful for readers to refer to these profiles or the stories in the Appendix to provide more context as they read the results.

Naomi

Naomi is a 37-year-old successful business owner. She grew up in a strict Christian household in which discussion about sex focused on purity and the consequences of premarital sex, which left her more curious. Once she got to high school, she felt her “churchy” background made her an outcast. She wanted to fit in. She hoped having sex would connect her with her peers but found herself being misunderstood and pitied instead. After high school, she moved to escape a relationship. Shortly after, she found herself in another sexual relationship. During a visit to the doctor to confirm a pregnancy she learned that she was pregnant and tested positive for chlamydia. She was 19 at the time. This experience prompted Naomi to reevaluate her choices and prioritize her health and the well-being of her child. She became more cautious and selective in her relationships, realizing the importance of protecting herself and her child. As she reflected on her journey, Naomi attributed her curiosity to the lack of open discussion about sex during her upbringing. This motivated her to create a more open and comfortable space for her daughters to communicate with her, especially about matters concerning sexuality.

Kathleen

Kathleen is a 62-year-old mother of two daughters and one son and a grandmother. Growing up, her parents ensured that her and her siblings' needs were met. However, her father's death when she was 14 years old left a void in her life, which she attempted to fill with attention and love from boys and men. Not long after the time of her father's death, Kathleen learned she was pregnant, and her mother insisted on an abortion. Prior to this, her mother had provided minimal guidance on topics such as reproductive health or sexuality, leaving Kathleen feeling uninformed and unable to ask questions. As she continued to try to fill the void left by her father, she often found herself in casual sexual encounters. At the age of 19, Kathleen contracted an STI for the first time. After a few other experiences with STIs, Kathleen realized she needed to change. She became more discerning in her choice of sexual partners and started to prioritize her own well-being. She no longer sought validation through sexual relationships. Because of her experiences, Kathleen makes it a priority to have open and honest conversations about sex with her children and grandchildren. She believes that providing them with knowledge and awareness from an early age will help them make better choices.

Kasey

Kasey is a 36-year-old mother of three daughters. The women in her family instilled values of cleanliness and femininity. However, her family's teachings on sexual health were limited, leaving Kasey with a lot of questions. As she got older and learned about sex from external influences like her peers, she had questions, but was adamant about waiting until marriage to have sex. She married the father of her children when she was a teenager and later realized he manipulated her into having sex by promising her marriage. She eventually left that marriage but found herself in a relationship with a partner who was unfaithful, which she learned when she contracted chlamydia. Having chlamydia motivated Kasey to become more vigilant about her sexual health. Kasey felt disadvantaged in her sexual experiences and her ability to navigate relationships because of her lack of knowledge. She did not want the same experience for her daughters, so she provided them with knowledge and prepared them to counter negative influences. Kasey has not only become an advocate for herself and her children, but she also encourages and empowers other women to make informed decisions about their health.

Diamond

Diamond is a wife, mother, daughter, and women's health worker in her 30s. She was raised by her mom, who had her first child at 14. Her mom did not talk about her teenage pregnancy often, but she had strict rules regarding dating and sex. When Diamond got to middle school, she realized how sheltered and uninformed she was. When her friends discussed sexual topics, she knew nothing about them. In high school, she was able to negotiate with her mother to start dating. She became sexually active with her boyfriend after she was older than 14 because she did not want to repeat her mother's situation. Diamond learned her boyfriend had been cheating, which sparked a fear in her about contracting an STI. Diamond entered a new relationship once she got to college and remained in the relationship until she graduated. However, this partner was not monogamous. While in this relationship she contracted trichomoniasis and had a genital wart. She felt disgusted, betrayed, and ashamed, but found solace in a supportive friend and participating in the Vagina Monologues. The monologues helped her to heal and redefine her perception of sex. She became extremely cautious about her sexual choices taking a 2-year hiatus from dating. When she resumed dating, she entered a fulfilling and healthy relationship with her now husband.

Madison

Madison is a 26-year-old biracial woman who is just learning to love and embrace her body. She struggled with body shame from an early age which was only exacerbated by her only onset of puberty. When she started her period, she did not understand what it meant, and she felt unsupported by her mother because she had never talked to her about anything concerning sexuality or reproductive health. Madison was raised in a Catholic household, so she embraced the idea of chastity, especially in high school when others were having sex and she was not. She tied her worth to her virginity. Once she got to college, her perspective on sex shifted as she became more influenced by societal expectations and media portrayals of college life. She finally felt prepared to have sex. Shortly after, she experienced sexual assault, which she tried to cope with by becoming hypersexual. She also immersed herself in education, learning about sexual assault, gender-based violence, and intersectionality. Despite her newfound knowledge, she still faced instances of assault, which she believes resulted in her contracting HSV 2. The diagnosis plunged her into a depression as she internalized societal messages concerning STIs. As she tried to move through her depression, Madison embraced spirituality and practices like dieting and mindfulness. She also found solidarity when a friend confided in her about their diagnosis. Since her diagnosis, Madison has been intentional about prioritizing her sexual and reproductive health by getting tested for STIs routinely and staying up to date on pap smears. Madison understands how different systemic factors contributed to her vulnerability and encourages open and honest conversations to foster her resilience.

Taylor

Taylor is a 43-year-old mother of two. It was not until she turned 38 that she realized she did not know who she was. She spent a lot of her upbringing feeling insecure about her "thick" physique. Despite the way she struggled with self-appearance, she did not seek validation through sexual attention from boys. Her mother had given her warnings not to trust men, which shaped her perspective on relationships. Her mother had also instilled a fear of sex in Taylor. Throughout high school, Taylor was adamant about not having penetrative sex. Once she got to college, she fell in love and lost her virginity. They got married and she quickly got pregnant because she was not on birth control due to some of the negative things her mother had said about women who are on birth control. After the divorce, Taylor explored her sexuality. She rejected societal judgement and engaged in multiple sexual encounters. Taylor believes that she contracted gonorrhea and chlamydia from one of these encounters, although she was in a relationship at the time of her diagnosis. Following this experience, Taylor became hyperaware of her sexual health, prioritizing condom use and routine STI testing in subsequent relationships. She reflects on her journey as a lesson learned and has tried to provide her daughters with a different perspective from the one, she experienced growing up.

Kennedy

At the time of the interview, Kennedy was a 28-year-old mother of three. She grew up in a household with minimal sex education. Kennedy's mom put her on birth control when she was

13 or 14 years old because she did not want Kennedy to be pregnant at 16 like she had been. Once Kennedy got to high school, peer pressure influenced her to engage in her first sexual experience, which left her feeling unfulfilled and betrayed when her best friend also became involved with the same boy. After this, she did not have sex again until college, so she felt inexperienced. She went down a path of engaging in casual sexual encounters trying to have an experience similar to what she observed in pornography. Once Kennedy returned from college, she got into a relationship and had her first child. This relationship occurred at a tumultuous time because shortly after she left the relationship, she discovered he had cheated on her, and she found out she was pregnant. Kennedy relied heavily on her mother and sister as she navigated being a single new mom. It was not until last year that Kennedy was diagnosed with an STI for the first time. She suspected her boyfriend was cheating and it was confirmed he was when she tested positive for chlamydia and gonorrhea. This experience left Kennedy feeling hurt and embarrassed, further restricting her ability to trust in romantic relationships. She remained in the relationship for a little while longer, but she required them to use condoms. She also started therapy around this time. Kennedy and her boyfriend are now broken up and she has established new boundaries for future sexual encounters. She is also determined to provide a better future for her children and is committed to ensuring they are educated and supported on their sexuality journeys.

Jazmine

Jazmine is a 25-year-old mother of two. Although she grew up in a loving environment, she lacked proper guidance and information about sex. Her curiosity about sex piqued when she got to high school because of peer pressure and the influence of her friends who were already sexually active. She decided to have sex at the age of 15 with her boyfriend at the time. Her first sexual experience did not align with what she had been told by her peers, but she continued having sex, primarily relying on her boyfriend to provide condoms for protection. As she shared her story, she expressed regret at not having an adult to educate her about protective sexual practices and having to rely on her friends and classmates for information. After high school, Jazmine entered a new relationship in which she contracted chlamydia and gonorrhea. This led to the painful realization that her boyfriend had been unfaithful. The aftermath of the diagnosis was a period of self-reflection and caution, during which Jazmin prioritized her sexual health. She emphasizes the importance of open communication and education about STIs, highlighting the need for more discussion within the household to help young people make better decisions.

Candace

Candace is a 26-year-old gay Black woman. From a young age, she knew she was not straight, having kissed girls as early as fourth grade. Candace's parents never talked to her about sex, but what her friend in middle school shared about the first time she had sex made it seem unappealing to Candace. Once she got to high school, Candace confided in her older cousin about her sexual identity. Her cousins suggested Candace just needed more experiences with guys. Candace acted on this advice, entered a relationship with one of her cousin's friends, and she had sex for the first time. In college, Candace fully embraced her sexuality, seeking to gain experiences she missed out on in high school. This approach to exploring her sexuality led to several instances of contracting STIs, but after the first one, she learned how to handle them better. She now puts measures in place to prioritize her sexual health and while also exploring her sexual desires and fantasies.

Lashawn

Lashawn is a 48-year-old mother of three adult children and has one granddaughter. Though Lashawn's mother was strict when she was growing up, she did not provide Lashawn with the guidance and attention she needed. Lashawn was influenced by what she observed in her surroundings and became sexually active at the age of 13. Since her mom did not talk to her about sex and relationships, Lashawn had to learn on her own. Luckily, she had her uncle and Godmother to provide her with some guidance when she became pregnant at 17. She tried to be more cautious in her relationships; however, during another pregnancy, she discovered she had contracted trichomoniasis from her child's father. This revelation devasted her, but luckily, she had the support of a caring and compassionate Black woman doctor. Motivated by her responsibility to raise her children, Lashawn became involved with local churches and received assistance from them. She became more cautious in her romantic and sexual relationships, prioritizing protection. Most of all, she was focused on her role as a mother. Lashawn was determined to be a better parent than her own. She made conscious decisions to protect her daughters and to be an example for them.

Kese

Kese is a 47-year-old mother of one and an active leader in her community. She grew up with a mother who candidly educated her about life, including sexual matters. Kese did not get the chance to make decisions about sex for herself because she was raped when she was younger. She hid the assault for a while before eventually telling her mother. Kese felt justice was never served, and the experience left her feeling ashamed and detached from her body. When she was 17, she fell for a guy who only wanted her for sex. Months later, she discovered she was pregnant and learned she had trichomoniasis, which added more confusion and fear. She was left to raise her child alone, but she found strength through her son, the support of her mother, and a group of single mothers. Kese is still trying to overcome her pain and find the courage to trust and love again.

Monique

Monique is a 25-year-old new mom. She grew up without proper guidance on sex and relationships. Monique’s mom had her at a young age and tried to protect her from anything related to sex. She could not be friends with boys, so Monique wound up exploring her sexuality with girls. Up until she was about 20, Monique only dated women. When she started dating men, she contracted an STI. This experience significantly damaged her self-confidence and her trust. After this she entered new sexual relationships guarded but insistent on using condoms. It was not until Monique began dating her husband that she learned to trust again, although some of the emotional scars remain. Monique views her story as a lesson learned and wants to ensure that her son does not have to learn the same lessons in the ways she did.

Bou

Bou was raised in a strict African household and conversations about topics related to sex were not discussed. When Bou entered middle school, she learned more about sex because her classmates were sexually active, and some were even pregnant. Once Bou entered high school and started attending an early college program, she had a lot more freedom to explore her sexuality. Bou did not realize how uninformed she was until she consulted a friend after her first sexual encounter. Her friend encouraged her to get tested and while at the doctor, Bou finally got in depth and accurate sex education. After this she made sure she regularly tested for STIs and used condoms consistently. Despite the precautions she took, Bou contracted chlamydia from her boyfriend who was unfaithful. Bou felt betrayed embarrassed and dirty about her diagnosis. She went through a period where it was difficult for her to have sex again because she feared contracting another STI. She also started getting tested for STIs excessively. Bou found some solace about her diagnosis by talking about her experience with her friends and other Black women. She says they have been her “safety net” which has helped her to move past the situation. Bou also established new boundaries for future romantic partners to ensure that she can still have fun and enjoyable sexual experiences.

Leslie

Leslie is a 35-year-old mother of three. The parents who raised her adopted her when she was about 2 years old. She grew up with a mother and a father, but she reported neither of them discussed sex with her. Leslie was raped when she was 12 and then continued to have sex. Since no one talked to her about sex, she was trying to figure things out on her own. She feels this led to a lot of heartbreak. Leslie was diagnosed with a STI for the first time when she was 18; he repeatedly exposed her to infections. The turning point in Leslie’s story came when she was diagnosed with a STI a couple of years ago while she was pregnant. She did not confront him or tell anyone about the infection, but she decided she needed to practice abstinence because she believes it would help her make better decisions overall. Over the past few years, she has been intentional about making changes to get better outcomes in her relationships.

Destiny

Destiny is a 23-year-old fiancé and mother of one. Despite her mother’s positive affirmations, Destiny struggled with low-self-esteem and feeling unworthy for a significant amount of her life. Her mother taught her that her body was sacred, but Destiny had difficulty seeing herself as valued since her father abandoned her. Instead, she searched for validation from men through a series of casual sexual encounters. In one of these encounters, she became pregnant with her daughter. She learned she tested positive and had been treated for trichomoniasis when she was discharged from the hospital with her daughter. Becoming a mother was a pivotal point in Destiny's story. She wanted to be a positive role model for her daughter, so she abstained from sex and focused on being a mother. When she started engaging in sex again, she made sure she educated herself and used condoms. Now, Destiny is engaged, and her fiancé and his family have been instrumental in helping her improve her self-esteem.

NikAsia

NikAsia is a 37-year-old mother of four. She remembers being sexualized because of her shape as young as 12 years old. She felt she needed to "work" her body because she was not pretty. She waited before having sex. Her parents had a conversation with her about sex before she started her menstrual cycle. She thought sex would hurt, so she waited to have sex until she was 18 even though her friends were sexually active. When she first started having sex, she was insistent on condom use, but as she got older, she relaxed her standards because she attempted to solidify relationships through sex. At age 35, she was diagnosed with HSV 2. She was initially embarrassed and apprehensive about sharing her diagnosis, but she decided to confide in a friend and her cousin who offered her reassurance and encouragement. NikAsia acknowledges some of her behaviors made her susceptible to the infection. To her, acknowledging her role is empowering. She is grateful because she understands things could have been worse. She is practicing abstinence to protect herself and others. She plans to continue moving forward by educating herself so she can help others who may be in situations similar to hers.

Part II: Structural Analysis Results

In the first two sections of this segment of the results, I provide a summary overview of the dominant patterns that begin the participants' stories. These aspects of women's stories provide insight on the vulnerabilities that positioned women to contract an STI. Next, I unpack the setting and high point/climax of the narratives, which is the story of the episode when women learned of their infection. Following this, I discuss the resolution strategies the participants employed in response to their diagnoses. I draw attention to the characters that contributed to the resolution, illustrating the role of the interpersonal level of analysis in the narratives, by highlighting the role of people who contributed to the resolution of the STI episode. I then explore the coda and how participants end their stories. I close by highlighting women's reflections on their participation in the study, which provides insight on the value of storytelling.

An Overview

This section discusses the narrative storylines that lead to participants being diagnosed with a STI. Many of the women began their stories in childhood or adolescence, describing what they understood about sex, sexuality, and their bodies at that period of time. Each of the women's beginnings highlighted the roles their family and important institutions in their community played in setting them on a path toward vulnerability.

Initiating Action—Learning About Sex

Most participants' narratives focused in some way on how little they learned about sex as young girls and adolescent women. Limited discussion or complete silence characterized most participants' descriptions of this phase of their lives. In the cases where there was a discussion about sex, it often occurred in formal manner via sex education in school, or informally through peers, friends, and family.

When women were asked to tell a story about messages they received about sex, their stories often centered on parental silence. Naomi, for instance, explained how the messages she received about sex early in her life came from the church and not from her parents:

> “I come from a strict, Christian, churchy background and so our messaging around sex was always, um, purity. And so, like, growing up, I was a part of a purity class at church and at the end we had the ceremony. Everybody wore their white dresses. We took the vow we wouldn't have sex until marriage, blah, blah, blah. That was cute, but I mean, there were people—not me at the time—but there were people like in the group, like they was having sex with each other and getting their award every year.”

Naomi said she was about 13 or 14 years old when she took this class. Since she was taught that she was to wait until she was married to have sex, she also believed that it was not appropriate for her to ask the questions she had about sex. So, she did not.

Other participants shared that they had little to no conversation about sex with their mothers. Participants emphasized their mothers’ silence on the topic of sex. When there was a conversation about sex, mothers simply directed their daughters not to have it. Consider Taylor for example, whose mother told her “You better not be out here fucking.” Taylor came away from conversations with her mother with beliefs such as birth control was only for “whores,” which ultimately set Taylor up for experience pregnancy as a teenager.

Almost all of the other women had similar experiences to Naomi and Taylor in which their parents neglected to educate them adequately about sex or relationships with men. It was common among the women who reported this experience to feel like they could not ask questions or go to their parents for advice on relationships or sex. Kathleen (62 years of age) and Kasey (36 years of age) attributed their inability to ask questions about sex to the generational context they grew up in. “Cuz you know, like I come from a era where you not, you don't question adults. And so, whatever they say is what, what they say and you can get in trouble for like asking more,” said Kasey as she explained that she learned more about sex from adults outside of her family as she grew older. The story was slightly different for those younger women who also reported an inability to discuss sex with the adults in their household. Kennedy (28 years of age) and Jazmine (25 years of age) both ascribed their hesitancy to have a conversation about sex with their mothers to the relationship dynamic with their mothers. Jazmine stated, “my mom isn't the type of person where I can go and talk to her about that stuff.” Regardless of the reasons, the impact of not being able to have these conversations with their parents had a profound impact on the women’s sexual encounters and romantic relationships.

Quite a few of the narratives included a story in which the participant described learning about sex through their peers or friends. Since most of the women experienced silence at home regarding sex, what their peers shared with them was often their only source of information about sex. Candace is one of the many participants who lacked parental guidance on sex. She vividly recalled some of her earliest conversations about sex being those she had with her friends at school:

> “It was like in middle school cuz like nobody around me had sex until middle school. And so, when my friend came back one day and was like, ‘I lost my virginity, guys’ and like we were talking about and everything and I don't know, even just listening to that just sounded so unpleasant.”

Candace’s conversations with her friends established the baseline for her understanding of sex. She continued her story by sharing that the friend mentioned in the quote above was the only person she knew who had sex and openly talked about it. Consequently, Candace developed her understanding of how her first sexual experience should happen based solely upon her friend’s experience. Candace and the other participants whose understanding of sex were predominantly influenced by their peers and friends, later found themselves having to piece together the fragmented information they had about sex as they attempted to maneuver sexual experiences and relationships.

Almost all of the participants recounted having some degree of formal sex education in school. Women most frequently recalled sex education being offered in the latter years of middle school or in high school. Some women said formal sex education provided to them in school emphasized the importance of always using protection and the possibilities of acquiring STIs. Others said their sex education was not robust or informative. When reflecting on the sex education she received, Bou stated:

> “We had the gym teacher who would be like the health teacher. They would sit us in the classroom and, I mean, we had the books. And they would say ‘Alright everybody. Pick up a book. Go to this chapter.’ But nobody was listening. The teacher couldn't teach. As soon as you said one sexual term, everybody in the class lost it. Like, I vividly remember those classes was a joke. Like nobody took it seriously. Nobody learned anything.”

Here, Bou points to the inadequacy and shortcomings of her sex education experience in high school. Even if Bou wanted to take advantage of the sex education she was being offered, the atmosphere of the class prevented her from doing so. Another participant, Madison, described her sex education as “goofy” and “not helpful.”

There were striking similarities in several other participants’ stories about their experiences and perceptions of sex education. They described instances in which the teacher was ill-equipped or where there were large gaps in the information they received, which left them feeling unprepared to set boundaries around their sexual interactions. Ultimately, the participants were disengaged from what they were being taught. They needed a different approach for their sex education to be effective. Later in their narratives, the lasting impact of these women’s inadequate sex education experiences became more evident.

Only one participant talked about their mother having an open and honest discussion with them about sex. When Kese was asked how she initially learned about sex, she replied:

> “My mom. But she have always taught her children that to come to her if we was having those types of desires and things like that. She was very strategic about how she was teaching her young sons, her young daughters about the way of life. And my mom was not one of the ones that, that sugar coat nothing. She was straight from her hip. She told us about diseases and germs and this and that and the third.”

Kese’s statement reveals how her mother touched upon multiple important topics regarding the realities of sex. She informed Kese on how she may experience arousal and discussed STIs as a possible risk of engaging in sexual activity. However, Kese’s mother appears to be an anomaly in this study. The dominant script beginning their stories was one of insufficient knowledge. As a result, women simply felt unprepared for future sexual relationships.

Complicating Action—Dating, Relationships, and Sexual Initiation

The next element of the participants’ narratives was the complicating action. Labov (1972) described a complicating action as “then what happened” (p.370). The next portion of women’s narratives generally included stories about their first sexual experiences and the actions that lead to it. This element of the participants’ narratives provides clear evidence the sex education some of them received left them vulnerable to multiple external influences to have sex such as peer pressure. Kennedy believes if she had received adequate sex education early in life, they might not have succumbed to peer pressure to have sex for the first time at age 15. She describes the connection between the poor sex education she received, peer pressure, and initiating sex at 15 years old:

> “I think the first picture they showed you was like the uh, the waffle or uh, the blue waffle or something, which is the, the vaginal disease where it's like a whole bunch of bumps and stuff and it's like discoloration…it was so scary and at the time like, I'm glad it scared me. It scared me and I'm like, I don't even want to talk to boys. I don't want a boyfriend, nothing. And then I went to high school and of course peer pressure and friends I lost my virginity at like 15. But I feel like if I would've got the education a little sooner, I would've been a little more prepared for the, for the um, the friends and the pressure and the peer pressure. And I would've been like, yeah, no. Did y'all, y'all seen all them pictures? Right. But because it was like, I think it was like a week maybe that we had sex ed and it was only the one time it was a such a small thing.”

The latter half of this statement reveals some of the shortcomings of Kennedy’s sex education experience. Initially Kennedy was resistant to having sex and even interacting with boys because she was scared of acquiring an STI. As she got older and went to high school, her friends influenced her to have sex. Kennedy expressed discontent with the sex education she received.

She felt it was not extensive enough to equip her to resist peer pressure and it was provided too late.

Other women were not necessarily pressured into having sex, but the lack of conversation and subpar education they received about sex left them curious and eager to explore. LaShawn is one example of this. Like most of the other participants, her story began with the absence of an informative conversation about sex within the household. She had sex for the first time when she was 13 years old. The following quote provides a glimpse into how LaShawn made the decision to have sex at such an early age.

> "I guess I saw others doing this, so I was like, well, I wanna try it, you know? But I was young… I mean, a lot of people that I grew up with on my block, they were having sex. Some of them were older than me though. You know, some of the young kids they were older than me. So, it's, when it's around you and you seeing it, you know what I'm saying? Of course, you gonna get curious and wanna do it. So, you know, that's what, that's what happened."

LaShawn's experience reflects what several other participants reported. With little to no foundational information about sex and all that it entails, their innate curiosity compelled them to have sex. As these women observed other people discussing sex or engaging in sex, they resorted to experimentation to learn more.

Women's lack of education made them vulnerable to men's sexual advances, which led them to have sex earlier than they had planned. Kasey and Taylor both wanted to wait until they were married to have sex, but because they were in love, they relaxed their boundaries and had sex. When Kasey reflected on her decision to have sex for the first time, she stated:

> "My ex-husband was older than me and then he was, you know, he's 8 years older than me. So, the boys, the younger boys that was my age trying to talk to me. I'm like, nope, nope, nope. But, you know, older men and sometimes they really do, they're, they're, they're able to manipulate you and know to say the right things because they're older and they've been around the block. So, you know, him being around the block having sex, of course a lot already. He was able to manipulate me and talk me into it."

Kasey had a lot of questions about sex when she was growing up that went unanswered, and as a result she feels she was manipulated into having sex before she was married. Although they did get married eventually, Kasey had not been equipped with the tools to be able to assert her sexual boundaries before marriage. Kasey's and Taylor's experiences highlight a unique pathway in which the lack of sex education can shape a women's susceptibility to engaging in sexual activity. Although participants shared other experiences within their narrative, only peer pressure, curiosity that was not satisfied by the minimal information they had, and relaxed boundaries can be clearly linked to the initiating action discussed earlier in the participants' stories. Their stories illustrate how the absence of complete, accurate information about sex, sexual health, and relationships with men through ongoing familial conversations and comprehensive sex education significantly disadvantaged these women.

Several of the narratives deviated from the linear narrative structure in which the initiating action is followed by events or circumstances that are escalated in the complicating action. This can be seen in Madison's story. Although her story began with feeling afraid and ashamed of her body and not having adequate sex education, she knew that she wanted to have sex "the right way" because of her Catholic upbringing. Once she got to college, she became confident in her body and relinquished some of the ideologies she had internalized regarding the 'right' way to have sex and the moral value of staying chaste. When she decided to have sex, she felt in control of that decision. Instead, her complicating action is defined by instances after she has sex when she was unable to engage in effective condom negotiation. In the following excerpt, she briefly discusses her experience with trying to use condoms:

> "I started having sex when I was 18. All while I knew that condoms were used and I didn't have a problem with using them. I would always get denied. It's about in the situation, like, 'Hey, I got these', you know, 'I'm hoarding this whole bag of them.' No, there was always an excuse for it. And so, I was just like, young and impressionable. I

> was just like, okay, well then, you know, fuck what I'm saying? I don't know what I'm talking about."

This story excerpt is important because it illustrates the variation in how the initiating action propels participants' storylines forward, while also providing another example of how the absence of open and transparent communication about sex leaves Black women and girls vulnerable to different forms of pressure and coercion.

Evaluation. As participants narrated the early parts of their lives, they expressed disappointment and regret at the silence and lack of education about sex they experienced. They acknowledged how this absence resulted in a stunted sexual knowledge and awareness. Bou said "Wow! I wish someone had told me these things or I wish, you know, my mom didn't feel like 'okay I couldn't have these conversations with her.'" Some women believed they would have done things differently if they had been able to talk to their parents and develop a more solid foundational knowledge about sex. As their stories unfold, it becomes clear how their early experiences are a catalyst for their later challenges with sexual health.

Summary

Although the beginning of the participant narratives does not provide explicit insight on what it means for Black women to be resilient in the context of an STI, it does provide valuable context that is helpful for understanding some of the circumstances that lead to them being diagnosed with an STI. The beginning of the narratives highlights how many women start from a point of disadvantage due to inadequate sex education and negative socialization to sex. As a result, women's journeys become complicated as they enter sexual relationships without sufficient knowledge on how to prevent negative sexual health outcomes and on how to have positive and empowering sexual experiences. In the next section, I briefly discuss the high point and the setting of the narratives, which is when participants tell the story of acquiring and being diagnosed with an STI.

The STI Episode

The early parts of these narratives illustrate the various circumstances and pressures that make Black women susceptible to contracting an STI. The setting and the high point provide critical information about the adversities women experienced along with their STI diagnosis. This segment of the narrative underscores the dire circumstances to which women later demonstrate resilience.

Setting

The setting in narrative research refers to the physical location in which a story takes place (Daiute, 2014; Riessman, 2008). However, Ollerenshaw & Creswell, (2002) suggest that setting can also include the context of the participants' experiences, by which they mean a confluence of factors that comprise the context of the participants' stories. In this study, I am focusing on the relational setting in which the participants acquired their STI. Focusing on setting in this way provides insight into the intrapersonal and interpersonal dynamics women had to navigate as a function of their diagnosis. Their stories highlight the complex dynamics and emotional conflict women must confront within their relationships.

Monogamy. Half of the participants were diagnosed with an STI while they were in a relationship that they perceived to be monogamous. In these situations, several of the women made the decision to get tested for an STI because they started experiencing symptoms and told a friend about what they were experiencing. Jazmine is one of the participants who found themselves in this situation. For a while, she had suspicions about her boyfriend being unfaithful, but she could not confirm them. Then she started experiencing symptoms:

> "I'm at school. Me and my friend and I go to the bathroom and it's like this clear fluid like coming outta me. It's like I had to wear a tampon or a pad. Like I wasn't bleeding but it's just this clear fluid flowing outta me. And my friend was like, 'you need to go to the doctor.' I wasn't thinking nothing of it. Like I wasn't. She was like, 'you need to try and go to the doctor.' So, I was like, okay, let me go to the doctor and see."

Other women told similar stories about suspecting their boyfriends were cheating prior to experiencing symptoms. LaShawn was 8 months pregnant, and like Jazmine, had started experiencing symptoms. It was itchy when she urinated, and she had a discharge. Initially, she attributed the symptoms to pregnancy. She confided in a friend that she "was feeling funny down there" and her friend encouraged her to get tested. Bou was also in a monogamous relationship when she contracted chlamydia. Her story is slightly different than LaShawn's and Jazmine's though. She was not experiencing symptoms herself; she noticed her partner's penis bleeding. She describes this scenario as the moment she knew she needed to get tested:

> "This one time it was like literally during one of our like breaks in class, but I went to his place. We only went to like take a nap, but we clearly didn't go to sleep. We had sex. And afterwards, once he had um, pulled the condom off, I saw a little blood on the head of his penis, and I had never ever seen that happen before. I'm like, what the hell? And I looked at him and he looked nervous. I was like, Why are you like bleeding?"
>
> "He said, Maybe we were being like too rough or something. Like, he tried to like, he tried to play like I was crazy. I'm like, I'm literally looking at blood on you. Like, are you okay? And I got scared. Like I immediately thought, I'm like, this man has like HIV or AIDS or something. Like, I just didn't even know. I didn't even know. I'm like, oh my god. Like, I'm like, I'm literally about to die. Like one of those moments again. I'm like, I just, my life is over. ''m like looking at the man I've been sleeping with and there s blood. He was like we just had like rough sex, like maybe that's what it is. And I'm Iike, No, cuz we don't…I'm like, we do this often. Come on. At this point we were like year 3 in, I'm like, We know how we are."
>
> "Like, you've never bled. You're playing with me. I was like, Is there something you need to tell me? and he laughed. He was like, bro, you're literally crazy. And whenever a man tell you're crazy, you're not crazy. But, he was like, absolutely, you're literally crazy. And I was like, I'm not crazy. I was like, we've had sex how many times? Mind you like me and my like first boyfriend, we were very like sexually active, like we had sex like a lot. So, I'm like, I don't think this is what it is. And someone just told me like, you should probably go get checked. So, he was like, um, there's nothing to tell you. I was like, are you sure? There's nothing to tell me. He was like, no. Like, he was like, I'm trying to

> imply I'm cheating on you. He got real defensive strike two. He got real defensive and he was like, no, I'm not doing anything like that's crazy. Like it was just, we had rough sex. Like, just leave it alone. I'm like, okay. I'm like, well, if it's nothing, I'm gonna go get tested."

Prior to noticing the blood on her partner's penis, Bou had suspicions that he was cheating. She told me that she knew something was off because the things he would tell her were not adding up, but she could not catch him. After seeing the blood on his penis, Bou sprang into action and made an appointment to get tested at a clinic the next day.

Multiple Concurrent Partners. A comparable, but different storyline arose for the three participants who contracted their STI during a time where they had multiple sexual partners. There was quite a bit of nuance and complexity in why the participants on this pathway to resilience sought testing. In some cases, these participants experienced symptoms. Taylor's story provides a detailed example of this. After her divorce, Taylor had a moment that she described as "thotting across the land." She felt oppressed in her marriage and had "only seen one penis." Once she became single, she wanted more sexual experiences. She explains:

> "I had sex a lot and I had sex with a lot of people. Not a lot like that, but like, not that I, I didn't give a shit about judgment, but overall, like I probably had sex with like five guys in the course of 6 months. And that's an approximation cuz I honestly stopped counting cuz I was like, I'm not gonna let a number judge me. Nah."

As Taylor leaned into her sexual liberation, she slept with someone without a condom. A couple of months later, Taylor got into a new relationship that was monogamous. They were not using condoms or any other contraceptive methods. While in this relationship, Taylor realized she needed to get tested.

> "I went to the bathroom one day and I was like, man, it really hurts to pee. Like this is really, really hurtful. Like pain, a ton, ton, tons of pain at that point. And I think I had noticed it before, but I had had yeast infections and I think I was like, oh it's just a yeast infection. No big deal. So finally, it got bad enough to where I was like, 'I'm gonna go up to the clinic at the school and I'm gonna just get yeast infection. Like this is clearly just a horrible yeast infection."

Although Taylor was in a relationship at the time she was diagnosed, she was unsure of if she contracted chlamydia and gonorrhea from her partner since she had slept with someone prior to him without a condom and had not been tested in between those encounters. She reflects:

> "It was very reasonable at that time that it could have been me as well. It could have been either one of us. Cause I asked him, the last girl that you had sex with were, did you protect yourself? And he was like, no. And I was like, Okay, cool. Either one of us at this point. Here. Take your medication. I'm gonna take mine."

In other words, Taylor did not know where or when she contracted the STIs, whereas other participants in relationships that were intended to be monogamous knew the source of their infection. The impact of the uncertainty about the source of her diagnosis becomes clearer in the resolution strategy element of Taylor's narrative.

Two of the women were having concurrent sexual relationships at the time of their diagnosis. Both of these women were young and exploring their sexuality. Monique had dated women for most of her life and had only started dating men shortly before her diagnosis. Candace was in her freshman year of college with "all this new attention." As she explained, she was taking advantage of newfound freedom:

> "It was me leaning into like, I do have the freedom to do this. And there's a lot that I had felt like I had missed out on during high school that was in my face now. And so I think I did go a little overboard. I definitely went a little overboard, but I settled down."

At the time Candace was diagnosed, she had three women and one male as sexual partners. She was not experiencing symptoms and had gone to the clinic for something totally different:

> "I was going there cause you know, I'm living away from home. I need a doctor. I have like crowned migraines. I need prescriptions on. I can't be coming to Lansing all the time to get my medicine. Like I need to find a doctor in the area, go to this place and you know, new patient, you pee in a cup, you do all the things."

Monique's reasoning for testing closely resembled Candace's. She had been admitted to the hospital because she was in a car accident. While there, they tested her for STIs.

Prenatal Care and Pregnancy. The last narrative setting is the women who were tested because of a pregnancy. It is important to differentiate women who had this experience from those in the previous categories because there are extremely specific psychological, emotional, and physical concerns associated with having an STI during pregnancy. These women were faced with the possibility of transmitting the STI to the baby or having complications during the pregnancy caused by the STI. The way they grappled with these possibilities is discussed further in the high point and evaluation. Naomi, one of the participants who received STI testing because she was pregnant, discusses her STI testing experience:

> "So, let's think back. Cause I was 20. Um, and actually I went to the doctor, um, okay. I went to the doctor because I had a positive pregnancy test. With your pregnancy test, they do all these other checks. And, um, so they did confirm my pregnancy, but, um, they also let me know that I had chlamydia."

Kese and Destiny were also tested because they were pregnant. Interestingly, both women did not know they were pregnant until they were full term. Their stories did not include many details about when they were tested because the tests were administered amidst several other medical tests. Kese had gone to the doctor with stomach pain. They ran several tests which confirmed she was 8 months pregnant and positive for trichomoniasis. Destiny was not aware testing occurred until she received her diagnosis on her discharge papers after giving birth. These women had to navigate several challenging circumstances: unexpectedly becoming mothers, their relationships with their child's fathers, as well as the impact of the diagnosis.

This section revealed three relational settings in which women experienced STIs: in relationships they assumed were monogamous, in concurrent or serially monogamous relationships, and in the context of becoming pregnant, which occurred in both monogamous and non-monogamous relationships. In all cases, the STI was a surprise. The details of learning about the STI will be discussed in the next section as the high point of the narrative.

High Point—Aftermath of Receiving Positive Test Results

Shame. Learning of their positive STI diagnosis is the high point in the participants' narratives. The high point of the story illustrates the various challenges participants had to navigate to bounce back from the STI. Women said they experienced embarrassment, shame, and anger regardless of the setting in which they contracted the STI. Kasey was one of the participants who contracted the STI while in a relationship that was supposed to be monogamous. She learned that her partner was cheating when she tested positive for chlamydia. While she was initially embarrassed by his unfaithfulness, she felt they could gain monetary benefit from the woman he cheated with. She explained,

> "At first, I was embarrassed he was cheating. But then when I figured out the girl was cheating with him, I was like 'She got a lot of money. Just bring her money home." Literally like just bring her money home.' I was more embarrassed at the fact that you would bring, you don't care about me enough to bring, you know what I'm saying? You brought something home to me. And then, um, this is embarrassing cuz it's such a stigma against people who have sexual transmitted diseases."

Kasey's embarrassment was more rooted in her partner's disregard for her health than in his unfaithfulness. She has internalized the negative societal perspective about STIs, which also contributed to her embarrassment. Acquiring an STI within the context of her monogamous relationship represented a violation of the relationship. Furthermore, Kasey is conveying STI stigma as one of the adverse factors she confronted. It is possible that the lack of sex education Kasey experienced in her early years made her more susceptible to societal judgements about STIs, as evidenced by her anticipated STI stigma.

The participants' sex education, or lack thereof, in their early years did not equip them with the necessary tools to combat the general stigma around STIs. Without proper education, women were reliant on societal perspectives about STIs and about the people who contracted them. Comprehensive sex education or adequate sex talks from adults in their family may have provided them with accurate information about how common STI's are. These learning opportunities may have also dispelled negative myths about people who have STIs.

Many of these women chose not to disclose their diagnosis to others or seek social support because of the embarrassment, shame, and perceived stigma they experienced. In fact, four participants had never disclosed their diagnosis to anyone but me. Diamond did tell one person about her diagnosis primarily because her friend disclosed to her first. She revealed shame, embarrassment, and an absence of information about how to talk about STIs hindered her from discussing it:

> "Why did I only tell one person? Obviously, I was embarrassed. I was scared. And then the reason why I did share with the one friend is because she had a longer sexual history than me and she had shared with me. But I don't, I wouldn't even say every friend knows. If I had more friends that had told me that that was their experience, I don't even think I would've still spoke up because nobody tells us really how to deal with it. Even like when you take a pregnancy test, like the writing is this big and it's this small, you're trying to figure out if you're pregnant or not., but like you can't even see the document. you trying to figure like, what do I do next? That should be like the biggest bold step. maybe contact your OBGYN, right? Like. So can you be the same kind of thing when people get those kind of test results back, especially if it's from a blood draw versus like a culture, like all of a sudden now you're testing a positive. So, I don't know, just maybe something there that just… But you're saying it in plain language, like embarrassment, um, not able to say it out loud, just feeling very shameful."

Several other participants only talked to one or two people about their diagnosis. Like Diamond, they were overcome by embarrassment, shame, and a fear of being judged. Their hesitancy to disclose is unsurprising given what the earlier parts of their story reveal about the ways they were socialized to sex and sexual health. Sex was not something that should be openly discussed.

Taylor's story followed a different path. She chose not to disclose her diagnosis to anyone except her partner. At the time of the interview, I was the only person she has confided in about her diagnosis besides them. She stated her diagnosis was "between me and the Lord, as far as I was concerned." As she talked about why she kept her diagnosis to herself, she shed light on how embarrassment and shame affected her:

> "I was embarrassed. I was ashamed. I felt disgusting. I felt like even though I knew I wasn't a whore, I felt like one. Like, even though I knew I wasn't out here just sleeping with everybody. Like I said, at that point, I think I maybe had six sexual partners total. Yeah. And I was 24. Like, that was pretty good compared to my friends, especially my white girlfriends. They were in the double digits at that point. Yeah. but I just felt like people are gonna judge me, you know, and talk about me."

Taylor's perspective might have been shaped by the absence of adequate sex education earlier in her life. The story of how she learned about sex in her early years did not include any mention of sex education in school, it focused on things she had been told by her mother, like girls who use contraception are whores. In addition, a lot of what Taylor's mother told her led her to believe that others' opinions of her were significantly important. She kept her diagnosis to herself because she did not want to be judged.

Anger. The unexpected positive diagnosis left some women infuriated with their sexual partners. Destiny found out she had been diagnosed and treated for trichomoniasis when she was leaving the hospital with her daughter. She admits she was not making the best decisions for her sexual health when she got pregnant, however she was still angry when she learned that her child's father knew he had trichomoniasis but had refused treatment. She responded with the following when asked what emotions and reactions she felt regarding her diagnosis:

> "Angry. I was upset. I remember being upset because it's like, it's common sense if you know, you know… I was upset because it's like if you knew you had it and you gave it to me, why wouldn't you, you know, get treatment? So, you wouldn't transfer to other people? Like I felt like who, you know, they were being selfish."

Feeling Unclean. In addition to feeling embarrassed, ashamed, and angry, some participants had internalized societal messages that contracting an STI means one is dirty or unclean. Monique battled with negative feelings about herself for a while after she received her diagnosis. She recalls what happened after she got the call from the hospital with her results:

> "I literally just cried. I just held myself and I cried. Cause I'm like, how could I be so I feel disgusting. And I told that to, I, I literally screamed that to myself. I feel disgusting. I, I feel nasty. I don't, don't feel good. So, it was just like my whole body just visually turned brown or green. Yeah. And it, yeah. So that, that, like I said, it will forever, that memory will forever be in my head and yeah. And even though like they have those, you know, the little commercials or whatever, you know, and they have free condoms everywhere. It's just people don't really care about it for some reason. And I was one of those people and I can't believe I was one of those people."

As Monique's example illustrates, the mental and emotional aspect of having an STI can be particularly challenging. The diagnosis greatly challenged her self-image. Although she alluded to being exposed to information about protective sexual practices in the media, her formative years were filled with her aunt and mother attempting to prevent her exposure to things related to sex. As such, she did not learn the importance of contraception in her early years, which may be connected to why she was one of those people who said she did not care about condom use.

Depressed. Three participants described themselves as depressed after receiving their diagnosis. Madison described drastic changes in their schedule and a lack of interest in doing their usual day-to-day activities after being diagnosed with HSV 2. Kese had a more severe example of depression. After learning of her STI diagnosis, giving birth to her son, and having to raise him alone because the father was not present, Kese tried to commit suicide. When explaining how she was involuntarily committed to a mental health facility after she tried to commit suicide, she tearfully explained:

> "My mom thought it was postpartum what I was going through, but it wasn't the postpartum. I was just depressed all around. I gotta raise the baby by myself. He, he's nowhere to be found. He don't want nothing to do with me. And I already was feeling bad about my body already. And you just made it worse."

Kese attributes her depression to a combination of her circumstances when she was diagnosed, as well as trauma that was caused by sexual assault when she was younger. After years of avoiding sexual activity following her assault, she was distraught when she was diagnosed with trichomoniasis. She recognized how old wounds had reopened "I just felt re-hurt after this situation. I was devastated. Like, you know, I tried to trust somebody after somebody already hurt me."

Fractured Relationships. For women who contracted the STI while in a relationship, their diagnosis often caused a wedge between them and their partners. In most cases, as noted previously, women harbored suspicions that their partners were cheating. In their stories, the STI diagnosis confirmed the infidelity and introduced feelings of betrayal and a loss of trust. Bou recalls the confusion and disruption to her sense of sexual health she experienced when the clinic called her and told her she tested positive for chlamydia.

> "I was like, what? So, my blood work, all everything else was clear. So, I'm like, okay. But again, I still didn't understand like chlamydia. Cuz again, I had never experienced this but I knew what it was, but I didn't. I'm like, what do you mean? Like I'm safe. I'm safe. And that's, I think it was a very, I would never forget how I felt in that moment. I was really embarrassed. And I was really disgusted And I, it was like this feeling of betrayal, like they say by the bug, if you are getting tested every 3 months and you are getting tested after every partner and you are using protection and you are limiting yourself to one partner and your partner not sleeping with other people cuz you would think your partner is being honest."
>
> "I'm like, I'm good. Like I'm as safe as safe can get. Yeah. But no like, it just, it didn't matter. I think that's why I was so upset cause I was doing my part. And every training was like, you weren't doing your, you did not consider me when you were out here."

Although many of the women did not implement measures to protect themselves from STIs, Bou had an established routine of regular STI testing and consistent condom use. The burden of her diagnosis had a profound impact on what it meant for her to be "safe" sexually. She realized her partner's dishonesty completely undermined all she put into place to mitigate her risk of contracting an STI.

Another participant also brought forth betrayal when discussing what came up for them once they received their diagnosis. While Bou described being betrayed, Destiny believed she was the betrayer. She communicated that she had not heeded her mother's message about treating her body as a temple. When she caught the STI by being intimate with someone she barely knew, she said she felt like she was "betraying her mother in a sense." She was critical of herself and the circumstances in which she contracted STI because it was not reflective of what she had been taught growing up.

A few participants lost trust in themselves, which they linked to the perception they had not been able to judge the character of their sexual partners. Others narrated their skepticism of trusting others, especially in future relationships. Kennedy talked about how her sense of security in herself and trust in her partner were damaged as a result of her diagnosis.

> "After that I had never actually trusted him again. I was like constantly going through his phone, constantly, um, trying to find out where he was at, telling him like, we need to be in communication at all times. And like, I'm not that person. I'm not that girl. And it, I just felt, I felt the insecurities and the untrust that the trust that I didn't have for him. So, when everything happened it kind of just was like, it just made everything fall into place and everything was exposed more to it. And I'm like, you know, I, I had a gut feeling like, you know what I'm saying, not to trust him and I just didn't have the, the X, Y, and Z to put everything together. Yeah. But like I knew it was something."

Kennedy opted to stay in her relationship even though her boyfriend's infidelity was the source of her STI diagnosis. She and her boyfriend started intertwining their lives, so she stayed with him for the sake of their children. Although she stayed, her story reveals a new layer of the impact of being diagnosed with an STI. The loss of trust led her to engage in behaviors, such as going through her partners phone, that were uncharacteristic of her usual self. She turned into someone she was not.

Participants varied in whether they disclosed their results to their partners. Among those who did tell their partner(s) of their positive diagnosis, some were faced with harmful and negative reactions in response. Candace felt obligated to tell each of the people with whom she was sexually active about testing positive for chlamydia. At the time, she felt like notifying her partners was one of the hardest things she had to do. Although she had some worries that people would perceive her as a “dirty bitch,” she wasn’t deeply hurt by their reactions:

> C: “The guy had the typical reaction. You know, who you been fucking? Yeah. Oh look, don't come to this party. What? Like whatever. I don't care. One girl didn't really care, but the last two, I don't remember how they reacted. I must not have been too terrible. I can't remember. Yeah.”
>
> I: “How did the guy's reaction make you feel?”
>
> C: “I think it's always been hard for me to take men seriously anyway. And so like, he was, you know, calling me all types of names and whatever, but it didn't really bother me that much. Like it bothered me, but I don't think I ever cried about it. I think I actually just cussed him out, but I didn't cry about it because I'm like, I don't really care if you think I'm a ho. Like it's you, I've been around you. I don't care what you think.”

Candace was slightly worried about the reaction she would receive from one of the women she notified because she was interested in dating her. But according to Candace, the woman did not care that much. This part of Candace’s story reveals an intriguing point. Prior to informing her partners, she was extremely nervous about how her sexual partners might perceive her after she notified them she tested positive. However, her unbothered response to her male partners’ reactions suggests she may have relinquished some of her concerns regarding their opinions.

Monique, on the other hand, had a more distressing experience when she disclosed her results to the people with whom she had been sexually active.

> “At the time, I didn't know who gave it to me at all. Um, I ended up having to call maybe four, five people. And I'm just like, I don't know when I got this. I don't know what happened. I don't know, you know? I don't know if it was you or if it was someone else. And I got called so many names. I got into so many arguments, and it was devastating. It, it took a hit on everything. Like my confidence, it took a hit on my womanhood, it took a hit on everything. I just wanted to stop. I wanted to stop my whole entire life.”

Her partners’ reactions to her disclosure took a toll on her self-esteem. Their comments, coupled with Monique feeling “disgusted” by her diagnoses, left her with significant internal conflict she had to resolve to move past her diagnosis.

High Point Evaluation. In part because of the flawed or complete absence of sex education that participants received in their earlier years, several participants stated they never expected they would contract an STI. Many of these same women were shocked to learn they tested positive for an STI. In addition, a couple of participants thought perhaps their parents were correct in pushing them to wait for sex. Naomi explained how she thought back to her parents’ warnings to wait until marriage to have sex:

> “I remember thinking though like, ‘oh, maybe my parents were right. Either A, I should have, um, waited until marriage or not dove in so fast.’ like, so 15 was way too young. So, by the time I got to 20, that was like, that was 5 years, right? So, within 5 years it seems like at 20, so like I'm experienced right? But at 20, I still don't know anything.”

In hindsight, Naomi recognizes that there may have been some value to what her parents tried teaching her. As Naomi thought back to how she struggled to come to terms with the fact that she was 20 years old, pregnant, and positive for chlamydia, she also expressed some regret about some of her decisions. Other women also described reflecting on the validity of early messages to avoid having sex.

The high point of the narratives shed light on the ramifications of the STIs. Many of the women described their diagnosis as a deeply unsettling and tumultuous emotional experience. The diagnosis highlighted dilemmas about their relationships and about the messages they had heard as girls and younger women. Some of the ways women interpreted their diagnosis were based upon ill-informed assumptions about their bodies, sexual health, and relationships. To move forward, these women had to resolve the challenges and conflicts they experienced. The high points of the narratives reveal several major adversities. In some cases, the adversity was about whether to continue to explore their sexuality unhindered. In other cases, it was about continuing a relationship or moving past shame while still being a sexual person. Understanding the impact of each of these is fundamental for understanding the actions that participants take in the next parts of their story in an effort to reclaim their sexual health and well-being.

After

Resilience becomes prominent in women's narratives after the diagnosis. Once women received their diagnoses, they confronted their challenges and navigated the way forward. The following section reveals how resilience develops and operates for Black women within the context of a sexual health experience that has physical, emotional, and social consequences. First, I discuss resolution strategies, which are the actions that the women employed in response to the high point. Then I discuss prominent characters in the narratives, which provides insight on socioecological influences on participants' path to resilience. Last, I examine the coda element and identify how participants' reflection points reveal unique understandings of resilience.

Resolution Strategies—Resolving the Impact of the Diagnosis

After participants described the episode in which they learned of their infection, the focus of the stories shifted to the various ways they tried to resolve the adversity they experienced because of their diagnosis. Following the setbacks described in the high point and evaluation of their narratives, women discussed a range of social and behavioral changes they implemented in response to their diagnoses. Most of the changes are helpful for preventing future diagnoses, while others permit women to better navigate the emotional complexities of their diagnoses or adopt a new lens on sex, dating, and relationships. One of the goals of this study is to explore how Black women demonstrate positive adaptation after being diagnosed with an STI. As such, the excerpts that follow will primarily illustrate the social and behavioral changes that women made to help them move forward in a positive and productive way to avoid future STI acquisition.

Preventative Sexual Health Practices. Nearly every participant discussed implementing at least one preventative sexual health practice as a way to help them move forward from their diagnosis in a positive manner. Women viewed the incorporation of these practices as a proactive strategy to safeguard them against future STI acquisition. Some of the preventative sexual health practices that women discussed were consistent proper condom use, routine STI testing, vetting their sexual partners, and limiting their number of sexual partners. The findings related to preventative sexual health practices as positive adaptation are presented as one section because participants often cohesively narrated the actions they took as one episodic story, grouping behaviors like routine STI testing and open and honest communication together.

Several participants used the word “cautious” to describe the changes they made to move forward. LaShawn talked about a plethora of changes she made to be more cautious after she was diagnosed with trichomoniasis when she was 8 months pregnant. In the narrative excerpt below, she identifies strategies that include becoming more selective about who she has sexual relationships with, limiting her number of partners, and using condoms and other contraceptives.

> L: “Started being more cautious and watch who I involved myself with. Protect myself. Um, I just didn't get involved with a lot of people and if I did that, I stuck with, just only one other person. And I just wore protection and got, got me some, got me some stuff to protect me from catching anything.”
>
> I: “Stuff. Like what?”
>
> L: “Huh?”
>
> I: “What kind of stuff did you get?”

> L: “I mean, I just got like condoms got, uh, with the shot, you know, pregnancy shot, you know, got on birth control. It won't no more. I didn't want no more kids, you know? that too. And also they won't, no diseases, you know. So I just started being more cautious about what I do. And I didn't wanna be with anybody, you know what I'm saying?”

For LaShawn, the diagnosis served as a catalyst to change some of her sexual behaviors. Being cautious and watching who she involved herself with meant only having sex with people if they were in a committed monogamous relationship. Even then, she slowly approached engaging in sexual activity. She emphasized how she never got another STI after this one instance.

Much like LaShawn, Kennedy also used the term “cautious” to summarize the preventative behaviors she implemented. Kennedy described being fearful of catching another STI. She recalled the pictures of STIs she saw in middle school and articulated a desire to avoid becoming what she saw:

> K: “I definitely started using condoms.”
>
> I: “Really?”
>
> K: “Yep. For sure. Every time condoms. Uh, I was so scared I was having flashbacks so that sex ed from middle school and I'm like, I can't, I can't have that. I don't want that. And um, I, like I said, I lost the trust in him. So I definitely was like, I'm about to just go back to the college me and just do me. But I was so scared of catching something else. I couldn't even try to talk to somebody else or be with nobody else. It was just…So I think that kind of shaped me. And I guess a, I can't say it's negative cuz it is, it's, it's positive to be safe and have safe sex. But I think it was, it was a well needed way I should say. Because I was kind of careless and I can't, not even careless cuz he was my boyfriend. So I thought we had that trust and we, we had built that level of trust to where if something like that was to happen and we did have a conversation to where if one of us was to cheat on each other, like we would have to tell each other because we wouldn't want anyone outside of us to tell us instead. Yeah. And that was a conversation that we had. So it was just like, you know, not the only did this happen, it happened over a weekend and I'm trying to contact you and you didn't come tell me until you brought me something back. Yeah. So I, I do think it shaped me in a, a well needed way, but I was definitely more cautious.”

Although Kennedy lost trust once she realized that her partner’s infidelity is what lead to her contracting the STI, she adopted a different lens on the situation to help her move forward. That lens, rather than focusing on betrayal of trust, influenced her to be safer in her sexual life in a way that was much needed. She also mentioned starting therapy to help her cope with all that she was experiencing with her boyfriend.

In addition to being more cautious, four participants stopped dating altogether and began practicing abstinence to protect themselves and others. NikAsia explains this rationale in more detail.

> "I feel like the smartest one is being celibate and not, um, putting anyone else in harm's way. Even though I'm, I'm sure I pray that I find a way that like, yeah, if you, you know, you do decide to be with someone, you're not necessarily putting them in harm's way."

NikAsia's decision to practice abstinence resulted from introspective reflection. Prior to her diagnosis, she acknowledges she tried to use sex as a form of validation and was not using protection. Once her youngest child's father abandoned her during her pregnancy, she knew she wanted to do something different regarding the way she approached sex and relationships, so she decided not to have sex for a while. At the time of her diagnosis, she had not had sex in 2 years. Now, however, her decision not to engage in sexual activity is doubly motivated by her desire to have healthier romantic relationships and mitigate the spread of HSV 2.

Destiny also made the decision to practice abstinence after her diagnosis. For her, the diagnosis raised concern and awareness about her sexual health. She explains how this awareness manifested in her behaviors:

> "I wasn't having sex really. Um, I was abstinent I should say. Um, um, um, I'm sorry. So yeah, I abstained. Um, because I abstained, I didn't feel like it was really much of a purpose. If I felt there was anything wrong down there or you know, uh, any weird smells or discharge, I would go to a doctor to get that checked out. Um, but because I was abstaining from sex, I didn't feel like, you know, if I'm, I'm not doing anything, how can I get anything? I'm okay. So, as long as I knew that, as long as I wasn't doing anything, I should be okay. And um, even like when I first got with my fiancé, I was still, you know, just regularly checking not only for my health but for his."

Destiny adopted the perspective that as long as she remained abstinent, she would be protecting herself from sexual risks such as STIs. She reported that in the event she made the decision to be sexually active again, she knew she had to be more aware than she previously was and get tested. Abstinence was also a way for Destiny to resolve some of the other conflicts that made her vulnerable to STI acquisition in the first place. She did not want her daughter to grow up with the perspective she had, viewing herself as an object to be used for sex. By abstaining from sex, she believed she would set a positive example for her daughter and demonstrate values of self-worth and self-respect.

Throughout her interview, Leslie explained that she never pictured her life to be the way that it turned out. She shared that she always wanted to be married before having children and that it does not feel right for her to have three children each with different fathers. For her, abstinence is a step to making changes in her life more generally. After wiping away tears, she said “I just wanna a clear view and like I just don’t wanna be having sex with somebody and now I’m done for you because that is so good and I’m just, um, failing to see everything else. So, I just feel me being abstinent will make me have, will make better choices to be honest.”

Other women opted to alter their dating practices. Some took a complete pause on dating while others continued dating but set boundaries within their future relationships. Diamond’s story consisted of both of these steps, taking a break and establishing new boundaries when she resumed sexual activity. However, her path to these decisions was not linear. After her visit to Planned Parenthood where she confirmed her genital wart diagnosis, she continued her relationship with her boyfriend from whom she contracted the STI. It took outside support for Diamond to move away from this relationship. She explains:

> “It was like 2 years between that gentleman then when I dated my husband. But it was a lot of healing for me to go through and trusting and, um, and not wanting to get another

> and not wanting issues with my sexual health. Like that really bothered me. That was a lot."

Diamond felt that her STI diagnosis left her "scarred in a way that was uncomfortable." Her 2-year dating hiatus was a method for her to heal and think about ways to avoid issues with her sexual health. During this time, she established boundaries around what she required in future relationships:

> "I wanted to be with a monogamous person. I was like very adamant about, I'm not, I don't want to share sexual partners. Um, cuz I even out, like I, if people wanna have polyamory or whatever they want to, that's wonderful for them. But that makes me uncomfortable because you don't know what other people are doing. And then there's still the spreading of disease and infection."

Though Diamond grappled with the fear of contracting another STI, she put measures in place to protect herself and minimize risk. She believed having a monogamous partner would minimize the uncertainty about other's sexual activity, and thus minimize her risk of contracting another STI.

Monique expressed a lack of trust as one of things she experienced after testing positive for an STI. As she tried to move forward by remaining open to dating but still struggling with trust, she developed guidelines for her sexual relationships. As she describes "Then I started the, the rule. The rule I gave myself it was: I'm not having sex with you unless you're my boyfriend. And that's that." In addition, she no longer slept with multiple men at the same time. She explains why:

> "After I got diagnosed, I, and you know, I realized okay, I dodged the bullet by only having it for these couple of days and thankfully I wasn't able to spread the, spread it in the couple of days. So, um, it was literally woman at a time. And so I at least if I did get it, I would know, like I would know who I could go to. I don't know who to cuss out."

Monique also reported that as a result of the diagnosis, she required her partners to wear condoms, whereas before, she did not care. Monique's resolution strategies demonstrate taking control of her sexual health.

Although Monique implemented strategies to minimize the risk of contracting another STI, she has not yet resolved all the emotional challenges associated with the STI. She explained that she is still attempting to recover what was damaged by her sexual partners' reaction to her disclosure:

> "I don't think I ever actually fully rebuilt it. Really do not think that it ever, because it was such a big hit to me, I still have vivid memories of arguing with everyone and all the things that they were saying to me, and it, it'll always be in my head. Like those things, the way that I felt in that moment, that'll always be stuck in my head that at one point in time I was just, and I don't wanna say it in that way, but I was just this nasty person."

This detail of Monique's story reveals the dynamic nature of resiliency, especially within the context of being diagnosed with an STI. She has resolved one part of the conflict she experienced because of her diagnosis, but not the other. In fact, she alluded to the idea that she does not ever know if she will rid herself of the self-perception she is 'nasty.'

Kasey became an advocate for condom use for herself and for others after her diagnosis. She stated:

> "I'm the, the queen of having all the spermicides and um, condoms and everything you need and plugs and birth control and all that. I'm more of that instead of shunning people, I'm more of want to be like a connection between a healthy way of doing things."

Kasey followed up by describing the need to be "more aware and more careful" as it relates to her sexual behaviors. She gave the following example of how she does this in her current relationship:

> "Yes, we're using condoms, I don't care that we've been together for a year. I still wanna use condoms, I wanna do this and that. So, it made me, um, be more of an advocate for myself and my body."

Kasey is another example women’s ability to move forward as inextricably linked to resolving prior inner conflict. The diagnosis compelled her to redefine the relationship she had with her body in a way that would be beneficial to having a healthy sexual future.

Several women started to engage in routine STI testing to maintain their sexual health and wellness after their diagnosis. STI testing is critical for reducing the transmission of STIs because it is the only way to determine if treatment is necessary. Women’s decisions to implement routine STI testing is an indicator of their positive adaptation because prior to the diagnosis, most participants did not receive STI testing regularly. Madison explained that after learning she had HSV 2, she now goes to the doctor to get tested more frequently than she does for checkups for other things. She does this to ensure that she is informed of her sexual health status and to ensure nothing new has come up.

Other women expressed similar thoughts. Candance spoke of the importance of testing as she continued to explore her sexual fantasies. She had been diagnosed with STIs before, but the most recent encounter prompted her to set some boundaries for future sexual encounters:

> “The most recent diagnosis made me realize like, I also have to be realistic about like, the outcomes of said fantasies. You know, like, and then that helps with the boundaries of okay, if we’re gonna do this again, then we need to make sure that this person is clean, that I’m clean, that you’re clean, like we’re gonna have to get tested, make sure we’re all good before we do this again.”

Candace reveals that she understands that there may be risks associated with the way that she wants to fulfill her sexual desires. However, she purposively crafted a plan to help mitigate those risks in the future.

Taylor had never received any STI testing besides the testing that is done when a woman is pregnant. Her diagnosis made Taylor hypersensitive about her sexual health in multiple ways, so she developed a consistent STI practice to better manage her sexual health:

> "In between partners, every time I would always full panel, like everything Hep B, Hep C, like don't just do gunnery and chlamydia and all that and everything. HIV, pull my, take my blood. Like, I was so adamant at that point, and even up until recently with my current boyfriend that I've been seeing for a year before we started even having sex protected or not. Imma need to see your test results. And you, here's mine."

Not only was it important for Taylor to make sure that she was getting tested, but she also expected it of her partner. Bou's case was slightly different than the other participants because she routinely tested for STIs prior to her diagnosis. Her narrative is an exemplar of the importance of STI screening by both partners. She shared that her routine testing was a protective measure, but it was also driven by paranoia. Being diagnosed with an STI intensified the paranoia and she began to over-compensate by getting tested even when she knew it was not necessary. She explains in her own terms:

> "Yeah, it sent me back. Um, it was so bad. Uh, my doctor had to like, essentially tell me to stop coming in cause I was getting tested like every like other day like, you know, like not clearly every other, but I was getting tested so often. She was like you got a new partner or something. I know. And I'm like, no And she was like, you were just here. Like, like I became obsessive with getting tested cause I was so scared."

Bou's behavior provides insight on the complex nature of positive adaptation in the context of sexual health. Rather than maintaining her sexual health practices, she overcompensated, yet the way she overcompensated is technically protective in so far as she would identify a new infection early. At the same time, her obsessive behavior could be an indication that she did not effectively cope with the diagnosis.

Overall, these findings reveal one of the primary ways Black women change following an adverse sexual health experience. As demonstrated in the high point, many of the participants were devastated by their results. They attempted to resolve the devastation by putting several practices in place which included things such as condom use, enforcing monogamy, abstinence, and routine STI testing. In some cases, the resolution strategies served multiple purposes. These women wanted to avoid this illness experience in the future, but they also had to address preconceived notions from their upbringing and previous experiences regarding matters of sex. Although there was a great deal of overlap in the strategies women developed, their rationale varied depending upon what they prioritized for their sexual experiences, proactively taking control or adopting a defensive strategy.

Education. In addition to preventative sexual health practices discussed above, women took initiative to educate themselves about their diagnosis. Most of the women's stories started with a discussion about how they lacked valuable knowledge concerning their bodies and sexual health. At this point in the narrative, women move past discussing their education as a hinderance and begin to equip themselves with knowledge needed to prevent future infections and move towards healing more holistically. They acknowledged how their decision to get more knowledge was directly related to their diagnosis. Immediately after being diagnosed with HSV 2, Madison began to seek out information about the disease. She explains "I spent days it seems like, on the internet after I got the diagnosis on the internet looking for like YouTuber people who were talking about it and just folks were not, especially women were not talking about it." Although she did not find the information she hoped to, she continued searching until she found information she was satisfied with. Once she found information about having a relationship with her womb and reducing the likelihood of flareups, she began a spiritual and natural journey of healing. She described this entire process of educating herself as empowering. Taylor also engaged in research on STI data. She sought out epidemiological statistics to better understand the risk associated with having sex in a new city:

> "Even when I moved up here, I looked at the statistical data for sexually transmitted diseases, um, in Ingham County. You know, when I moved up here, like how prevalent is it out here? Like, you know, and how like staunch am I gonna have to be?"

By educating herself on the STI prevalence and incidence in the county she lives in, Taylor was able to formulate a plan for how she would engage in future sexual encounters. Her actions are illustrative of how forward-thinking women became after their diagnosis.

One woman delayed her knowledge-seeking process compared to other participants, the rest of whom immediately began to educate themselves after they were diagnosed. Initially, NikAsia believed whatever the doctors told her about her diagnosis because she considered them to be experts. She also confessed, “I wouldn't educate myself because I felt like accepting it or admitting it would be accepting it.” Now she is at a point in her journey where she is eager to learn more and become an expert on her sexual health. When asked to elaborate on how she takes things and makes the best of it, she explained:

> “Being educated. I'm sorry to cut you off, but yeah, just being educated. Um, I've been just rolling with the punches forever and it's like, no, because now you are always on reactive mode instead of being on preventative mode. Like, if I know ahead of time whatever comes my way, I'll be better equipped to deal with it. So I remember sharing with you like, I haven't Googled anything, I haven't researched it, but if I do that, um, whatever the case may be, I'll be better equipped to, to deal with it. Whether it be good or bad or just, just information. Knowledge is power. I'm a eighties baby and schoolhouse rock, they taught me that way. Early. Knowledge is power.”

NikAsia took full responsibility for her diagnosis which deviates from the other narratives where participants largely faulted their partners for their diagnosis. She says:

> “My actions, my choices. Like, everything has an outcome or a consequence or a side effect, I guess. Like, you know, you did this and this is the outcome, this is what happens after that. And so being accountable, like, I walked this path, I made these choices, these decisions, and so this is the end result of it. So yeah, just accountability. Like it's so easy to, to blame everything else or anything else, but like, no, I did this. So accountability definitely helps me to be okay with it. Like, no, well, in the sense of the reason why I'm qualified for this study, my son's dad, like, true. I didn't have a say in that, but he knowingly was, was out here doing what he was doing. But I did play a part in that, you know, by not using protection, but it is not too many things that I could say, oh, somebody did this to me, it's their fault. And I'm such a victim. Like, I, I don't wanna play a victim. I'm, I'm, I'm accountable for my actions. So this is the outcome. Whether it be good or bad, I played a big part in this.”

This excerpt also illustrates how NikAsia confronted the reality of her diagnosis head on. She acknowledges that her behavior played a role in her diagnosis. She does not want to be a victim. Taking accountability provides NikAsia with some resolve about her diagnosis. She further explains how she experiences a sense of control by taking accountability for her diagnosis:

> "I guess it's a little, a tiny bit empowering to, to again, take some type of ownership. Like, no, it wasn't done to me. Nobody held me down and forced this on me, 100%. But I had a, a choice in this matter… [There's] nothing anybody can do to change it. It's already done. So, own it and, and don't let it keep me down."

Spirituality. It is not uncommon for spirituality to be referenced as a coping mechanism or protective factor among Black women (Blakey, 2016; Graham, 2016; Gregg, 2011; Mattis, 2002; D. Rao et al., 2018). However, that was not the case for most of these women. Only three women explicitly mentioned the role of spirituality in reconciling the conflicts they experienced because of their infection. LaShawn and NikAsia referred to spirituality as something that helped them make peace with their diagnosis. While LaShawn was about 8 months pregnant, her child's father was killed. When she was diagnosed with chlamydia about 1 month after he passed, she was unable to confront him like other participants had been able to confront their partners. She turned to a higher being instead: "I just got on my knees, talked to God, asked God to forgive me. And then I forgave him." Her closure came through prayer which helped her to grieve his loss and process the emotions she was feeling about her diagnosis. Prayer helped her to "deal" with her diagnosis by first accepting it then doing something about it.

NikAsia also embraced spirituality as a resource after her diagnosis. Although she has accepted her diagnosis, NikAsia still struggles with viewing herself as "dirty." She relies on her faith to help her navigate this negative self-perception**:**

> "Again, my faith girl, cause the Bible, my God, God loves us. And so just reading that more and accepting it, like even after all this you done did, even after all these times, you didn't let me down, down like, you, you good, you good. You know? And so just reading

> the Bible and accepting it and understanding it and, and believing it, I really feel like that's, that's my only hope and I'm okay with that. And so I will start doing that."

The Bible provides NikAsia with a deeper understanding of God's love which is helping her to understand that she is loved by Him, despite all she's done. As she tries to accept God's love, she is also renewing her perspective on herself and learning to view herself the way that she believes a loving God would view her. This provides NikAsia with hope about her situation, which is paramount to resilience and moving through and past her diagnosis.

Madison started engaging with Yoruba religion as a form of alternative therapy. Her involvement with this religion has taught her more about her womb, which assists her in taking better care of her reproductive organs:

> "I got really into like Yoruba religions. And, and I was reading these different books about, um, what was the book called? The Sacred Woman Text. I have it over there and it's full of like prayers, fear, womb and things. And some of the language is very outdated, but this idea of like having a relationship with my womb was nothing I'd never heard of before. And that's actually when I started. Really? Yeah. I just started actually caring about the maintenance and the care of that space versus just like having it presentable. You know, like objectifying, it's really crazy how you think about your own body parts, um, as a commercial commercialized entities versus like what they're a true rooted part of myself and um, nature."

Madison also reported that some of the practices she's adopted from Yoruba religions have provided a pathway to healing for her. She says "Meditation was huge. I started go, I went vegan for a couple of months and that I thought I cured myself because it just was without that. Um, so just learning. So yeah, learning so much about diet and what I consume and how it um, truly took my body as a temple." As these excerpts illustrate, spirituality offered Madison a sense of healing mentally and physiologically. Through developing a better relationship and understanding of her womb, she also adopted a new perspective on her body as a sacred vessel.

Resolution Strategy Evaluation. The cocreation interviews provided an opportunity for participants to step back and assign evaluative meaning to their stories**.** For this aspect of the narrative structure, the external evaluation is reflective of what it meant for participants to implement these recovery strategies. Madison exemplified this point when she noted educating herself was a form of resilience: “I mean, definitely starting to look more for my own education. Seeking my own education. Like not being satisfied with what I've been given.” Several other participants also identified seeking education as a sign of resilience.

Other participants spoke about their resolution strategies more broadly as reflective of resilience. They indicated the changes they made were representative of personal growth. As Jazmine explained “Like right after I had it, I was more careful. I mean, I wasn't like, you know, a saint or anything like that, but I was a lot more careful right after that had happened and I hadn't received anything after that. Like no more STDs, STIs, I was the first, and I won't say the last time, cuz you never know, but up until now.” Jazmine was one of the participants whose resolution strategies included more consistent condom use and routine STI testing. Monique shared similar thoughts regarding her resolve following her STI diagnosis. She described resilience in her story as “The fact I was so disciplined, um, to, you know, I, I was disciplined in my sex life , like it wasn't, you know, just even though at some point it was, um, it wasn't just all me being wild and out there, it was, you know, I did have some type of discipline with, you know, um, with having rules and actually following through with my rules, Um, so I did have that self-control over my body.” According to Monique, as a woman, having control over her body again was an indication of her strength, especially considering previous experiences when her ability to make choices about her body were taken from her. These excerpts suggest being diagnosed with an STI was a catalyst for some participants to adopt protective sexual health practices they perceived as acts of agency.

Another participant spoke to the more of the psycho-emotional aspects that followed the diagnosis. Candace's first STI did cause her to be more aware of her sexual behaviors, but her reflection on this part of her story was less about this awareness and more about how she had been concerned with others' perceptions of her. She explains:

> "After the STI I was reading it and I'm like, damn. Like if you really think about it, what, what I was kind of living in was the stigma and like how people were treated if it came out during high school that they had an STD during high school. Oh, you were gonna get tore up! And I think because I hadn't had much of that experience in high school going into college, I just thought that that's how it would be, because I knew that's how it was in high school. But just like playing into those different stigmas cuz it's like, man, like as an adult, I don't, well depending on what type of person and what social group, I don't encounter those issues."

This statement reveals a great deal about Candace's attitude toward how she initially handled her diagnosis. She expresses some shock about how she anticipated being stigmatized about her diagnosis. As she continued to reflect on this part of her story, she discussed how she is no longer in a place where she fears what people may say about her. Her takeaway on this part of her journey is the fact moving past caring about others' opinions of her, her sexual health, and her sexuality is part of her becoming resilient. Her resilience was exemplified when she "really started to not care too much about outside opinions" and relinquished the negative emotions she experienced. She took emotional control.

Overall, the resolution strategy element of narrative provides critical insight on the decisions women made to move past the adversities they experienced in the high point. Taking a close look at this element reveals how Black women enacted positive adaptation after their diagnosis. They explicitly discussed routine STI testing, consistent condom use, seeking more knowledge, and enforcing monogamy as ways they changed following their diagnosis and as strategies to reduce their risk of contracting an STI again. Although there was less explicit discussion of how women resolved the emotional fallout from the diagnosis, in some ways it was addressed by way of the strategies previously mentioned. It appears educating themselves and implementing the preventative sexual health practices created a space for them reclaim some of their sexual agency which in turn helped them to move forward emotionally. Several of the participants were able to use their strategies to help them navigate new sexual encounters and romantic relationships. Utilizing these strategies assisted them in rebuilding trust and identifying partners with similar values. Those who discussed practicing abstinence described it as an approach to confront some of the internal and social dynamics that made them vulnerable to STI acquisition.

One participant mentioned journaling and a few discussed prayers as ways to help them cope, but these will be discussed in more detail later because they were discussed as drivers of their ability to move forward as opposed to resolution strategies. The limited discussion of the emotional resolve may indicate that women have not completely worked through the emotional conflict they experienced with their diagnosis. However, the resolution strategy exposes a great deal about how women changed their behaviors after their STI diagnosis. They demonstrated control over their sexual lives by enforcing boundaries for themselves and others such as condom use and requiring monogamy. They displayed agency by seeking out knowledge to enhance their capacity to make informed decisions about their sexual health. Furthermore, the evaluation within this element of narrative illustrates how several participants consider this part of their narrative as a marker of resilience.

Character Element of Narrative

There is quite a bit of variation in how the character element of narrative is presented in the narrative plot structure (Daiute, 2014; Ollerenshaw & Creswell, 2002; Patterson, 2013; Riessman, 2008). Riessman (2008) discusses characters as a part of the orientation to the study because it contributes to setting the stage for the story. Daiute (2014) presents character as an individual element of narrative that includes the participants in the story as well as how the story is narrated. For the narratives in this study, the significance of the character element is found in the crucial role that the supporting characters play in shaping the participants' journey to resilience. The characters in the earlier part of the participant narratives, such as peers, mothers, and romantic partners played controversial roles in the narrative. Peers provided models of early sexual initiation, sexual exploration, and at times misinformation or partial information. Other characters withheld information, introduced negative stereotypes on women's sexuality, manipulated some into having sex when women did not seek it, and betrayed women's trust. One example of this is the tension participants described when discussing how they could not have conversations with their mothers. Many of the women expressed tension with their mothers regarding their lack of communication with them about boys and men, sex, and relationships. Some of these women described a deep longing for the ability to have open and honest conversations about sex with their mothers. Others regretted missed learning opportunities from their mothers, of which some may have been life altering.

In addition to mothers, other major characters consistently seen in the beginning of the narratives were romantic or sexual partners with whom the participants often had complicated relationships. The roles of sexual and romantic partners followed two different paths before and after the narrative high points. Many of the sexual and romantic partners discussed in the early parts of the narratives had detrimental impacts on the participants. For several women who were in a relationship at the time of their diagnosis, the storyline before and during the diagnosis included some mention of concerns about their partners' faithfulness. As participants narrated their stories, they often included a reflective evaluation on how they should have reacted when their partners' behaviors raised red flags.

Following the diagnosis, women present sexual and romantic partner characters differently. Several participants recalled how their new romantic partners were major resources for them as they resolved some of the emotional adversities they experienced following their diagnosis. Some stories reveal the significance of new intimate relationships in helping participants to advocate for their well-being. For most of her life, Destiny struggled with her self-worth and allowed people to use her. Her fiancé has helped her transform into someone who no longer tries to please others at her own expense. She describes in more detail:

> "My fiancé is a big aspect in the help of it for me. Um, I'd say before him I was pretty much like a doormat. Um, but he's the one who's been teaching me that it's okay to say no, don't feel guilty about it. Um, you know, don't be afraid to speak up for yourself. Um, talk out about it. There's been, you know, issues with our relationship, but it stems from my family and me having to learn to talk back and stand up to them and tell them, no, that's not how it is. And no, that's not how it's gonna go. Either you're gonna respect these boundaries or I'm gonna have to step back. Um, him telling me every day how pretty I am."

Her reflections unveil new insights about the positive role of romantic and sexual partners within this context. Her fiancé has supported her in reestablishing relationships with her family members in a way that is healthier for her. Bou, Diamond, and Monique referenced their new romantic relationships as a safe space that allowed them to rebuild trust in other people. When discussing her now husband, Monique said "I don't know, I guess all of those, all of those worries that I had, all of those, everything that I have felt he just made him go away." Although she still struggled with feeling dirty, she saw a lot of her concerns about trusting men recede into the background. Similarly, Bou had this to say about her new relationship, "I don't feel anxious. Like literally even when my ex, after we have sex, I'll be like, make a doctor's appointment. Like I was just like get like, nope, can't even do it now. It's like I feel very safe like with those experiences now because I have a partner who is, you know, he meets me in the middle. Yeah, it's just respectful." This illustrates how some of the anxieties Bou experienced about contracting another STI have been minimized by having a partner who shares similar values.

Participants spoke about several other characters who played a supportive role in helping them move forward. Often these characters were close friends or family members to whom the participant disclosed their diagnosis. Sometimes these characters got women to seek help when they noticed symptoms. NikAsia was initially too embarrassed to disclose she had been diagnosed with HSV 2, but she recently told her cousin and a close friend. Despite her initial hesitation, disclosing was an important part of NikAsias story.

> "I was embarrassed to tell my cousin, but to prevent me from going on Google trying to find out things. I was like, this is where I am, this is what it is. You can judge me if you want but tell me what you know about herpes. And it was, it was a blessing. She said, it is not the end of the world. It is not a deal breaker. Like you may meet someone and there are ways that you can manage this infection and cope with it. And it's not the end of the world."
>
> "Like life goes on, you can still get remarried and all that. I'm like, wow. She was like, yeah, just stick with your doctor and if you have questions you can call me or call your doctor and stuff. So yes, my cousin, she was definitely a lifesaver for me and a shoulder. Um, I don't think I had moments where I would cry or where I needed to call someone because I was crying or anything, but just to have someone to talk to about it."

By telling her cousin, NikAsia gained support that might not have otherwise been available to her. Moreover, her cousin provided a sense of hope, which is important for fostering resilience. Talking to her cousin helped NikAsia to realize that despite her diagnosis, she could work towards a romantic future with a healthy sex life. A few other women also confided in a friend or close family member about their diagnosis and received a supportive response. Friends were instrumental in a more positive manner during and after the STI episode, whereas in the beginning of the narratives peers often pressured participants into sexual activity. This indicates a shift in the role of peers and in the participants' support systems.

One of the most distinctive attributes associated with characters towards the end of the narrative’s was the dialogue that participants were able to have with these characters about their diagnosis and sexual health more broadly. In the following excerpt, Bou shares how the people in her life have helped her to shift her perspective on her diagnosis and make it into something positive. She places emphasis on solidarity among Black women because of the unique struggles they face in society more broadly. This emphasis calls attention to the systems that fail to provide Black women with the tools they need to achieve optimal sexual health outcomes.

> “I think it's creating safe spaces for us to do so; you know, I feel like if I would've seen anyone else proposing this research, I probably wouldn't have done it. Um, you know, I feel like especially as black women in society is 10 times harder on us and we are also very hard on us, you know? As black women. So, getting, creating that safe space, feeling validated and then like having access to education.”
>
> “A lot of us who have ended up in situations like this, you know, it's not our fault, but it's like this lack of education as well. You know, nobody's really telling us these things. Nobody's really telling us how to protect ourselves. So, you know, we beat each other down and we side at each other before we tell each other, all right, this, this looks like, and this is what this needs to be. So I think, again, like with me, you know, getting to that age, like I'm able to talk about these things because of spaces I intentionally put myself in now and like having other black women like, you know, see me for me.”
>
> “Every experience isn't like the end all be all. And like, again, like these past few months, years is reaffirming that like, these hard conversations can like happen. Like I was telling you about the classes that I'm taking now. Like this is an experience that I've shared with you, but in class, like, I'll share like home, like, you know, like childhood trauma or relationship trauma, friendship trauma and stuff. Like things I always tell myself I'm not sharing this outside of my intimate circle. Like I always say that like, I'm not sharing this or like, you know, I know I'm not the only black girl that feels this way, but black women can be harsh they can be really harsh. So it's even, I personally feel like it's even harder to have these conversations in those spaces sometimes cuz you don't know what nobody's thinking. Like you don't know if they're looking at you differently. But again, trying to like push away from that ideology and realize they're like, we can be that safety net for each other has helped me tremendously.”

For Bou, the supportive characters are not necessarily individual Black women, but communities of Black women that support each other. Despite her perception of Black women being ‘harsh’ toward each other, Bou recognizes the potential for healing that can happen when Black women come together in support of one another. Bou emphasizes the importance of safe spaces with other Black women to discuss topics that may be considered taboo like sexual health and wellness. As this excerpt illustrates, Bou has had the opportunity to experience a supportive environment with other Black women, which has offered her a safety net. This experience has been integral to her ability to take control of her sexual health after her diagnosis.

Diamond and Kese also discussed how communities of women helped them to move past their diagnosis. It was not until Diamond's second interview that she realized she overlooked participating in *The Vagina Monologues* as a major part of her resilience journey. The following excerpt briefly describes this part of her story.

> "That's all about reclaiming your you know, your strength… but that experience helped me to heal. I didn't, I guess I hadn't even thought about that until talking with you now. Well, *The Vagina Monologues.* Yeah. Being in the monologues, the meeting so many women who, you know, they identified as queer, lesbian or, you know, we, I think they shared a lot of like deep secrets about sexuality. I just didn't even think about…Like I wasn't even on that radar. I, one lady was like, I married my husband, and I realized now I don't wanna be married to a man. I wanna make me married to a woman. And she was like telling us all this stuff and confidence and it's like a small cast, you know, maybe 20 of us."
>
> "But those women I still have some relationships with to this day because it was like, it was a big deal. Yeah. So it helped me to heal. Um, my college roommate was in it with me. I did it again later in life. I did it as an adult too after I graduated college. I hadn't even thought about that. But that, that experience taught me that it was okay, I, you know, I'm gonna go through things sexually that are gonna be uncomfortable, nuanced, funny, hilarious. like sex is not always what you see. Like it was like glamorous on tv. Like it's okay to fumble."

Participating in *The Vagina Monologues* during her senior year was vital to helping her break the tie with her then boyfriend. Through the relationships she developed with her castmates, she gained new insights from the play's content about sex and sexuality. This experience also encouraged her to release some of the shame and embarrassment she had about her diagnosis because she learned that mishaps occur in sex and in relationships.

As noted in the introduction of this section, the findings above are reflective of a pattern of characters that supported participants along their resilience trajectory. There was minimal discussion of other supportive characters in the narratives. For example, Kasey discussed how helpful her OBGYN was in helping her understand her sexual health. She explains “having a very non-judgmental OBGYN who was open, and understanding was very helpful.” For other participants, however, the treatment interaction with providers was seldom discussed in a positive manner if at all. They were not integral characters in the stories women told about this experience. The limited discussion of other characters who were a part of shaping how women approached their health may be associated with the fact that many women did not disclose their diagnosis to anyone after it happened. Therefore, many of their journeys were defined by self-reliance. Women mentioned how helpful it might have been to have access to a support group with other women who shared similar experiences. Nonetheless, across the participant narratives, the supporting characters usually had similar functions along the participant’s journey primarily by helping participants to develop new perspectives on relationships, sex, and their health.

Coda—Story Ending

Coda is the last component of the participant narratives. It is the conclusion of the stories and a return to the present. It often involves reflection on the narrative (Daiute, 2014) This element provides insight on where the participants are now because of their diagnosis. It also includes participants’ reflections on their story, as well as any other closing thoughts about their experience of being diagnosed with an STI. As participants ended their stories, they touched on several things including educating their children about sex, reflections on resources they wish they had, and self-love.

Parenting Differently. First, many of the participants who were mothers expressed they have or planned to take a more open an honest approach to educating their children about sex. Kathleen was the oldest participant. She grew up in a setting in which there was an absence of conversations about sex. Even if she was curious, she was unable to ask questions, so she had to figure things out on her own. She did not want her children and grandchildren to have the same experience. Instead, she established transparency with them about sex. She shared the following regarding how she keeps an open line of communication with her children and grandchildren:

> “My mom used to say that I talked, I talked to my children about a lot of things that shouldn't be talked about. Just like when AIDS first came around and I would talk to my children about that and, uh, sexually transmitted diseases and, um, my, or herpes and things that, and my mom says, you, you, you talk too free with your children. I was like, ‘well, if I don't talk to 'em, who will?’ Right. If I don't make them aware, who, who's going to make 'em aware? Just wait till they get it and say, oh yeah, now I'll talk to you about something you may have been able to prevent if I had spoken to you before. Now you know. So, you know, uh, just sit down and be, be real. Just be real. Especially now with my, my granddaughter and my grandson who are here.”

Here Kathleen provides a compelling example of how she has been open and honest with her children. Although it is a sensitive topic, Kathleen knew the trajectory her children and grandchildren may follow if she did not provide them with information needed to make informed choices. She also articulates how it is her responsibility to ensure her children and children have solid knowledge because if she did not provide it, no one would.

> “Uh, my, my granddaughter, I think she was about 10, she's 14 now, she was about 10, nine or 10. And she, she came to me and said, because at this time my, my daughter was on um, um, drugs. So, you know, she wasn't really in the home. I was more, you know, the mom at that time, she, my dog granddaughter came to me and said, grandma, I like girls and I like boys. And I was like, okay. And so she went in to tell me, you know, what she thought and how she felt and, and uh, I didn't, I just talked with her and they said, oh no, you can't do that. Oh no, that's not possible. Her mom on the other hand was like, I'm a girly girl cause you gonna be a girl, girl. I said, that's not the way you handle it. you don't just decide for her what she's gonna do, how's she gonna be.”

> “So, um, it's whether you like it or not, whether it's something you would or would not do. I say accept it and be it as kind as you can. Listening is a lot better than saying, oh

> "No, you're not gonna do that." That's not happening in this house." You know, I just think that that is how conversations should go. Give and take. Not just you take this and live with it cuz it's the way it's gonna be."

This excerpt is a powerful example of a mother who became committed to open and honest communication regarding sex because of her diagnosis. The second paragraph in her narrative illustrates how Kathleen's openness created an environment where her granddaughter was comfortable coming to her to ask questions and seek guidance. She also draws attention to how she had to coach her daughter and how she ought to respond to her child's curiosity. She emphasizes the importance of talking with her granddaughter as opposed to talking at her and making decisions about her sexuality on her behalf. In the last part of the excerpt, Kathleen shares her perspective on how to approach these issues with children successfully. As the narrative suggests, she believes it is important for communication to be bi-directional and for adults to be kind and accepting.

Monique is a new mom. Her son was about 8 months old at the time of her interview. Yet, her story ending still included ideas for how she wanted to address topics related to sex with her son. She wanted to do things differently than they had been done with her:

> "I strive, I do, I strive to one day let my son be as knowledgeable without having those experiences that I went through. And even though he's the opposite sex I know, but, um, yeah. Like I don't want him to go through it the hard way. Absolutely. Or I don't want him to bring that to another female. That, that's like me. So Yeah."

Preventing her son from having the same experiences she had signifies that Monique wants her son to learn to learn another way. She alludes to the importance of equipping her son with knowledge so that he will not have to learn on his own through experience. Many of the other participants who were mothers expressed sentiments similar to those expressed by Kathleen and Monique. If they had not already begun having these conversations with their children, especially their daughters, they desired to do so. They wanted to use their personal experiences to help their children avoid some of the challenges they experienced with their sexual health.

Desired Knowledge. Secondly, a handful of women ended their stories by reflecting on the sex education that they wish they had. They specifically shared how they wanted to be able to have open and honest discussion with their parents about sex. Along with this, they talked about how having been able to have conversations with their parents early in their lives might have impacted sexual health behaviors, experiences, and outcomes. Jazmine elaborated on this concept saying:

> “It needs to be talked about more. Like in households. Mainly in households. Cause schools, like I said, school is okay, like it's good that they teach you that, but *it is better when it's coming from somebody who really loves you and cares about you*. So yeah. That's what I'm gonna do for my kids when they get older.”

According to Jazmine, it is especially important for children to learn about sensitive topics like sex within the household. Doing so could create an environment where children are more likely to ask questions because they know that the adults in their households do not mind having these types of conversations with them. Like several other participants who are mothers, Jazmine plans to have these types of conversations with her children once they are older. At the time of her interviews, both of her children were under age 4.

Leslie was another participant who articulated a desire for more robust sex education from her parents. Her mother was one of the parents whose discussion of sex narrowly focused on inappropriate touch. She felt the lack of education had a profound impact on the ways she approached sex and relationships. She had to learn on her own and reflected, “I more so wish I had got it from my mom than in the streets. It would've saved so much heartbreak and STDs, all of that, you know?”

These examples demonstrate the insight women developed on the crucial role that parents can play in shaping their children’s sexual health trajectories. When women reflected on their stories, they were able to point out how missed opportunities for discussions on topics related to sex contributed to their vulnerability in contracting an STI. Their narratives emphasize the need for children to be exposed to age-appropriate communication about sexual topics before they start exploring and learning on their own from outside influences.

Support From Other Women. Another resource participants referred to in their story ending was support from women who had similar experiences as them. These women needed more than their prescription from the physician. As demonstrated earlier in the narratives and in the research literature, there are significant emotional consequences associated with being diagnosed with an STI. Support from women who had a common experience would have been another form of care for some women. Monique emphasized the importance of Black women supporting each other in being “sexually resilient.” She explains:

> “That's where the support groups come in at. That's where the talking to your friends and not being ashamed about it. Because a lot of people look at that as, you know, being hot or fast or, you know, whatever you may call it. Um, not in a good light. They don't look at people like that in a good light. ‘Oh, you made this mistake?’ or ‘Oh, you caught it STD and that's nasty. That's dirty.” And I wish there were more people that will be, um, I wanna say supportive, but that's not the word. Um, okay. I guess I'll just use that. Yeah. I wish there were more people who would support each other rather than knock each other down.”

Monique is one of the participants who did not disclose her diagnosis to anyone. This is likely because of the reactions she received when notifying her partner, but also because of anticipated stigma. She believes that a support group would be a space for meaningful conversation among Black women to lift each other up and to normalize and destigmatize being diagnosed with STI. Perhaps, a support group may have assisted her in reframing her self-perception after her diagnosis. Several women echoed Monique’s sentiments regarding the utility of a support group for women who had been diagnosed with STI’s as a missing resource. Like Leslie who stated:

> “I don't see a lot of like groups like that talk about things like this. So, it's like, like say if I'm Googling like just support group for rape or a support group for STDs. I don't know. It may be, but I, I wouldn't, you know, I don't think it's a lot out there because I don't hear about 'em, you know. Like I don't, I don't hear about 'em. So, if it was like a group like that that people that's going through the exact same thing, you know that I'm going through you more inclined to like wanna hear and listen because, this person know exactly what I'm going through. They know exactly how I'm feeling. So, in case if they made it out they could help me with some things that I could do.”

Other participants offered a different rationale for support groups. These women referred to sharing stories with other women to not feel alone. By talking to other women about their experiences of being diagnosed with STIs, Kasey was able to shift the blame away from herself, and feel less embarrassed:

> “So I didn’t tell anybody about the, like the STD part or anything like that, but I know a lot of times we did have a lot of conversations when people were going through stuff with their men and just like having that support system to be able to talk things through and with people that were like you going through similar stuff, kind of, um, made a difference because we would give each other advice like, girl, don’t deal with that. Don’t take that. I know at first, I didn’t share a lot cuz I was embarrassed. But then when I started listening to other stories, I’ve even sat down with other women who admitted that they had STDs and they didn’t. And it was like, wow, you’re not embarrassed. Like why would I be embarrassed? He did it to me. And I’m like, wow. And I started to feel that way about abuse. *Like why am I embarrassed about somebody, um, abusing me? I didn’t hit myself, he hit me.* So that’s, you know, just being around other people kind of helped as, as an adult, like older, you know, just, just kind of gave me a different view too on different stuff.”

This excerpt illustrates Kasey’s transformation going from being reluctant to disclose her diagnosis to a willingness to share her story for the current study. Talking to other women with similar experiences created a space to get advice and receive affirmation. These conversations altered her thinking and pushed her to reject societal judgement about STIs that caused her to be embarrassed. Moreover, this reflection highlights how one can grow and demonstrate resilience within this context.

Self-Love. The next aspect women incorporated into the end of their narratives was offering encouragement to young women and girls. This included inspiring girls and young women to love themselves and discussing the importance of being an advocate for your body and sexual health. When looking back over their stories, a select few of the participants partially attributed the circumstances that led to their diagnosis to issues of self-worth. Earlier in her life, LaShawn had been looking for self-love in boys and men. Her journey following her diagnosis included the realization of self-love. She wanted other young girls to know the importance of self-worth and love, so she closed her interview telling young Black women "You gotta know your worth. Know your value. Love yourself." LaShawn believes that self-love is critical for helping women to protect themselves. This is not an uncommon idea regarding Black women's sexual health and wellness (Davis et al., 2022; Gause et al., 2019; McNeill et al., 2017; Shirley M. Timmons, Richard L. Sowe, 1999). Earlier in her narrative she shared that sometimes God allows people to go through hardship to learn from it. Her experience with the STI taught her to love herself better so that she will not repeat the past and have another STI episode. She has not had one since her initial diagnosis.

Along the same lines, Destiny also left a closing message for Black women saying:

> "Do not be afraid to make mistakes. Not be afraid to go and get the help that you need to get the testing done that you need without being afraid of judgment or what other people think or is going to say. Because your health is more important than what any anybody else's opinion is. And if nobody advocates for you, you have to be the biggest advocate for yourself."

This excerpt illustrates Destiny's awareness of how important it is for Black women to take control of their sexual health. She acknowledges that there can be some apprehension to seek help because of anticipated stigma or judgement but follows by speaking to the necessity for women to prioritize their health. This quote also highlights Destiny's transformation from being someone who perceived herself as a “doormat” to encouraging other Black women to be their own advocates.

Story Meaning and Reflections. The last common aspect within the story endings revolved around reflections on their story in its entirety. After reflecting on their first interview and reviewing their stories during the second interview, some participants offered additional insight on what the STI experience meant for them. Some women described it as something that contributed to their development as Bou shares:

> “Like, I'm glad I'm 22 figuring out now and I'm not in my late twenties or like late thirties, thank God I done already experienced all that I have possibly experienced. I feel like at this point there's still more, but it is like the majority has passed and I've experienced it and I have learned from it and I'm grown from it.”

Other women saw their infection as a lesson learned. Consider Destiny for example. After discussing being diagnosed with an STI and the circumstances surrounding it, she stated “Honestly, I just try to look on the bright side and just think positive you know. You can take something negative and turn it into something positive as well, just the way you perceive it.” She went on to explain,

> “It's another lesson learned all, you know, I mean, life is just a bunch of lessons that you learn in life, you know, whether, uh, either you learn from it or you run from it, you know? You can learn from your past or you can run from it. And I choose to learn from not only my past, but other people's past. So yeah, it's a downfall. Yeah, that sucks that this happened, but at least it's not something that's permanent, it can get taken care of and now you know what not to do.”

Here, Destiny emphasizes how although her experience was challenging, it taught her to navigate her sexual health behaviors in a different way. Kathleen expressed similar sentiments when she said “I have never been able been the one to lay down and, and not get back up. You know? So with everything, you either going to learn from the lesson and keep it moving or you're gonna stay there and die. And it, I don’t wanna stay there and die.” Reframing the experience in this way appeared to be an important takeaway because adopting this perspective also prompted participants to reflect on what they will do differently in the future.

Although it was not explicitly stated, what NikAsia shared suggests she views her overall experience as a lesson learned:

> “At the end of the day, I am owning this. I played a huge role in this. Um, I definitely did not see it happening, but if I’m 100% honest with myself, I wasn’t trying to prevent it. Um, this is the conversation and things that we don’t talk about regularly. Um, everybody’s just, oh yeah, you gotta go to the clinic and get that shot and then you’ll be all right. But what happens when the shot doesn’t help, when the shot doesn’t take it away? And these are the conversations that we don’t have. But, um, back to me personally, um, I’m accepting it. I’m moving forward, um, and I’m gonna educate myself and protect myself and anyone else that I get involved with, I won’t let it get me down. It's, um, it's a little speed bump right now. I’m slowly getting back in th’ lane to, to uh, full speed, but gradually I’m in no rush and I’m just gonna educate myself.”

This example highlights the different ways NikAsia has learned from being diagnosed with HSV 2. Owning her diagnosis prompted her to learn more about the disease and implement strategies to prevent transmitting it or contracting another STI. By doing this, NikAsia is taking control of her sexual health. Furthermore, NikAsia exhibits resilience and positive outlook as she describes her diagnosis as a “little speed bump.” Monique also framed the experience as a lesson learned but extends it beyond herself. She does not want what she learned from her experience to stop with her:

> “I want to pass on the information, and I don't just wanna keep it as a learning experience. it's, it's not just, it shouldn't just be my learning experience. Like my, my situation should be, you know, for everybody, because it's a lot to learn from that.”

Madison appeared to have a new revelation about her experience, which was motivated by her reflection on her story during the second interview. In her first interview, she shared she thought it may have been possible that she was born with herpes. However, in her second interview she said that she had not “humored that possibility” and had taken responsibility for her diagnosis. She continued her reflection by stating resilience for her “can look like helping yourself and others taking those first steps." Reflecting on her story gave Madison this space to share how she had taken responsibility for her diagnosis. It also points to how she defines resilience.

The coda offers valuable insight into what the diagnosis now symbolizes for the participants. Many of these excerpts demonstrate a shift in their perspective. Immediately after being notified of their diagnosis, almost all of these women experienced a notable amount of emotional distress. They were upset, embarrassed, ashamed. Some felt betrayed and hurt. Now at their stories' ending, it is clear they have generally shifted to have a more positive outlook. They have managed to turn a harmful experience into opportunities for growth and teaching others. The ways participants ended their stories demonstrates their growth past the diagnosis and the path they plan to take to continue forward.

Structural Analysis Epilogue: The Researcher's Perspective

One of my priorities in using narrative inquiry methods was to ensure that Black women were in control of their stories. One aspect that was not captured within the participants' narratives but is essential to the foundation of the study, is participants' feedback on the storytelling experience. To establish rapport with participants and provide them an opportunity to practice storytelling, I opened the interview by asking women to tell a story about why they decided to participate in the study. Some women jumped right into the story of their STI diagnosis, while others expressed a desire to be heard. At the end of every interview, once the storytelling was complete, participants were invited to share reflections on what it was like to participate in the project. Nearly every participant enthusiastically conveyed positive sentiments regarding their participation. They expressed a range of emotions, including gratitude at being able to share their stories and emphasized being heard:

- “I enjoyed it to talk to other women. It's always good to talk to other women to share our experiences. Just share what we've been through. That's how you learned from other people.” —LaShawn

- “It’s a great thing. Um, we don't get to tell our story.” —Diamond

- “So, one of the things I wanted to say was I appreciate what you're doing. Um, I appreciate you even take the, taking the time to even listen to people and hear people's stories and then the fact of even trying to make sure you get it right by, um, understanding about people wanting to be private. Um, and also just glad that there are people that care enough to ask questions. Like even if it's, you know, no matter what it's for it or what reasons for just to let people speak and give people a, a space to even, you know, getting these type of things out makes a difference.” ―Kasey

- “It helped me because I didn’t even know I was holding in until I came here. And I said it out loud and it hurted so bad that I didn’t know. Cuz I been just walking around acting like everything okay.” —Kese

- “I do think this is something that should be implemented into therapy because it is such a powerful way, like I said, like you don't know where you're going until you realize where you come from. Yeah. So that is like a good way for you to be like, especially like if you seeing somebody that may be suicidal or whatever, you can tell 'em like, you know, you've already overcome and accomplished so much. Like you definitely can do so much more. Especially with the focus of realizing what you've been through. Yeah. And that resilience is just going to help you and build you up stronger.” ―Kennedy

- “Putting it on paper and seeing it in words, I felt like, yeah, this is my story and that's what I went through and I'm better for it.” —Monique.

Some also shared that they felt more confident and empowered by sharing their story:

- “Participating in this has been like a pleasure truthfully. Cuz also it allowed me to stop suppressing things. You know? I will say, like, I did say I shared more with other people, but I have put it in the back. and I did put it in the back of my mind, honestly. When I read it, I'm like, have I, “Yeah, actually you did girl when you were 19 you experienced this.” Like Yeah, I literally had like put it in the back of my mind. So like opening, I guess like, I wouldn’t call it a wound anymore, but like opening that back up. So, it's been nice. I feel like I needed this experience.” —Bou

- “I'm just glad I was able to finally, you know, get it out. Cause like I said, it's been in holding in for like years and years. Like I said, the first when I was 18, I'm 35 now, so I spent how many years just had that bottled up.” —Leslie

- “I'm so thankful to be a part of this. And like you were saying, did I see myself like? Girl, I forgot that self. Like, oh my goodness, that was me. You took me back, girl. So I appreciate being a part of this. Thank you.” —NikAsia

Some women talked about wanting to help others and encouraged other women to tell their story to do the same:

- “I mean, it was really good. It's something different to do. I think everybody should wanna participate in something like this. I mean, it is good to get your message out there, your story out there. It really, it, it really is. Cause you never know who you might be inspiring. You don't know who you might be uplifting. You don't know who you might be encouraging.” —LaShawn
- “I just want to encourage women to please don't hold it in so long to where it is affecting you to a point that your physical body starts to fail you.” —Kese
- “Anyone that's, you know, struggling with having an s, STD or STI, um, who may be, you know, afraid to talk about it. Just knowing that there's other people out there that may, may have gone through the same thing. Like me, it wasn't my fault. I mean part of it was, but you know, I received it from somebody who I thought, you know, we were good. We were in a relationship. So yeah. I love this. I just, I think it'll help a lot of people that really want the help.” —Jazmine

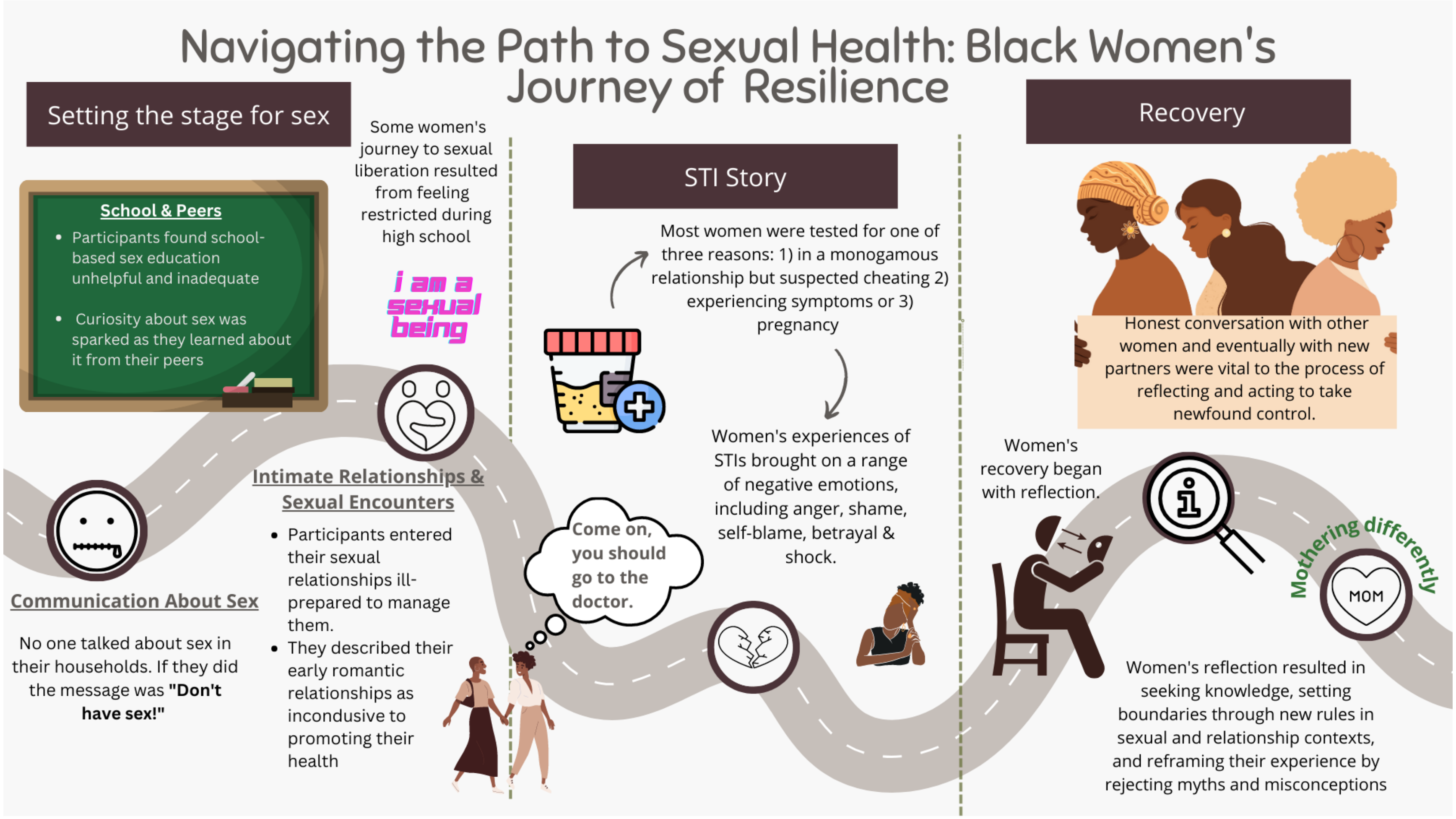
These comments reveal the profound effect of telling one’s story. As illustrated by the quotes above, using this methodology allowed me to engage my participants in data collection in a way that affirmed them. This is central to a Black Feminist approach which prioritizes the validation of Black women’s experiences and stories as a form of knowledge and knowledge production (Collins, 2002; Evans-Winters, 2019). Furthermore, these quotes provide further evidence in support of research literature that deems storytelling as healing and a stimulus for resilience. The implications of these findings will be discussed further in the next chapter.

Summary of Analysis

The structural narrative analysis revealed areas in the participant narratives that followed a common storyline or areas where they diverged. By and large, however, the elements of narrative reveal a journey of sexual health resilience that is consistent across participants, despite unique elements. For example, although some participants identified as biracial, there were no observable differences in their stories attributable to their biracial identity. This lack of distinction may be because all participants had Black mothers, which may have contributed to common experiences in their narratives. Figure 2 provides a visualization of the participants' journey of navigating their sexual health. Delving into the structural aspects of the narratives also unearthed the meaning and significance in what participants shared. In addition, women highlighted the value of participating in the study as a positive experience that may function as another step in their journey. I will discuss the implications of the findings for understanding resilience in the next chapter.

Figure 2

Black Women's Sexual Health Journey Map



Navigating the Path to Sexual Health: Black Women's Journey of Resilience

Setting the stage for sex

School & Peers

- Participants found school-based sex education unhelpful and inadequate
- Curiosity about sex was sparked as they learned about it from their peers

Some women's journey to sexual liberation resulted from feeling restricted during high school

Communication About Sex

No one talked about sex in their households. If they did the message was **"Don't have sex!"**

Intimate Relationships & Sexual Encounters

- Participants entered their sexual relationships ill-prepared to manage them.
- They described their early romantic relationships as inconclusive to promoting their health

STI Story

Most women were tested for one of three reasons: 1) in a monogamous relationship but suspected cheating 2) experiencing symptoms or 3) pregnancy

Women's experiences of STIs brought on a range of negative emotions, including anger, shame, self-blame, betrayal & shock.

Recovery

Honest conversation with other women and eventually with new partners were vital to the process of reflecting and acting to take newfound control.

Women's recovery began with reflection.

Women's reflection resulted in seeking knowledge, setting boundaries through new rules in sexual and relationship contexts, and reframing their experience by rejecting myths and misconceptions

Chapter 4: Discussion

In this dissertation study, I investigated pathways to resilience among Black women after being diagnosed with a STI. Through narrative inquiry methodology, I examined how resilience was displayed in this context, identified factors that contributed to the participants' resilience, and explored how participants define resilience. Using narrative inquiry allowed me to implement a participant-centered and creative approach to engage with Black women on a sensitive topic. I conducted episodic narrative interviews, which prompted the participants to tell stories that were specific to their sexual health. Following the initial interview, I worked with each participant to co-create a story that illustrated their sexual health journey. Many of these stories began in childhood and ended with a reflection on their hopes for maintaining a healthy sexual future for themselves and, in some cases, their children. Then, I employed a structural analysis to compare, contrast, and theorize across participant narratives. To my knowledge, this is the first study investigate how Black women move through and past their STI diagnosis. As noted in Chapters I and II, the research on Black women's sexual health and well-being often comes from a deficit-oriented framework, which tends to focus on risk and disparities. This dissertation departs from this framework to examine strength and resilience. This chapter includes a summary of the key findings as they relate to the research questions and other seminal literature in the field, as well as discussing implications for practice, theory, and future research.

Summary of Key Findings

Initially, I set out to answer three questions regarding 1) how resilience is defined in the narratives of Black women, 2) how Black women display positive adaptation amidst the social, physiological, and mental challenges associated with being diagnosed with an STI, and 3) the socioecological factors that drive resilience among Black women within this context. Although I was principally concerned with how Black women recover from the experience of being diagnosed with an STI, the findings from this study also provided insight on some of the ecological factors that impedes Black women's sexual health. In addition, significant findings related to the appropriateness of storytelling and narrative inquiry methodology for the study design emerged.

Roadblocks to Black Women's Sexual Health

Although my study was not intended to be about women's vulnerabilities, understanding barriers to their sexual health is important for shifting the blame away from Black women and exposing the structural factors that sustain inequity. Women's stories revealed how they entered their sexual relationships ill-prepared to manage them in the ways they wanted to. Their lack of preparation can primarily be attributed to systemic inequities at multiple levels of analysis. One of the greatest commonalities across almost all women's stories was how sex was not discussed in their household. Like findings reported by Crooks et al., (2019 women learned about sex from their peers or through experimentation to fill the knowledge gap left by the adults in their household. Previous research has documented deficiencies in parental communication with their adolescent and young adult children about sex (Goldfarb et al., 2018; Grossman et al., 2016; Holman & Koenig Kellas, 2018). Women's description of the silence, fear and abstinence-based messages they received are consistent with other studies that have found parental messages about sex to be non-existent or negative (Goldfarb et al., 2018; Holman & Koenig Kellas, 2018; Rubinsky & Cooke-Jackson, 2017). Raising Black daughters in a society that objectifies (Stephens & Phillips, 2003; Ward et al., 2013) and stereotypes Black women and girls (Anderson et al., 2018; Brown Givens & Monahan, 2005; Collins, 2002; Wyatt, 1998) may prompt mothers to socialize their daughters in resistance to these stereotypes. However, this may lead to daughters getting messages that are not helpful in navigating their sexuality. The culture of silence, risk-based and abstinence only messaging women received may have reinforced stereotypes that hypersexualize Black girls and harm their self-image (Leath et al., 2020). According to prior research, Black mother's hesitation to communicate with their daughters about sex may be rooted in politics of respectability (Dennis & Wood, 2012). Although participants did not explicitly state why their mothers did not have these conversations, many wished they had been able to have open dialogue and receive sexual education from their mothers. Future research could further explore Black mother's hesitancy in talking to their daughters about sex.

Another major challenge women faced was inadequate sexuality education in school. Their narratives suggest the sexuality education provided to them was not sufficient in helping them to resist pressures, negotiate boundaries, or make informed decisions related to their sexual experiences. Unfortunately, this finding is consistent with other literature that purports sex education offered in United States' schools to be ineffective in providing adolescents with accurate sexual knowledge and positively influencing their attitudes and beliefs about sex (Bute & Jensen, 2011; Schalet et al., 2014). While Weinstein et al., (2008) indicate that the connection between sexual knowledge and sexual behaviors to be elusive, findings from this study suggest otherwise. Consistent with findings from Lindberg & Maddow-Zimet, (2012) results from this study suggest there may be a connection between adolescent sexuality education and subsequent sexual behaviors.

The Impact of the Infection

Studies on STIs among women have consistently found that contracting an infection leaves women with a range of psychological and emotional consequences (Crooks et al., 2019;

East et al., 2012; East, Jackson, Peters, et al., 2010; Merin & Pachankis, 2011; Nack, 2000a, 2002) The results of this study replicate these findings. Women described psychological and emotional distress after they had been diagnosed with an STI. Women experienced negative emotions including shame, anger, self-blame, betrayal, and shock f. They also had internalized stigmatizing societal messages that deem people who have STI's as dirty and damaged (East et al., 2012; Lichtenstein et al., 2005; Melville et al., 2003; Shefer et al., 2002), and exhibited internalized stigma (Major et al., 2018). Irrespective of setting in which women acquired the infection, they were all shocked. Some perceived sense of invulnerability to STI's and like the women in East, Jackson, Peters, et al's (2010) study, experienced a conflict with their prior beliefs regarding their sexuality. Furthermore, like reports from women in prior research, women in this study expressed concerns about implications of the infection for their future romantic relationships and sexual encounters (East et al., 2012, 2017).

Reflection and Reassessment

Contracting a STI can be disruptive to one's sense of self (East, Jackson, Peters, et al., 2010) and romantic relationships (East et al., 2017). Contrary to literature that highlights denial as a form of self-preservation after contracting an STI (East, Jackson, Peters, et al., 2010; Melville et al., 2003), some women in this study became introspective and reflective as they attempted to reconcile the psychological and emotional adversities following the infection. This was especially common among the women who decided to practice abstinence following their diagnosis. Pausing dating was helpful to regaining control and moving toward relationships and sexual encounters that prioritized sexual health. Reflection aided women to commit to behavior change to protect themselves against contracting an STI in the future. According to Crooks et al., (2019) an STI diagnosis can be motivating for women to protect themselves. Given the surprise all participants experienced about their diagnosis, women's introspection was necessary to help them make sense of diagnosis and the circumstances leading up to it.

The Demonstration of Positive Adaptation

Considering my research questions, I was especially interested in how women displayed resilience following their diagnosis. Participants provided numerous unique examples of how they displayed positive adaptation after their diagnoses. In their stories, practicing consistent condom use, remaining abstinent, implementing boundaries, practicing monogamy, and self-education were discussed after their diagnosis as resolution strategies. Although almost all the participants shared that they experienced some form of shame or other negative emotion because of their diagnosis, many of them did not remain immobilized by the negative. Instead, they engaged in behaviors to reduce their likelihood of contracting an STI again, which can be illustrative of positive adaptation. Research has documented the challenges with establishing what constitutes positive adaptation (Mahoney & Bergman, 2002; Windle, 2011). This is because the positive adaptation must be assessed within the context of the adversity or risk. Therefore, it is appropriate to consider STI risk reduction practices as evidence of positive adaptation. Furthermore, these behaviors are consistent with the CDC and WHO guidelines on behaviors that prevent the transmission of STIs (CDC, 2023; World Health Organization, n.d.).

To date, there is a paucity of literature on the ways in which positive adaptation occurs within the context of a sexual health illness. As discussed in chapters one and two, the research on STIs among Black women typically focuses on the risks that make them vulnerable to STI acquisition (Cohn & Harrison, 2022; Opara et al., 2021). Seldom does the literature examine what happens after one is diagnosed. When research does address post-diagnosis experiences, it tends to focus on the challenges women experience because of their diagnosis (Blake, 2016;

Nack, 2000a) with limited discussion of the ways they navigate those challenges in an effective manner. Although there are not studies that provide specific examples of positive adaptation in the context of an STI, these findings align with research that defines positive adaptation as positive health behaviors (Dukes Holland & Holahan, 2003). The results from this study provide additional support for existing research that likens resilience in the physiological aspect of health to lowering the risk of acquiring illness (Sturmberg, 2018).

To an extent, findings from this study are consistent with prior research that documents the challenges with establishing the criteria for positive adaptation. Resolution strategies like knowledge seeking and boundary setting are not inherently tied to STI risk reduction in the same ways as consistent condom use, abstinence, and monogamy. For example, someone educating themselves to avoid future STI acquisition because they simply wanted to be more informed about their bodies is not typically identified as a form of positive adaptation but clearly was in these women’s experiences. Following their infection, several women saw their bodies differently (and more positively) than they did before. Women had varying motivations for this change in perspective: to be a better role model for their daughters, to achieve spiritual alignment. Women now saw their body as something to be proud of, to honor, and protect. They implemented resolution strategies to protect their bodies and preserve their sexual well-being overall, not just to avoid STIs, but to honor their bodies. At the same time, it was also apparent that some women adopted behaviors that are typically considered to be protective, like abstinence, for example, out of fear of acquiring another STI. No matter the rationale, choosing to practice abstinence is protective against STI acquisition and is therefore reflective of models of resilience that emphasize risk reduction, like the protective model for example (Zimmerman, 2013). However, because some women’s decision to be abstinent was driven by fear as opposed to bodily autonomy, agency, and control, in some ways abstinence as a marker of resilience in this study deviates from the strengths-based framing in which resilience allows women to experience fulfilling, pleasure-based sexual lives that meets their personal wants and needs. This finding also differs from frameworks in which resilience represents a return to normal functioning after experiencing adversity (Masten, 2007). This is because a return to “normal” functioning for these women would have involved having consensual sexual experiences without acquiring an STI. Some may even argue framing abstinence as a form of resilience is problematic and uncharacteristic of resilience because of the harm that can be perpetuated by promoting abstinence through abstinence-only education (Hoefer & Hoefer, 2017). The subtleties and nuances underscoring why women choose to adapt in certain ways further reveal the subjective nature of positive adaptation and the importance of investigating resilience journeys.

Socioecological Drivers of Resilience

Consistent with research on a socioecological perspective of resilience (Dulin et al., 2018, 2021; Ungar, 2011a, 2011b), findings from the current study point to the relevance of ecological resources at the interpersonal level to build resilience. The characters women identified in their stories – principally family and close friends - offered social support which helped them to process many of the negative emotions they experienced and remain hopeful about their romantic and sexual futures. Communities of women were integral to the process of overcoming and growing from the STI experience, helping women to feel less isolated, alone, and stigmatized. Other studies also find social support from other women plays a central role in fostering resilience among Black women (Dale & Safren, 2018). Engaging with other women also helped participants to unlearn some of the messages they received about women’s sexuality when they were growing up. It is important to note that this was not the case for all women, because some of them had not shared their experiences with infection with anyone other than me. Social support obtained through interpersonal and communal relationships moved participants towards resilience by providing an emotional and sometimes physical safety net. The ability to have honest conversations with new partners was also vital to women's resilience. Through these relational safe havens, women are reaffirmed (Dale & Safren, 2018; Koch et al., 2022; Lipira et al., 2019; Qiao et al., 2019; D. Rao et al., 2018). Furthermore, as suggested by Newton & McCabe, (2008) women's disclosure to their new romantic partners, may have helped them to overcome internalized stigma about contacting an STI and see themselves in a healthier way.

Other applications of the socioecological framework to resilience in the context of health have identified religious organizations, health facilities, health service providers, and community training programs as community and institutional level resources for resilience (Qiao et al., 2019). In women's narratives, these formal settings played virtually no role. It is not surprising that participants did not discuss higher-level drivers of resilience since many of the women had only talked to me or one or two other people about their diagnosis. The lack of salience of community and formal institutions as drivers of resilience could be attributed to several things. First, given the ways that women were socialized to sex, as well as the societal stigmas about STIs, most of the participants managed the impact of the STI intrapersonally to avoid stigma (e.g., anticipated stigma). There is a possibility that formal institutions had resources to foster resilience that women were not aware of, which points to a need for increased visibility of formal resources for STIs. A social representation of STI's as common, but less serious and therefore less urgent and visible than more chronic illnesses like HIV, may also be why formal institutions did not appear in women's stories. These findings are largely consistent with prior research that highlights the need for structural change such as increased availability and accessibility of formal helping systems to improve Black women’s sexual and reproductive health (Dehlendorf et al., 2021; Prather et al., 2016; Thompson et al., 2022). In addition, this finding has crucial implications for the need to destigmatize STIs. Anticipated stigma prevented some women from seeking help and support. Perhaps, if STI’s were not so stigmatized, services for people who have STI’s would be more widely available, and women may have been more comfortable seeking help and support from formal institutions.

What Does Resilience Mean to Black Women?

Central to the idea of learning from adverse experiences as a form of resilience is Richardson’s (2002) metatheory of resilience. Richardson asserts that resilience involves the capacity to learn and grow from experience. However, the experience must be disruptive to one’s view of themselves or the world. Consistent with this conceptualization of resilience, a few participants defined resilience as their ability to learn from their STI diagnosis. Despite the difficulties associated with contracting an STI, women re-framed the experience as beneficial. They indicated the experience taught them to navigate their sexual health behaviors in a different way which is what Richardson suggests in prompting self-reevaluation (Richardson, 2002). This finding also parallels existing research where resilience is characterized as a process in which one learns from challenging experiences (Kralik et al., 2006; Mooney-Somers et al., 2011). In other cases, some participants described resilience as their ability to acknowledge and take responsibility for their diagnosis. Women reported several positive benefits associated with acknowledging and taking responsibility for their diagnosis which included gaining a sense of control and initiating the help seeking process. The way women in this study defined resilience is consistent with Frank's, (1995, p. 1) quest narrative type, where illness is perceived as an experience from which something can be gained (p. 115). More specifically, these findings correspond with the manifesto sub-type of quest narratives where illness functions as a catalyst for change.

Simmons-Horton & Gibson, (2022) suggest that self-accountability prevents maladaptive behavior. In this study, however, self-accountability was not preventative. It occurred after the adverse experience and contributed to resilience by helping one overcome their exposure to adversity. The differences in these two approaches to understanding resilience are representative of the compensatory and challenge models of resiliency which have been used to explain resilience in the context of health (Zimmerman, 2013). The compensatory model posits that promotive factors compensate for risks such that they have an additive positive effect on a health outcome. The challenge model best explains situations where a moderate level of risk helps one to cope or overcome exposure to risk therefore decreasing their vulnerability to a negative outcome (Rutter, 1987). The findings in this study are more consistent with the challenge model of resilience where the infection led to the enactment of protective behaviors (Richardson, 2002). Future research should aim to further delineate the different ways in which Black women take control of their lives, especially in adverse and sensitive situations, and seek to understand how it is related to resilience.

The Value of Storytelling, Narrative Inquiry, and Black Feminist Thought

Another critical finding of this is related to the significance of using narrative inquiry for this study. The results support research that recognizes storytelling as a framework of healing (Chioneso et al., 2020; East, Jackson, O’Brien, et al., 2010). As discussed in the participant narratives, being diagnosed with a sexually transmitted infection can be a challenging situation. Often times, the diagnosis is accompanied by feelings of shock, shame, embarrassment, betrayal and a loss of trust. Research suggests that the process of storytelling has the potential to imbue a positive lens on an adverse situation (BigFoot & Dunlap, 2006; Chioneso et al., 2020; Comas-Díaz, 2016; Parks, 2007). This is a key feature of the current study. In their narratives women described various attempts to turn their diagnosis into a positive situation. Moreover, as demonstrated by the reflections that were discussed in the epilogue of the structural analysis, some women in this study found their participation to be therapeutic.

Additionally, by reframing their experiences, they are also disrupting dominant narratives such as those that present Black women's sexual health from risk and deficit-oriented perspectives (Hargons et al., 2021; Lindsay-Dennis, 2015; Townsend et al., 2010), or stereotypical images such as Jezebel and hoochie that present Black hypersexual and deviant (Collins, 2002). Many of these negative representations of Black women's sexuality can be traced back to slavery (Collins, 2004; Stephens & Phillips, 2003; Wyatt, 1998). Several researchers have called for a paradigm shift in the sexual and reproductive literature to move away from studies focused on individual-level risk behaviors, towards a more robust exploration of the social context that drives sexual and reproductive health inequities (Brawner et al., 2016). Within this call, researchers have also highlighted a need to push for research that deconstructs deficit-based narratives of Black women's sexuality (Barlow & Dill, 2018; Leath et al., 2020, 2021; Opara et al., 2021). Findings from this study extend the literature on Black women's sexual health by presenting narratives that highlight pertinent information about Black women's adaptability and resilience.

Black Feminist Thought. Data from this study supports the use of Black Feminist Thought as a theoretical approach in community psychology research. First, Black Feminist Thought emphasizes the importance of framing Black women's experiences in within the context of intersecting oppression driven by the US matrix of domination (Collins, 2002). Analysis of the early parts of the participants' stories reveals the larger structural issues that contribute to sexual health inequity among Black women and girls. Women discussed the social backdrop in which they were initially socialized to sex which typically included an absence or very limited exposure to inclusive and accurate sexual health knowledge. These findings revealed failure at the interpersonal (family/household) and community (school) levels to equip Black women with the tools needed to successfully navigate their sexual health. In addition to the community psychology theoretical stance which emphasizes interactions between Black women and their families/schools as central to the absence of their sexual health knowledge, Black Feminist Thought ideologies call attention to the specific social, historical, and political contexts that shape Black women's experiences. For example, concerning the disappointment women expressed with the sexual health knowledge they did (or did not) receive from their mothers, Black Feminist Thought framework highlights how Black women have historically been encouraged to be silent about sexual matters (Collins, 2000), therefore their mothers may not have been equipped to have these conversations with them. Furthermore, when participants shifted their perspective on their diagnosis, it demonstrates two core themes of Black Feminist Thought, self-definition and self-valuation (Collins, 2000). The findings illustrate how Black women are resilient, which represents a form of oppositional knowledge compared to research that perpetuates power imbalances by presenting Black women as powerless victims to their circumstances (Evans-Winters, 2019; Greene, 1990).

Limitations and Areas for Future Research

Although this study offers significant contributions to the current literature, there are still several limitations that should be considered. First are limitations with the selected approach to structural narrative analysis. This study used an integration of Labovian and plot structural analysis. Plot analysis is more flexible in terms of structure than Labovian analysis, however, both of these are linear models of analysis. Riessman, (1993) criticized Labovian analysis as one that does "Not provide an adequate model for subjective events that unfold over time and even extend into the present" (p.51-52). I found this critique to be true for the current study. The structural analysis focused much more on what happened in the narratives as opposed to a more experiential approach that focuses on the narrator's affective responses to what they tell. I found that this type of analysis does not provide a clear place for integrating emotion into story structure. I attempted to remedy this limitation by integrating evaluations at multiple points throughout the narrative as suggested by Daiute & Nelson, (1997). This strategy provided more insight on the underlying message associated with the women's narratives. Despite this, I believe the application of other analytic strategies may have yielded an enhanced understanding of the content of the stories. Future research on this topic may benefit from a more paradigmatic analysis of narrative which focuses on identifying themes to produce a more holistic view and generalizable findings (McCance et al., 2001).

Another potential limitation of this study is the variation in interview modality. Some interviews were completed in person while others were completed via Zoom at the participants request. While Zoom may have been convenient for the participants and enhanced their comfort, Zoom was subject to technical problems (e.g., internet connectivity) and my inability to control the interview environment (e.g., to limit interruptions, ensure the participants' undivided attention). During the analytic process, I noted where there were interruptions in the interviews on the interview transcripts. These interruptions tended to be very brief and minimally affected the flow of the conversation in many cases, but not all. One final limitation associated with the use of Zoom was the hindrance of social cues. All of the participants positioned their faces in the camera but their proximity to the camera varied. I was keen to observe participants' facial expressions and able to do so but was unable to observe other body language. This limited my ability to respond to non-verbal body language cues. I also felt restricted in my capacity to provide immediate comfort and support to participants, particularly when they cried. Women varied in what parts of their stories provoked this type of emotional distress. As with my interviews conducted in person, I still followed guidance on conducting sensitive topic interviews which recommends pausing the interview to allow the participant time and space to recenter themselves. Once the participant regained composure, I allowed her to decide if she wanted to continue the interview. I also offered resources for emotional support and self-care following the interviews. Nonetheless, the quality of the Zoom interviews may not be comparable in quality to those I conducted in person.

Although the use of storytelling, narrative inquiry, and Black Feminist thought were primarily beneficial for this study, each of these frameworks place a strong emphasis on giving research participant's agency with the information they share. They also draw attention to the importance of the participant's standpoint. In conducting the interviews, I attempted to honor these principles by intervening as little as possible in their storytelling. When I probed for more information, I posed questions that aligned with what they had already shared. This might have impeded my ability to explore other related topics I was curious about. For example, I was highly interested in how religious involvement might have impacted women's experiences, but the topic only came up for a few women. The removal of the two participants from the analytic sample is also related to this limitation. If I had asked them more structured research questions, I may have been able to garner more relevant information from their interviews to develop a cohesive story about their experience with infection. This limitation also reflects how qualitative work is a co-creation of reality between the researcher and researched. Despite my attempts to address my biases and assumptions and limit my interrupting during the interviews, what women shared in their interviews and the construction of the stories was not without my influence.

Since my recruitment approach focused on the mid-Michigan area another limitation concerns the extent to which the findings are transferable to a larger population of Black women, especially those from another geographic region, Whereas quantitative research is concerned with generalizability, Lincoln & Guba, (1985) proposed that transferability is a criteria for evaluating trustworthiness of qualitative data. Transferability is the extent to which qualitative research findings are applicable or relevant in similar contexts or among similar populations. Although the CDC reports similar rates of chlamydia and gonorrhea in the South and Midwest from 2011-2020 (CDC, 2022) there are major differences in the social, cultural and political environments that may affect how women navigate their sexual health following an STI diagnosis. I attempted to provide “thick descriptions” that enables readers to contextualize the study and assess the applicability of the study to other contexts. However, since this recruitment for this study only occurred in Michigan, it is possible that the transferability of the results to populations in other locations is restricted. This limitation points to a need for future work to replicate this study in other geographic regions.

There is also the possibility that bias may have been introduced in this study because there was not an explicit examination of differences in participant stories related to: type of STI (e.g., curable versus uncurable), age of first STI, age of sexual debut, and generational differences among the participants. Important distinctions in women’s stories regarding positive adaptation and resilience may have been overlooked by not specifically checking for differences across these factors. For example, the way women living with an incurable STI see their bodies and display resilience after their diagnosis may be different than women who are able cure their infection through treatment because having an incurable STI “casts a shadow of disease on the health and desirability of a women’s body, as well as on her perceived possibilities for future sexual experiences” (Nack, 2000a p.96). Moreover, the social responsibility of having an incurable infection may also affect how women react and positively adapt to their diagnosis. There were too few participants older than 50 years of age (n=1) and who had incurable STI’s (n=2) to be able to assess generational differences or differences based upon the curability of infection. Future research could explore if potential differences exist across these factors by having a larger participant sample, with equal sample sizes to allow for comparison across cases.

One final limitation associated with this study is the minimal discussion of pleasure, which I noticed after the interviews were complete. Many of the women’s narratives captured how STI infection led to adaptation of several preventative practices and self-knowledge. While this represents resilience because it demonstrates how they adapted to the diagnosis in ways that help them to minimize risk, this finding does not provide thorough insight on how Black women maintained pleasureful sexual experience which is important for shifting the narrative on Black women’s sexuality (Hammonds, 2004; Hargons et al., 2021; A. Jones, 2018; Ware et al., 2019). A more holistic understanding of Black women’s sexual health and wellness also requires an exploration of how Black women still experience pleasure while implementing preventative practices. The interview protocol for this study was not designed to probe for information about pleasure. As such, more specific questions could be asked to elicit information on this topic. It may have been beneficial to probe participants on their hopes for pleasureful sexual experiences after their infection toward the end of the first interview or during the cocreation interview.

Subsequent research can extend findings from this study to include an exploration of sexual pleasure.

Implications for Methodology

Applying this framework was significant regarding aspects of Black Feminist Thought that address knowledge production. First, this study contributes to the growing scholarship on Black women that privileges their experiential knowledge and voice (Barlow & Dill, 2018; Blount, 2018; Leath et al., 2021; Wade et al., 2022). This study also offers some support for the Black Feminist Thought assertion which centers the experiences of Black women's relationships with each other (Collins, 200). Several participants solely showed up to participate in my study because they wanted to help another woman who they presumed was Black. Others said that they would not have participated in the study if they were not going to talk to a Black woman. These claims support Collins (2002) assertion that "this issue of Black women being the ones who really listen to one another is significant, particularly given the importance of voice in Black women's lives" (p. 103).

Moreover, this study adds to the literature that uses Black Feminist Thought as a theoretical framework for studying sexual health issues among Black women. Fusing Black Feminist Thought and narrative inquiry methodology to study Black women's experiences in the context of a highly sensitive topic was valuable. This integrated approach yielded robust and unique insights while also engaging women in research in a way that appealed to them.

Implications for Theory

A central aspect of this study was defining resilience for Black women who had been diagnosed with sexually transmitted infection. Participants revealed a multifaceted understanding of resilience. For them, resilience was not limited to taking preventative measures because it also included transforming the experience of infection into something that enhanced their well-being. They used language such as “learning from my mistake” and “taking ownership” to describe how they moved past the diagnosis. Teti et al's., (2012) study of resilience among Black men also indicated learning from hardship as a form of resilience. Furthermore, while there is variability in the way resilience has been defined and conceptualized (Fergus & Zimmerman, 2005; Humbert & Joseph, 2019; Luthar et al., 2000), almost all seminal resilience research acknowledges that resilience is comprised of an adverse situation or risk, and a positive outcome despite adversity (Fergus & Zimmerman, 2005; Garmezy et al., 1984; Luthar, 2003; Luthar et al., 2000a; Rutter, 1987; Zimmerman, 2013). Defining resilience as learning from mistakes is consistent with this theoretical conceptualization as a two-part construct. When women say they “learned from their mistakes” learning is the positive outcome, and the mistake is the adversity.

The connection between taking ownership and resilience is less clear. However, Bottrell, (2013) suggests taking ownership and responsibilities for adverse situations is problematic, especially among marginalized populations. Portraying responsibility and ownership as a part of resilience places the burden of adversity or risk on the individual. For populations like Black women that face interlocking forms of oppression, framing resilience in this way can be harmful because it does not account for the structural inequities that place them at a greater vulnerability to adversity. Depictions of resilience in this way can contribute to stereotypes that present Black women as perpetually strong (Abrams et al., 2014), which has a range of psychological and physiological consequences (Abrams et al., 2014, 2019; Watson & Hunter, 2016; West et al., 2016). At the same time, it is also important to acknowledge the positive benefits Black women may experience from taking ownership of their diagnosis. For example, having a perceived sense of control is an aspect of psychological empowerment (Zimmerman, 1995) and psychological empowerment is protective against sexual risk behaviors among young Black girls (Opara et al., 2022).

This study also contributes to Resilience Theory by establishing criteria for what constitutes positive adaptation in the context of sexual health adversity. Because the majority of sexual health literature on Black women comes from a deficit orientation, strengths-based constructs such as positive adaptation have been overlooked and the specificity of what encompasses positive adaptation in this context has been understudied. Moreover, researchers have cited complications with defining positive adaptation in general (Luthar et al., 2000; Wright et al., 2013). The findings in this study align with a holistic perspective of positive adaptation (Mahoney & Bergman, 2002). This conceptualization emphasizes positive functioning beyond the absence of a problem. For example, rather than highlighting women's negative STI status as an indicator of positive adaptation, positive adaptation in the context of this study encompasses protective behaviors, finding ways to overcome the impact of structural inequities, and the acquisition of knowledge. More importantly, this study captures how positive adaptation also includes self-love, honoring one's body, moving towards personal control, and contributing to the health of other women. These findings are a unique contribution to Resilience Theory and the sexual health literature. Researchers should continue to use strengths-based theoretical frameworks to study issues of sexual and reproductive health among Black girls and women. Continued use of these frameworks may contribute to the development of more effective STI prevention and reproductive justice interventions and programs.

Implications for Practice

While the initial aim of this study was to highlight how Black women successfully navigate their sexual health following an STI diagnosis, the findings also reveal important information about vulnerabilities that make Black women susceptible to acquisition of STIs, as well as gaps in the provision of care in the health care system. As illustrated by the narratives, many women experienced extreme emotional distress upon being diagnosed with an STI. Although women were treated for the physiological aspect of the diagnosis, they were not offered any tangible resources for managing the emotional impact. This is not to suggest that physicians or other healthcare practitioners should doubly function as mental health service providers, however, it is important for practitioners to provide women with guidance to resources that may help with this aspect of the diagnosis.

The use of a strengths-based theoretical framework draws attention to assets that support Black women in their pursuit of sexual health and well-being. Researchers can learn from the way these women positively adapted and bounced back to support the development of future strengths-based sexual health intervention and prevention programs. Women discussed social support, especially among other groups of women with shared experiences as a driver of their resilience. This finding highlights the potential utility of developing prevention and intervention programs informed by Black feminist and womanist principles. The incorporation of a Black feminist lens into sexual health prevention research and interventions has several benefits. First, it requires a reckoning and resistance to the social and historical inequities that have negatively impacted Black women's sexual health outcomes. This will shift the focus away from individual level risk behaviors towards issues at higher levels of analysis. Second, the integration of these frameworks will lead to the development of prevention and intervention programs that equip Black women with the support, resources and tools needed for flourishment of their sexual lives.

Findings from this study also point to the utility of family-based prevention interventions. Many women expressed a deep yearning to have gained sexual health knowledge from adults in their household, especially their mothers. These interpersonal relationships were an immensely important part of women's microsystem, especially when their formative years (Bronfenbrenner, 1994; Bronfenbrenner, 1979). Researchers and practitioners should consider more widespread implementation of prevention interventions like IMARA (Donenberg et al., 2020) for example, that equip mothers with the skills needed to have healthy communication with their daughters about sex.

Findings from this study also have critical implications for clinical practice. There was a general absence of discussion of healthcare providers in women's stories. Very few women referred to their providers as a resource following their diagnosis, revealing a potential gap in the healthcare systems ability to support women navigating complex sexual health issues. The lack of guidance or insight from providers may leave women feeling disenfranchised and incompetent, which may deter them from seeking healthcare in the future (Cazeau-Bandoo & Ho, 2022; Cunningham et al., 2009; Logan, Daley, et al., 2021). When providers deliver positive STI results and prescribe treatment, they should also prioritize having non-judgmental, informative, and empowering conversations with their patients. Existing research on the experiences of Black women with sexual and reproductive health service providers suggest this conversation could include creating a space for the participant to ask questions, share their thoughts, and for their emotions and thoughts to be validated (Logan, Daley, et al., 2021; Townes et al., 2022). It could also involve some form of comprehensive sexuality education, going beyond directives to use condoms, ensuring the patient has access to testing or other preventative resources, as well as resources for emotional and mental health. These suggestions may be key for providers to become more prominent assets in helping Black women to successfully manage their sexual health.

Implications for Policy

The findings of this study also reveal significant inadequacies with sex education policy. The early parts of women's narratives illustrate how perfunctory sex education shapes women's ability to navigate sex and sexual relationships in a healthy and fulfilling manner. Many of their experiences with formal sex education in school were limited in scope and failed to have a lasting positive impact, revealing a dire need to improve sex education in the United States and Michigan more specifically. A recent literature review on sex education in the United States points to inconsistent goals and philosophies as one of the challenges to effective sex education (Goldfarb & Lieberman, 2021). This is likely because sex education is highly politicized. The intricacies of sex education including what, when, and how information is taught is determined at the state and school district level (Goldfarb & Lieberman, 2021; Hall et al., 2016). In Michigan, where this study was conducted, schools are not required to teach sex education at all though they are required to teach HIV/AIDS education. When sex education is taught, the curriculum is determined by the school district (SIECUS, 2021). What women shared about the contribution poor quality of sex education to their vulnerability suggests an urgent need for an evaluation of what is being taught, how it is being taught, and who is teaching.

Comprehensive sexuality education may be a solution to improving sex education. Comprehensive sexuality education is defined as "a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality" (UNESCO, 2018 p. 16). The goal of comprehensive sexuality education is to provide youth and young adults with the skills needed to healthily navigate social and sexual relationships. Implementation of a comprehensive sexuality education policy at the federal level will better equip youth and young adults with the knowledge and skills needed to healthily navigate at the federal level will ensure that young people receive adequate sex education that more will more fully prepare them for a range of issues concerning sexuality as opposed to narrowly focusing on STI and pregnancy prevention.

There should also be some policy to provide guidance on comprehensive sexuality education across the lifespan. Sex education should not be limited to the K-12 educational setting. The American College of Obstetricians and Gynecologists also advocates for a lifespan approach to comprehensive sexuality education (American College of Obstetricians and Gynecologists, 2016). Healthcare providers can play a crucial role in advancing patient sexuality knowledge across the lifespan, primarily through patient education. Since Obstetricians and Gynecologists are sex specific service providers, it is important for all primary care providers to incorporate some variation of comprehensive sexuality education into their practice.

Conclusion

All too often, Black women's voices and experiential knowledge have been marginalized or missing in sexuality research (Evans-Winters, 2019; Hammonds, 2004; Rose, 2004) Following Black feminist traditions, this study centers the voices of Black women and amplifies their experiences as a valid form of knowledge (Collins, 2002). This approach is a significant contribution to the sexual health literature which tends to frame Black women's sexuality from a deficit lens. In addition, the inclusion of a strengths-based theory such as resilience theory responds to the directive of Black feminist foremother bell hooks for researchers who work with marginalized to populations, especially Black people to employ frameworks that do not misrepresent the lives of the participant or perpetuate deficit narratives (Esposito, 2022; hooks, 2014).

Utilizing narrative inquiry and storytelling methodology, findings from this study weaved together the narratives of 16 Black women while revealing their attempt to successfully manage their sexual health following an STI diagnosis. Their stories depict a journey that frequently begins with a lack of comprehensive sexuality education, leading to difficulties in navigating sexuality and relationships. These challenges often stem from the knowledge gap that originated during their formative years and eventually resulted in contracting a STI. Data analysis yielded important insight regarding how they attempted to resolve the conflicts they experienced as a consequence of their diagnosis as well as the resources that helped them to do so. Their stories illustrate how they reframe the infection as an opportunity to learn and grow, which demonstrates resilience. Ultimately, their journeys exemplify a more holistic understanding of the complexities surrounding STI's and Black women's sexuality.

Shame, stigma, and silence often prevent stories like this from being told. However, the experiences of these women and others like them offer renewed insight about resilience. These perspectives are crucial for future research, practice, and policy. Above all else, sharing these stories provide a platform for Black women to connect, relate, and find support in their shared experiences.

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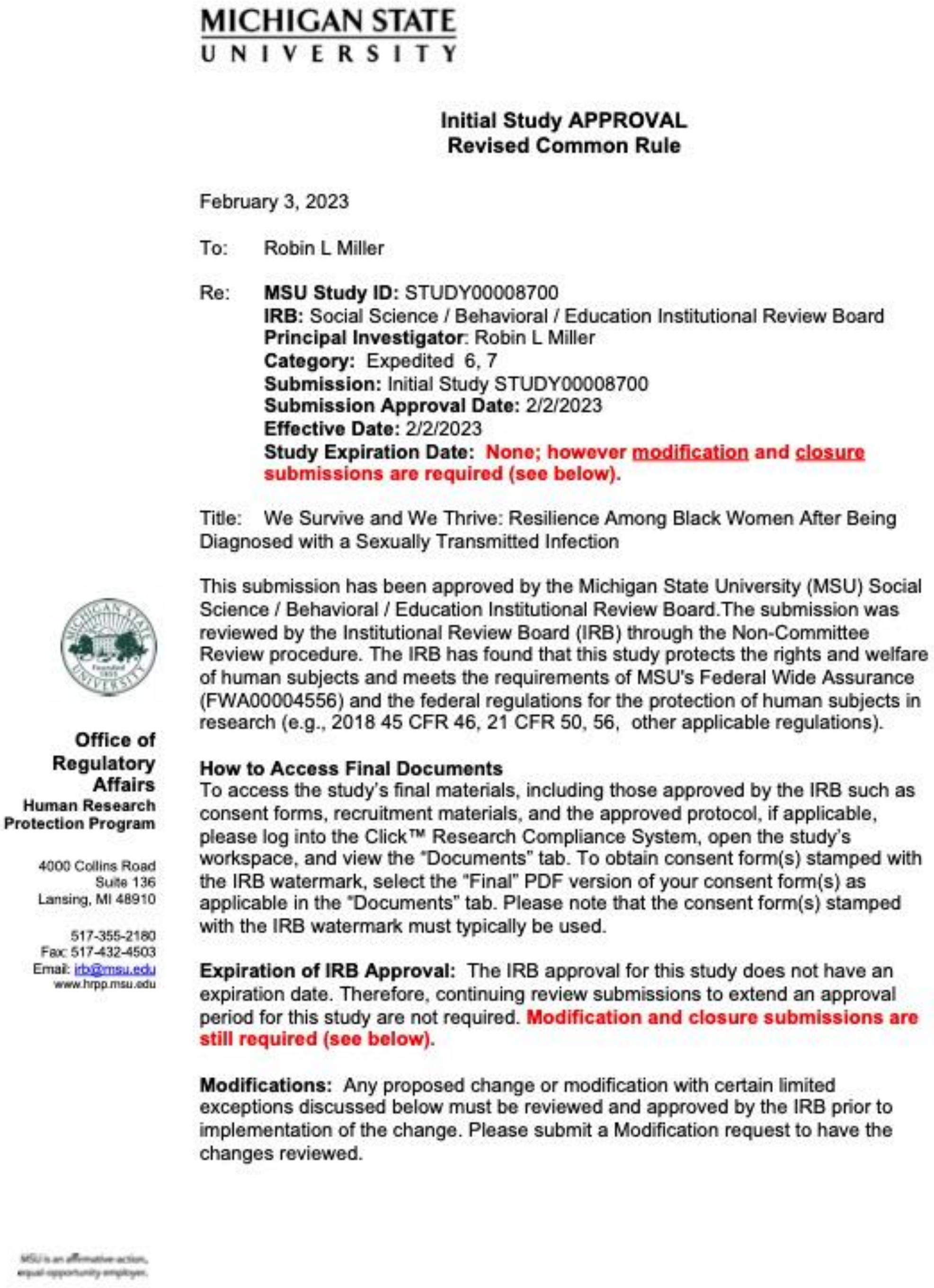
APPENDIX A: IRB APPROVAL LETTER

Figure 3

Screenshot of IRB Approval Letter



MICHIGAN STATE UNIVERSITY

Initial Study APPROVAL
Revised Common Rule

February 3, 2023

To: Robin L Miller

Re: **MSU Study ID:** STUDY00008700
IRB: Social Science / Behavioral / Education Institutional Review Board
Principal Investigator: Robin L Miller
Category: Expedited 6, 7
Submission: Initial Study STUDY00008700
Submission Approval Date: 2/2/2023
Effective Date: 2/2/2023
Study Expiration Date: **None; however modification and closure submissions are required (see below).**

Title: We Survive and We Thrive: Resilience Among Black Women After Being Diagnosed with a Sexually Transmitted Infection

This submission has been approved by the Michigan State University (MSU) Social Science / Behavioral / Education Institutional Review Board.The submission was reviewed by the Institutional Review Board (IRB) through the Non-Committee Review procedure. The IRB has found that this study protects the rights and welfare of human subjects and meets the requirements of MSU's Federal Wide Assurance (FWA00004556) and the federal regulations for the protection of human subjects in research (e.g., 2018 45 CFR 46, 21 CFR 50, 56, other applicable regulations).

How to Access Final Documents
To access the study's final materials, including those approved by the IRB such as consent forms, recruitment materials, and the approved protocol, if applicable, please log into the Click™ Research Compliance System, open the study's workspace, and view the "Documents" tab. To obtain consent form(s) stamped with the IRB watermark, select the "Final" PDF version of your consent form(s) as applicable in the "Documents" tab. Please note that the consent form(s) stamped with the IRB watermark must typically be used.

Expiration of IRB Approval: The IRB approval for this study does not have an expiration date. Therefore, continuing review submissions to extend an approval period for this study are not required. **Modification and closure submissions are still required (see below).**

Modifications: Any proposed change or modification with certain limited exceptions discussed below must be reviewed and approved by the IRB prior to implementation of the change. Please submit a Modification request to have the changes reviewed.

Office of Regulatory Affairs
Human Research Protection Program

4000 Collins Road
Suite 136
Lansing, MI 48910

517-355-2180
Fax: 517-432-4503
Email: irb@msu.edu
www.hrpp.msu.edu

MSU is an affirmative-action, equal-opportunity employer.

APPENDIX B: RECRUITMENT FLYER

Figure 4

Example of Recruitment Flyer

Black women experience threats to their sexual and reproductive health daily.

Help us understand what is needed to support Black women in navigating these challenges!

Jaleah Rutledge is a PhD student in community psychology at Michigan State University. She is conducting a study to explore how Black women navigate their sexual health and well-being in the face of adversity.
She is interested in conducting interviews with Black women between the ages of 20-29 years.

Please scan the QR code if you are interested in participating. The QR code will take you to a prescreening form to determine if you are eligible for participation.

Up to $50 will be provided for participation .

You may also contact Jaleah by phone to determine if you are eligible.

Please contact Jaleah by text at (205) 924-5052 or email rutled72@msu.edu if you need additional information or have questions.

APPENDIX C: CONSENT FORM

Research Participant Information and Consent Form

Study Title: We Survive and We Thrive: Resilience Among Black Women After Being Diagnosed with a Sexually Transmitted Infection
Researcher and Title: Jaleah Rutledge, PhD Candidate
Department and Institution: Department of Psychology, Michigan State University
Contact Information: rutled72@msu.edu
Sponsor: Robin Lin Miller, PhD, mill1493@msu.edu

Brief Summary ***(This is a general informed consent requirement)***
You are being asked to participate in a research study. Researchers are required to provide a consent form to inform you about the research study, to convey that participation is voluntary, to explain risks and benefits of participation including why you might or might not want to participate, and to empower you to make an informed decision. You should feel free to discuss and ask the researchers any questions you may have.

You are being asked to participate in a research study on Black women's experiences of being diagnosed with a sexually transmitted infection. You are being asked to participate in this study because you previously indicated having had and been treated for a sexually transmitted infection (STI) earlier in your life. We would like to learn how you navigated the experience of being diagnosed with an STI. We would also like to learn about any resources such as community groups and social media, or people that helped you physically, mentally, and emotionally after you were diagnosed. We are interested in interviewing you to learn more about what is needed to help Black women be well sexually. This research is being performed by a graduate student at Michigan State University as a part of her dissertation. Your participation in this study will occur in two meetings that should take about 1-2 hours each. In the first meeting you will be asked to share stories about your sexual health and well-being and the second is to discuss your story further.

The most likely risks of participating in this study is the potential of having a strong emotional reaction in response to some of the discussion during the interview.

The potential benefits to you for taking part in this study are increased emotional and psychological well-being from sharing your story. Moreover, your participation in this study may contribute to the understanding of the resources needed to help Black women improve their sexual and reproductive health.

What Is This Project About?

- You are being asked to participate in a research study of resilience among Black women after being diagnosed with a sexually transmitted infection. The purpose of this study is to explore trajectories of resilient responses to being diagnosed with an STI.
- This research study is part of a dissertation being conducted by Jaleah Rutledge who is a graduate student at Michigan State University. She is supervised by Dr. Robin Lin Miller.

- To be eligible for participation in this study you must 1) be Black, 2) assigned female at birth 3) currently identify as a woman 4) be 20 years of age or older 5) diagnosed with an STI, excluding HIV, at least once in life time 6) received treatment for the diagnosis, 7) complete a prescreener for resilience.

What Is Involved in Participating in This Project?

- If you decide to participate in the study, you will be asked to participate in one primary interview, and one follow up interview.
- The first interview will use a narrative interview approach. This means that the interview will primarily consist of you telling me stories about your experiences. Your participation in the first interview will take about 60-90 minutes.
- In the first interview, I will begin by introducing myself, explaining the interview procedure, and orienting you to the interview. Next you will be asked questions about your experience when you were diagnosed with the STI. Example questions include “Can you share with me how you learned you had an STI?” and “How did this experience impact your psychosocial and emotional well-being overall? “There are no expectations or requirements for the stories you choose to share. At the close of the interview, I will provide an opportunity for you to share any additional information or amend your responses to any of the previous questions.
- All of these questions are very personal. But we think they are important to ask about so that we can understand the things that may help young Black women navigate the experience of being diagnosed with a STI.
- The second interview will be an interactive process where we cocreate a story based upon the responses you shared in the first interview. I will present a draft of the story from the first interview, and we will make revisions for accuracy and clarity. The goal of the second interview is to ensure that you believe the story adequately reflects your experiences.

What Are the Potential Risks and Benefits of Participation?

- Participation in this study is completely voluntary, in other words, it is up to you if you want to participate.
- We hope these interviews will create a space for where participants feel that their experiences and knowledge are valuable. In addition, the narrative storytelling structure of the interview may foster healing.
- The analytic process has a participatory component that will facilitate co-learning among the researchers and participants. We, the researchers, will learn from the participants through what they share about their experiences via the interview. The participants will be engaged as co-researchers.
- Additionally, the valuable information that you share may help us learn about ways in which we may be able to promote the sexual health of Black women.
- This research project poses minimal risk to participants. The topic of sex is very sensitive, and it may be upsetting for you to talk about your experiences. All of the interviewers in this project have been trained on how to be respectful of individuals’ sexual experiences. You may experience some loss of privacy and discomfort in answering questions.
- Resources for counseling and sexual and reproductive health services are available for each participant.

How Will Confidentiality Be Protected?

- All the information you share with us will be kept confidential and as private as possible.
- If you indicate interest in reading the final dissertation, your contact information will be kept until you receive it. If you are not interested in receiving the final dissertation, your contact information will be destroyed upon the completion of your second meeting.
- Your name or any information that could identify you will not be used by the study team.
- The interviews will be audio recorded. The recordings from the audio recorders will be uploaded to a secure server after the interview and subsequently deleted from the recorder. They will only be used to transcribe the discussion verbatim. However, any names or identifying locations (e.g. school names) will be changed in the transcription to protect your confidentiality.
- You will be given an identification number so that your real name appears nowhere in print other than on this consent form.
- The interview transcriptions will be prepared by personnel at Rev. The audio files be uploaded to their secure server and protected from unauthorized access. In addition, all of their personnel have signed non-disclosure and confidentiality agreements.
- The interview transcripts produced by Rev will be stored on a secure server for 5 years to allow time for analysis and report writing. After this time, all records will be destroyed.
- Only the researchers and researcher staff, will have access to the data collected for this project.
- The results of this study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous.

Your Rights To Participate, Say No, or Withdraw

- Participation is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.
- You have the right to say no.
- You may change your mind at any time and withdraw.
- You may choose not to answer specific questions or to stop participating at any time.

Costs and Compensation for Being in the Study

- You will be compensated $25 for your knowledge and participation in the first interview and $25 for your knowledge and participation in the second interview.

Who Can Be Contacted With Questions?

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the Dr. Robin Lin Miller, 316 Physics Rd. Office 132, East Lansing MI 48824, mill143@msu.edu, 517-432-3267.

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 4000 Collins Rd, Suite 136, Lansing, MI 48910.

Documentation of Informed Consent

Your signature below means that you voluntarily agree to participate in this research study.

____________________________________ ___________________________

Signature Date

I agree to allow audiotaping/videotaping of the interview.

____________________________________ ___________________________

Signature Date

APPENDIX D: ELIGIBILITY SCREENER

Black Women's Resilience Project
Phone Prescreening Tool

Hello, thank you for calling the Black Women's Resilience Project. My name is Jaleah, and I am a PhD student in community psychology at Michigan State University.

I am conducting a research study to explore how Black women navigate their sexual health and well-being in the face of adversity and I am interested in conducting face-to-face interviews with Black women between the ages 20 years and older who have been diagnosed with a sexually transmitted infection.

I want to ask you a few questions to determine if you are eligible to participate in the study. It will only take about 5 minutes. It will ask you questions about personal background and sexual health.

You do not have to answer any questions you do not wish to answer or are uncomfortable answering, and you may stop at any time. Your participation in the screening is voluntary.

We will make our best efforts to keep your answers confidential. No one except for the research team will have access to your answers.

QUESTION	ELIGIBLE	INELIGIBLE
1. To start, how old are you? __________ *Age*	☐ 20 ≤	☐ <20 ☐ Declined to answer
2. How would you describe your racial background?	☐ Black or African American	☐ American Indian/Alaska Native ☐ Asian ☐ Latino/Hispanic ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Prefer not to answer
3. What sex were you assigned at birth?	☐ Female	☐ Male
4. Which of the following terms best describe your current gender identity	☐ Woman	☐ Man ☐ Transgender Woman ☐ Transgender Man ☐ Non-binary/non-conforming ☐ Not listed ☐ Prefer not to answer

5. Now I need to ask you a few questions related to your health. All of your responses will be kept completely confidential. Have you ever been diagnosed with a sexually transmitted infection? Common STI's diagnosed in Black women under age 29 include chlamydia, gonorrhea, genital warts, syphilis, herpes, trichomoniasis and human papillomavirus.	☐ Yes	☐ No ☐ Declined to answer
6. Did you receive treatment for the diagnosis?	☐ Yes	☐ No ☐ Declined to answer
7. What was your age when you received the positive diagnosis? __________ *Age*		
8. Please share how you learned about the study (e.g., flyer at nail salon, word of mouth, etc.). ________________		
Eligibility is determined by having ***all*** *responses fall under the eligible column.* *Participants will have to answer all the eligibility questions before they know whether they are eligible. This is being done to prevent prospective participants from figuring out what to answer to determine eligibility.*	☐ **YES** "Thank you very much for the information you provided. Based on your answers to these questions, you are eligible to participate in the interview. Are you interested in setting up a time to meet?" *If yes, set up an interview within the next 10 days.* *If no*, "Thank you for your time. If you change your mind, please feel free to call back again."	☐ **NO** "Participants for this research project are selected based on the questions you were just asked. Based on your answers, it turns out you're not eligible to participate in the interview. Thank you for taking the time to speak with me."

APPENDIX E: EPISODIC NARRATIVE INTERVIEW PROTOCOL

Informed Consent Script

NOTE:

Prior to the interview, provide a copy of the informed consent to the prospective interviewee for her records.

After providing a brief introduction, allow the interviewee to read the sheet. Answer any questions the interviewee may have.

At the end of this form, indicate whether the interviewee provides you their verbal consent to conduct and digitally record the interview and record your name, signature, and the date. If the individual consents to be interviewed, but does not consent to be audio recorded, assure them that the interview can proceed without it.

If they do not consent to participate, thank them for their time.

INTRODUCTION:

I am Jaleah, the principal investigator. I am in my 5th year as a PhD student studying psychology at Michigan State University. Thank you for being willing to speak with me today. This sheet, which you may keep, describes the research project in more detail. It also discusses the interview that we will do today. Please take a moment to read it.
Do you have any questions? (Answer questions as needed)

Do I have your permission to conduct the interview with you? (Select one)
☐ **Yes** ☐ **No**
Interviewee' s Name (print): ________________________________

Interviewee's Signature: ___________________________________

Do I have your permission to record the interview? (Select one)
☐ **Yes** ☐ **No**
Interviewee's Name (print): ________________________________

Interviewee's Signature:____________________________________

Your interview will help deepen our understanding of resilience and sexual wellness among Black women. My goal today is to simply be a listener as you share your story. I will be writing things down as you speak in case I want to follow up on something that you say. This interview will be extremely conversational and casual, so it may be very different from other interviews you have participated in.
For this dissertation research project, I'm only interviewing Black women because I am interested in how our life experiences, our communities, and our families act as resources to improve our sexual health, specifically after being diagnosed with a sexually transmitted infection. The stories you tell me will not focus on your entire life, but specific experiences around sex and sexuality.

There are no right or wrong answers to my questions. I will be writing things down as you speak and I may ask follow-up questions to get more detail and as much information as possible about what you are sharing with me.

Remember that everything that you share today is confidential and will be used for research purposes to help improve the sexual futures of Black women. So, thank you again for sharing your unique story and perspective. The information that you share will be extremely helpful in creating positive change around Black women's sexual health. You will receive $50 for your participation in this interview even if you decide to stop.

Following the interview, our conversation will be transcribed to text. I will use this text to write a story about your experience. As noted in the consent form that you signed, the story will be anonymized. I will share a draft of the story with you 2-3 weeks after today. My goal is to cocreate the final story, so I will schedule a follow-up interview to review and revise the story. If you are unable to participate in a follow-up interview, we can remain connected via instant messaging to revise your story. You will also receive $50 for your participation in the second interview.

Are you ready to begin the interview?

If you have any questions, as we go along, please feel free to ask. If anything is unclear, please ask me to explain it again. Remember this interview is completely voluntary. You are free to skip any questions you want. You may also end the interview at any time. If you do so, there will be no penalty.

Black Women's Resilience Project: Episodic Narrative Interview

Note: Be sure recording equipment is on unless consent to digitally record the interview was not provided. Ask participant to repeat her consent once audio recording has begun.

SECTION A: Opening questions

Interviewer script: One of the goals of this interview is to describe things as you experienced them when they originally happened, so I think it will be useful to start off by asking you a few questions that will help me get to know more about you and to help you practice telling me stories about yourself.

1. **When do you feel you feel you are at your best holistically, meaning spiritually, mentally, physically, and emotionally?**
2. **What do you love the most about your body and why?**
3. **Please tell me a story about why you decided to participate in this study. This can include how you found out about the study and any particular reasons you wanted to participate.**

SECTION B: Getting Started/ Defining the Phenomenon of Interest

Interviewer Script: When you expressed interest in being in this study, one of the reasons I wanted to meet you and learn your story is that you said you saw yourself as a resilient person.

1. **What does the word resilient mean to you?**
   - **Probe: How would you describe someone who is resilient?**
   - **Probe: What makes a person resilient?**
   - **Probe: What things have helped you become a resilient person**

SECTION C: Experience of an Episode

Interviewer Script: Now, I want to transition and learn more about your experience with sex and sexual health.

1. **Please tell a story about any salient messages you received about your body, sex, or sexuality when you were growing up. You can tell me a story about each one individually or together if you have stories about messages you received on more than one of those topics. The story can be about a positive or negative message.**

    - **Probe: How was the message conveyed?**

    - **Probe: What was your reaction to the message?**

    - **Probe: Did you share this message with others? Why or why not?**

    - **Probe: How did you decide who to share it with?**

    - **Probe: How, if at all, has the message affected your current views on sex, sexuality, and your body?**

    - **Probe: How, if at all, has the message affected your current views on sexuality?**

    - **Probe: How, if at all, has the message affected your current views on your body?**

    - **Probe: What prompted these changes in your views?**

SECTION D: Experience of the Phenomenon

Interviewer Script: I'm going to ask you now to tell me the story of your first diagnosis with an STI.

1. **Can you share with me how you learned you had an STI?**

    - **Probe: When did you realize you needed to get tested?**

    - **Probe: What happened when you got tested? What was that experience like?**

    - **Probe: What was your reaction once you received your results?**

    - **Probe: Did you tell anyone about your results?**

    - **Probe: How did you decide to whom to disclose your results?**

    - **Probe: What were their responses to the disclosure?**

    - **Probe: How, if at all, did you manage the different ways people responded to the disclosure?**

    - **Probe: Can you share who or what, if anything or anyone, was helpful to you as you managed those different responses?**

- **Probe: What, if anything, helped foster your resilience in this circumstance?**

- **Probe: Can you share the details about getting treatment?**

2. **Can you tell me a story about the ways you have changed, if at all, since you were diagnosed and treated? This can include changes in your sexual behaviors or social relationships.**

    - **Probe: Why did you make these changes?**

    - **Probe: What, if anything, helped you to make these changes?**

    - **Probe: When did you decide to make these changes?**

    - **Probe: Did you talk to anyone about making these changes?**

    - **Probe: Why did you decide to talk to them?**

SECTION E: Amendments or Additions

Interview Script: We are nearing the end of the interview.

1. **Is there anything you'd like to add, or change based upon the stories you've shared?**

2. **Let's revisit your original definition of resilience is there anything you'd like to change or revise?**

SECTION F: Closing

Interviewer Script: If it is okay, I would like to schedule your second interview now. Can you provide me with some dates and times you would like to meet during the week of [2-3 weeks after interview 1]?

Interview Script: Those are all the questions I had for you. Is there anything else you'd like to share? Do you have any questions for me?

Closing Statement: Thank you again for all that you have shared with me today. I greatly appreciate your time and experiential knowledge. You will receive $50 for your participation. I recognize that reflecting on issues around sex, sexuality, and sexual health can be challenging, so I am happy to share some sexual wellness resources with you. If you know any other women who would be interested in talking with me, please share this opportunity with them. Black women's voices are often missing from research, and when they do attempt to include us, the narrative negative and discusses what we lack as opposed to what we have. You can share the flyer with a few women you may know personally and encourage them to also share it with women they know. You will receive a copy of the story to review two days before your next interview. If you need to reschedule our second interview or if anything changes before then, please reach out to me via text or call (517-356-1449), or email (rutled72@msu.edu).

STOP. END OF INTERVIEW.

APPENDIX F: COCREATION INTERVIEW PROTOCOL

Climate Setting

The goal of this portion of the interview is to invite the participant to take ownership of the story.

Interviewer Script: It is nice to see you again, thank you for agreeing to edit your story together. The purpose of this interview is to ensure that your story is accurate and adequately reflects your experience. You are a co-author of the story, so I would like to hear any feedback and suggestions you have. I may also ask you to clarify some points that were unclear as I was drafting the story. Do you have any questions?

I have printed copies of your story for both of us to annotate and make notes. I will also be recording this session to ensure that I can listen again in case I think anything is missing from our notes. Do I have your consent to record?

start recording if consent is granted

Cocreation questions

What is your initial reaction to the story?

What stands out to you?

What emotions did you feel as you read the story?

What seemed like too much detail?

Is anything underdeveloped?

Are there any inaccuracies?

Do you see yourself throughout the story?

What details can be added to better portray your story?

What other suggestions do you have to improve your story?

Resilience

Where do you see elements of resilience in this story?

What insights do you take from your story that reflect how Black women move forward?

What permits black women to be strong and take control of their sexual health in their own story?

Does this capture you as you moved through & past the diagnosis?

What did you learn about resilience by reading and reflecting on your own story?

Let’s revisit your original definition of resilience. Is there anything you’d like to change or revise after participating in this study and sharing your story?

Closing

Is there anything else you would like to add to the story or share with me about your participation in the project?

Interviewer Script: Thank you again for participating in my project. I have learned a lot from you. Your story and participation in this project is instrumental in helping to improve the sexual well-being of Black women. You will receive $50 cash for your participation. If you’d like I can share a copy of the final dissertation with you once it is completed.

APPENDIX G: LANSING SEXUAL HEALTH AND WELLNESS RESOURCE GUIDE

As a researcher and community psychologist, I believe that is important for me to identify resources within the community for research participants. The information below is a starting point for resources that may assist you with your sexual and reproductive health and overall well-being. I welcome suggestions for additional resources.

Black Women Mental Health Professionals in the Lansing Area
Emerging Wellness, Nedra Cannon and Associates, Wild Ferns Wellness, Truss Counseling Services, Coat of Many Colors Counseling Services, Taylored Therapy, Evergreen Therapy, Peace and Harmony Counseling Services, and Shanita Wade, MA, LPC

Emergency Mental Health Services
Community Mental Health Crisis Services

Sexual and Reproductive Health Providers
Cedar Community Health Center- Women's Health, Alliance Obstetrics and Gynecology, McLaren Greater Lansing Women's Health, Sparrow Women's Health, Planned Parenthood-Lansing Health Center

Free HIV Testing
Lansing Area AIDS Network

Women's Outreach and Advocacy Organizations
Women's Center of Greater Lansing

Wellness
Rock the Block Studio, Socialight Society Bookstore

APPENDIX H: EXAMPLE PARTICIPANT JOURNEY MAPS

Figure 5

Participant Journey Map Used During Cocreation Interview, Example 1

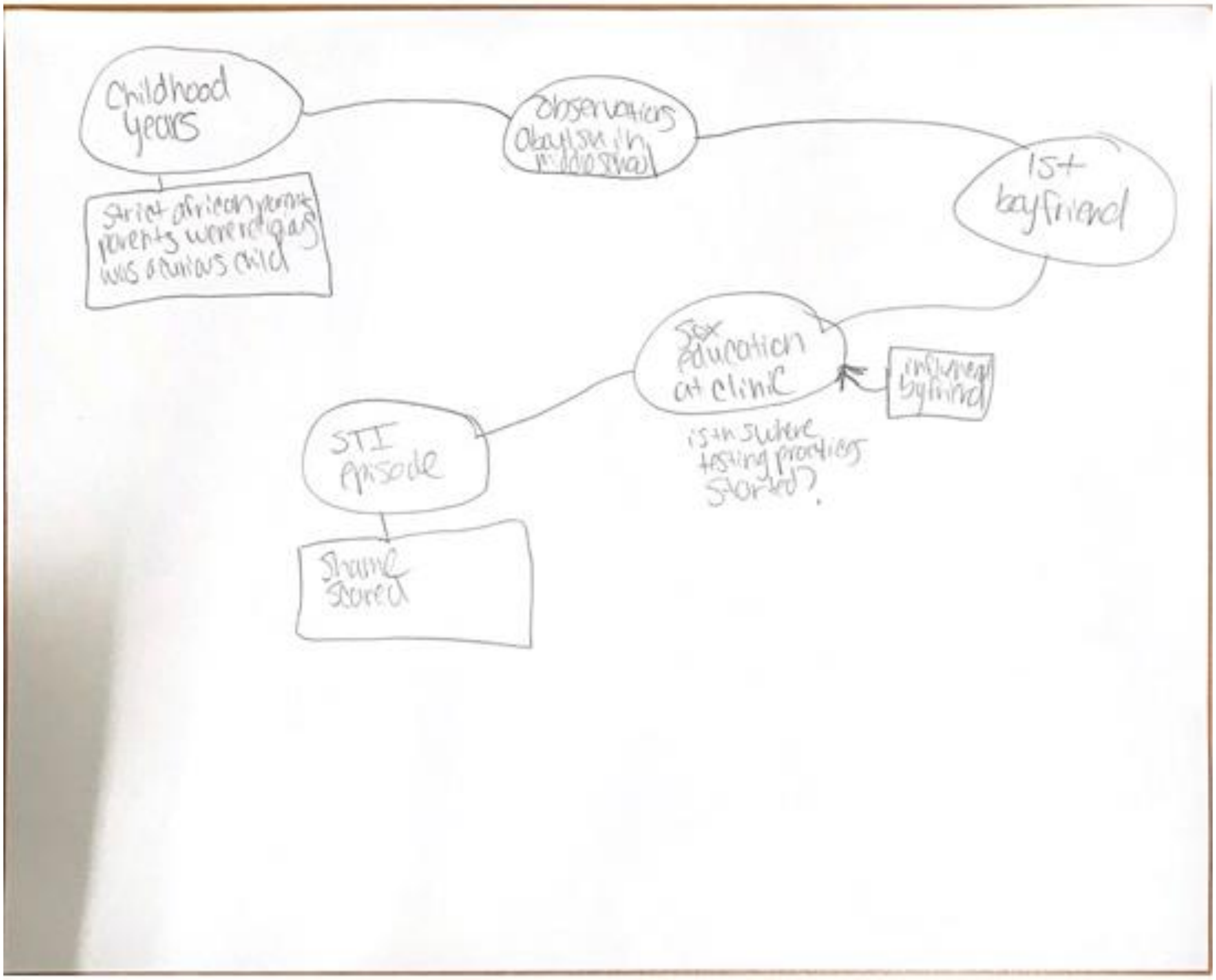


Figure 6

Participant Journey Map Used During Cocreation Interview, Example 2

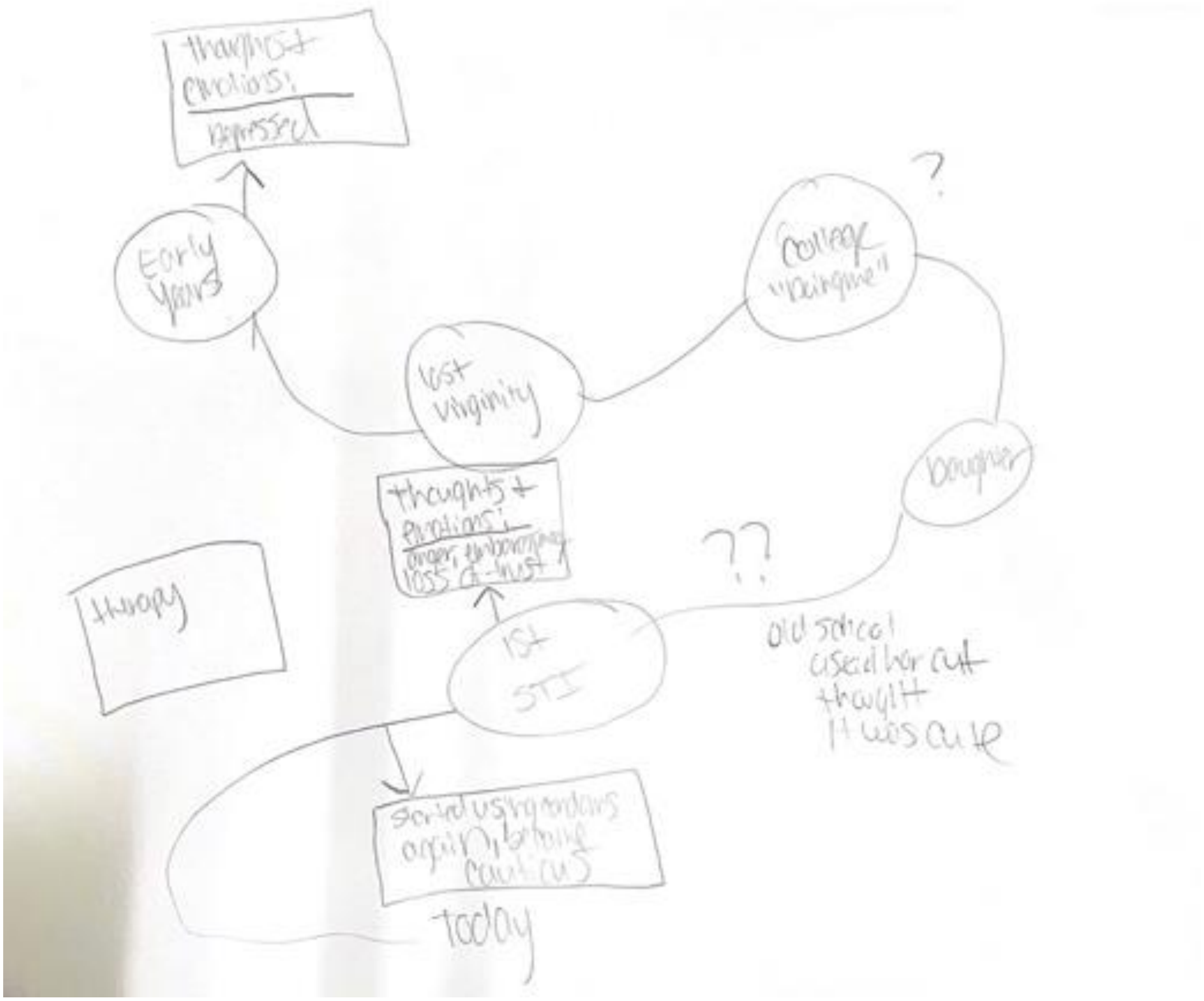
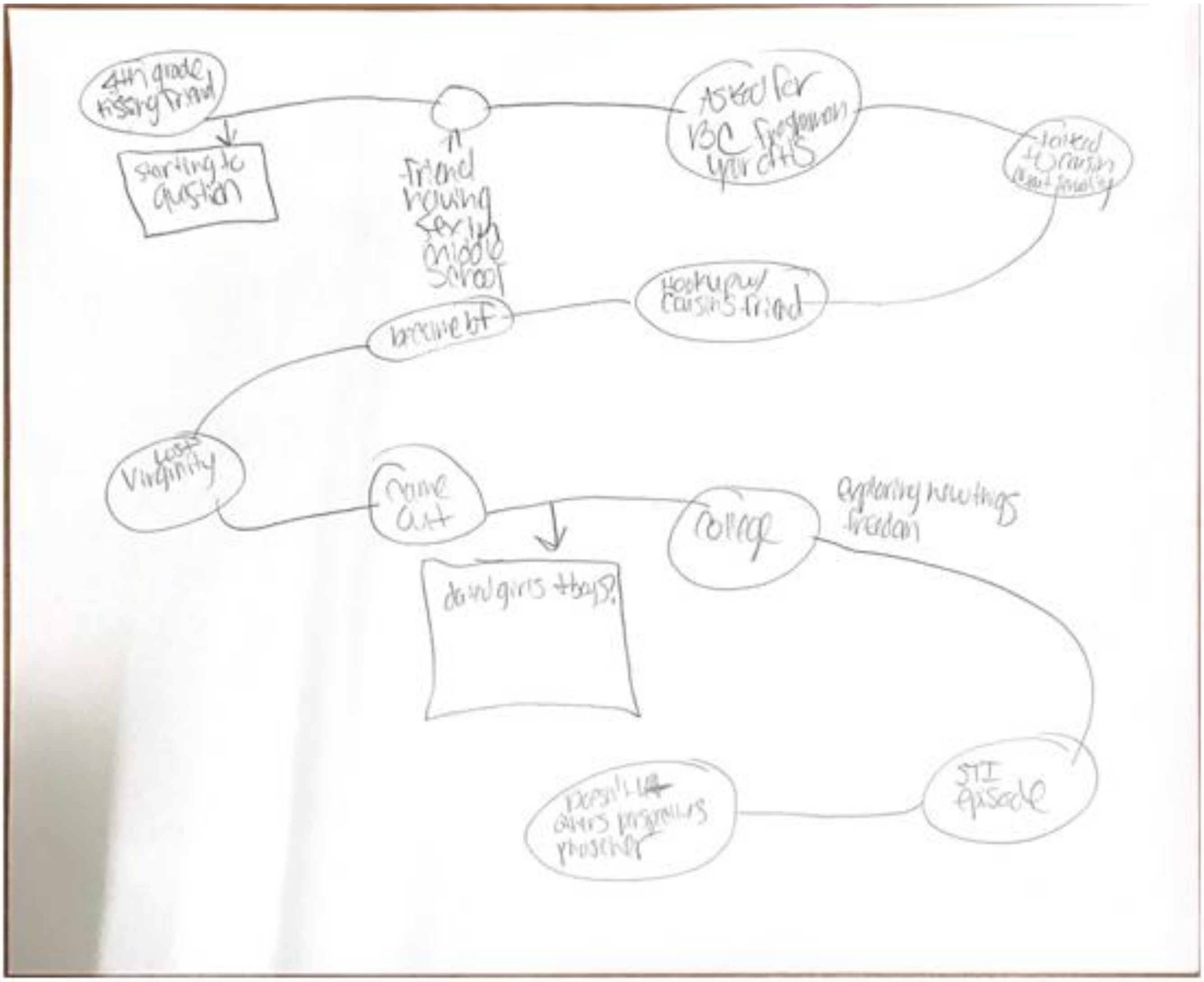


Figure 7

Participant Journey Map Used During Cocreation Interview, Example 3



APPENDIX I: PARTICIPANT STORIES

Through the voices of 16 Black women, the narratives in the following pages detail important contextual that is informative to the research questions for this study. More specifically, the narratives illuminate each woman's unique journey of navigating their sexual health and well-being. Each narrative includes background information about the participants' upbringing, and a broad summary of their sexual health and relationships, including the details of their STI diagnosis, and any actions taken after their diagnosis. The stories are presented from the participants' standpoint to privilege their voices. Black women women's voices are often absent in scientific research and regarding topics concerning sexual health and well-being. As such it was vital for me to retell their stories from their perspective. Their stories, individually and collectively, reveal how Black women move towards sexual wellness despite the structural, emotional, and psychological barriers they encounter. They exemplify resilience.

Naomi's Story

Naomi is a 38-year-old woman from the Midwest. She is a daughter, wife, and mother of three. She grew up in a strict Christian household. However, both of her parents instilled in her the importance of taking care of herself and not waiting for anyone else to take care of her. Today, she is a successful business owner. Naomi told me her story and we worked together as co-researchers to develop the following story which demonstrates a summary of her journey in relation to sex and sexual wellbeing.

The Early Years

I come from a strict Christian churchy background. So, any conversations about sex that I had growing up always focused on a discussion of purity. I was even a part of a purity class at church. The class happened over a couple of weeks, and we talked about things like the consequences of sex before marriage, the biblical perspective of having sex before marriage. We learned that God did not intend for sex to happen outside of marriage. We were told that we could get pregnant or contract a disease. I feel like neither of that matter because according to them we weren't supposed to be having sex anyway. There were a couple of times that we heard from different adult presenters. I remember one lady in particular who talked to us about how she didn't wait until she was married to have sex and she ended up getting pregnant. She had the baby but her and the child's father ended up getting married later and built those whole family. Her story was supposed to convince us not to have sex but in my mind at the time I thought it worked out for her. I didn't see what the issue was she seemed to be doing well. Then there was another lady who waited until she was married to have sex. She talked about how she looked forward to her wedding night and how sex was great for her. This story made me more curious as to what sex was about because she described it as an amazing experience. So once again I was not seeing the problem with having sex. At the end of the class, we had a purity ceremony where everyone wore their white dress, and we took a vow that we would not have sex until marriage. I was about 13 when I took this vow, I thought it was cool because that's what I felt I was supposed to do and because the older kids were doing it. Even though everyone was taking their vows and getting awards for being abstinent, people in the class were actually having sex with each other. I found that to be both ironic and funny. Outside of this, my parents didn't have many conversations with me about sex. They did, however, encourage me to always do what I need to do to take care of myself, and not wait on a man to take care of me.

Longing To Belong

When I was in high school, I felt like I didn't really fit in. I wasn't going to parties; I was always at church because that was the lifestyle my family followed. I had a desire to be accepted and I wanted to find a way to connect with other girls in my grade.

Hindsight Is 20/20

When I was growing up, everyone in my family had the same family doctor. I didn't trust that our conversations would be confidential because when I would go to the doctor, she would say things like "how's your grandma doing? Is her foot better?" So, when the doctor asked me if I was sexually active, I would say "no, because you might tell my mom." I didn't feel like I could be honest at that time, so I might have missed out on some conversations or some resources about sex and my sexual health there.

Sex Was the Key, So I Thought

I had sex for the first time the month before I turned 16. I thought, maybe purity just was not for me, and the class didn't work. At the same time, I also thought that having sex could connect me with some of the girls I wanted to be close with in my grade. I quickly realized that's not how that works. People found out that I was having sex. I thought that having sex was going to make me accepted and more a part of the "in crowd". That was not the case. As opposed to being accepted by the girls I desired to be connected with, I felt like they pitied me.

I Slipped Up

After I graduated high school, there was a point that I moved away from my hometown to help me get over a relationship that was not serving me. I moved down south with my best friend to share an apartment with her. My thought process was that this was going to be a great experience. While I was there, I met someone, and we had a sexual relationship. During this same time, I went to the doctor because I had taken a pregnancy test and it was positive. So, at the visit, the doctor confirmed that I was pregnant. They ran a couple of other tests on me, and they let me know that I tested positive for chlamydia.

Worried Sick

The doctors did not make a big deal about my diagnosis. They gave me instructions on what to do to clear up the infection. On the other hand, I was really shocked about the diagnosis. It wasn't even something that had crossed my mind as a possibility because when I was growing up, the emphasis was always on pregnancy prevention. We never really talked about the other outcomes of having sex, so contracting an STI was all the way at the back of my mind. I think sometimes we have the assumption that if I am healthy then other people are healthy too.

I was also worried because I was pregnant. I wanted to know if treating the infection was going to be as simple as the doctors said it would be. I wondered if the infection would pop up again. I also remember thinking if there would be complications from the infection that would affect my child. So, there was a lot of worry there.

I was scared and I was a little ashamed. I was ashamed because of the stigma that comes along with having an STI, that's not something you want people to know about. I feel like an STI is something that follows you. I have been married for almost 10 years now, but whenever I get tested for something or get my pap smear, I think back to when I was 20, wondering if the STI is going to pop up. So, it is a little nerve-wracking. I was scared because I wasn't sure what would happen next, and if people would find out that I had it. The only person I told about the diagnosis besides the person I contracted it from was my best friend. I tell her everything and she's a fixer. So, she did some research to help me figure out what I should do. She made me feel supported. Her mom was more open than mine, so my best friend knew where to go to get condoms and take a pregnancy test. It turns out that I was actually pregnant before I got to Atlanta, but I was unaware of the pregnancy at the time. So, in my 20-year-old naivety, the only person I believed I could have contracted the STI from was the guy I met in Atlanta. He did not really have a reaction, it was almost like he did not care, so I think I dodged a bullet by not engaging with him again.

Scared Straight

Having this scare with the STI prompted me to be more careful in my life choices. I was 20 and pregnant with an STI diagnosis. I quickly realized I had to be more thoughtful about who I was interacting with. I had to be mindful to not be as quick to make myself available to a sexual partner. I was not having sex with a lot of people, but I needed to slow down because I did not want to put me or my child's health and life in jeopardy. I had to protect my child as well. I could not fall apart. This was another obstacle, but it was an opportunity for me to learn.

Perhaps the lack of messaging around sex in my early years made me more curious. I didn't understand what the big deal was about sex. I wondered why is this something that we don't talk about? Or we only talk about it in the light of 'you don't need to do this. Now with having children of my own I believe it is important for me to create space where our children feel comfortable to talk about whatever with us. My 16-year-old tells me a lot, and sometimes I'm like Girl…okay! Thank you for trusting me with that. But I try to keep the lines of communication open.

Kathleen's Story

Kathleen is a Black woman in her 60's from a large midwestern city. She was raised by her mother and father until her father passed when she was 14 years old. When reflecting on her sexual behaviors and relationships, Kathleen indicated her father's passing as a major catalyst for what she called her promiscuity. Kathleen is a mother of two daughters and one son. Kathleen has a gift for being able to help others, especially those in her community. The following story details her journey from looking for protection in a man to a realization that the best thing she could do for herself is to be by herself.

Do as I Say

My parents made me believe that I could do anything I wanted. They were married and although they argued, I never knew my dad to have other women in our household. My dad's dad walked away to start a new life with a family down the street. Because of this my dad and his three sisters grew up really poor. My dad told me he had to wear hand-me-downs from another male in the family and wear shoes with a hole in them. My dad vowed to never do to his family what his father had done to him, so he always took care of home. He made sure we had what we needed to survive as a family. I did not realize how protected I was until my dad died when I was 14. After my dad's death, men began to prey on me, my mom, and my sister since there was no longer a man around. I remember one specific man from the funeral home who started to come around frequently after my dad died. He said he wanted to see how we were doing and that it was something about us that he really cared for. But he was actually after me a 14-year-old and he was a grown man. Nothing happened, but he was definitely coming around to prey on me.

Around this same time, I found out I was pregnant. I got an abortion because my mom told me "There's no way you need a baby right now." Prior to mt pregnancy, my mom had not talked with me much about my body, sex, or reproductive health. I started my period when I was eight and a half years old, and my mom gave me a book that presented information about the menstrual cycle and how it happened. There wasn’t much conversation; I was talked at, rather than talked to. My mom didn’t talk much about the emotions that could come along with sex. I didn’t ask questions because at the time it was “You do, as I say, you don't have no questions. And if you do have questions, you better not ask me.”

Damage to My Dignity

After my dad died, he left a void. I think I began to try to fill that void by looking for protection in boys and men. I started to get involved with boys who I knew were not all that interested and I would continue to be with them. After my abortion, I began dating another boy I went to high school with. He was also dating a number of other girls in the school because there was always someone approaching me to fight over him. At one point, I did have to physically fight a girl over him, and it was very embarrassing. I heard him laughing and talking with some boys about having two women fighting over him, but I only fought her because she hit me first. If she had kept talking and never touched me, then that’s all that would have happened. But I believe this entire situation lowered my self-esteem. It was to the point where I thought I should be with just about any boy that even looked my way. And so, a long line of one-night stands and things like that began.

The Hard Way

I was diagnosed with my first STI at 19. I was with my high school sweetheart who had just gone off to college. I went to visit him to spend time with him. By this point, I realized I had a pattern of unhealthy interactions with men, but I wanted to have fun and getting an STI was the last thing on my mind. He came to my hotel room, and we had sex and do all kinds of things. We would take different objects to have sex with not knowing if it was dirty and just grabbing it and using it. I ended up with one of the worst infections I think I’ve ever had by using those things because they should not have been going inside me. The infection was really bad it was like a cottage cheese consistency. I called my mom and told her about the discharge, but I didn’t tell her about why I thought I was having the discharge. I was only thinking about having fun and enjoying myself, so I really wasn’t thinking about getting an infection.

A couple of years later, I had another STI experience but this time the infection came from one of my one night stand encounters. Whenever the guy called me, I would brush him off because he had done something I didn’t care for. I wasn’t interested in spending any more time with him. One day, I answered the phone when he called, and I was trying to hurry the conversation along and he said “Oh, well by the way, I had got tested. I have gonorrhea and you probably got it too.” I was like “Say what?”. I was like okay people are getting venereal diseases and lightly telling you that you may have it too.

Talking about sexually transmitted infections wasn’t a conversation you had casually with people. You didn’t talk to your friends and definitely not somebody you really don’t know about it. At the time of my diagnosis, people who had gonorrhea and stuff like that were thought about as being promiscuous or prostitutes, so I didn’t tell anybody about the diagnosis.

Something Has Got To Give

After this encounter, I thought to myself “maybe you shouldn’t be as promiscuous”. I also started to realize I needed to think more about the people I was going to have sex with. I started to cut back on sexualizing myself. I wasn’t putting myself out there as much and I started to cover up a little bit. I was not as blatant with my sexuality because before I was wearing tighter clothes and stilettos every day. Instead, I wore baggier clothes and comfortable shoes to diminish myself physically. I wasn’t putting myself out there as so sexual and I thought this would help me avoid getting into sexual relationships.

Taking the Stripes That I've Earned, Lessons Learned

It took me almost 40 years to get past the heartache of not being with my high school sweetheart. Us being young and the sexual attraction really kept me stuck. If I had just gone on with my life instead of being stuck and messing with other guys because we weren't working out, I think it would've made a difference for my life. Even though I still had him in my heart and in my mind, I kept moving. I had some relationships that might have been off the wall and crazy, but I didn't allow them to stop me from doing what I needed to do. I didn't get on drugs, I didn't smoke or drink, I just kept moving.

I eventually got married to someone else. We only lasted for seven years because we would fight. I have three adult children and a few grandchildren. I'm at the point where I am okay without having sex at all. When I think about all the different men I've been with and try to remember their names or if I knew their names or whatever I say to myself: You was promiscuous. You was a hoe! I wish I had the wisdom that I have now back then. I would've known that I shouldn't have been doing what I was; I definitely wouldn't do it now. I got stuck in the moment and had to learn to love myself beyond that. I'm more than laying on my back or all fours, however you want to put it. I'm beyond that for myself and there are a lot of other things that need to be done.

When one of my daughters got deathly ill, I made a promise to God that I would not masturbate or have sex if God helped to heal my daughter. My daughter is alive and well today, so I kept my promise and I do not masturbate or have sex. Instead, I keep myself busy with community work. I told my children I'm probably experiencing some of the health issues I have because I used to deal with one well hung man and that's probably why my body is breaking down. My mom thinks telling my children stuff like that is talking too freely with them, but if I don't talk to them who will? So, I have always been open with discussing sex with my children. It was my job to make them aware and not wait until they get something and then talk to them. Cause they may be able to prevent things if I talk to them. I believe that if my mom had taken the time to talk with me as opposed to talking at me, I might have made different choices. I probably would not have become sexually active so young, and I would have thought things out better. So, I try to be real with my children and especially now with my granddaughter and grandson.

Kasey's Story

Kasey is a 36-year-old woman from a large midwestern city. Her mom played an integral role in pushing her to always do what needed to be done. In addition to her mother, her aunt and grandmother also strongly influenced the ways that Kasey presents herself as a woman. She is a member of a strong spiritual community, mother of three daughters and entrepreneur in the maternal health field. The following story details more about Kasey's journey with sexual health and wellness.

Being a Woman of Modesty

I vividly recall my grandmother and mother being very modest women. My mom might have worn short shorts every now and then, but for the most part she was modest. This gave me the sense that I was beautiful even with clothes on. I never saw men running in and out of the house. I'm glad this was my experience growing up because it helped me to be cautious with how I treated my body. They taught me how to be clean with my body and presenting myself as a woman. They emphasized the importance of being feminine and ladylike and not being in men's faces. I was not taught about sex, however. I was only told "Don't let nobody touch your private part" and "No sex til you're married." I feel like they should have elaborated on that more. They needed to tell me what a private part was and why it was private. I think the conversation about being sexual or sex as a woman was negative. It was taught in a way that made it seem like sex was bad. My reaction to this stuff was always why, because I saw all these women that aren't married, and they have kids, so I didn't understand the importance of waiting or why we had to be told what to do.

Things Got Weird

As I got older, the things my mother and grandmother taught me started to make sense. It was only because I started to be around people outside of my family who could explain. I couldn't question adults or ask for more because I would get in trouble. They thought it was a challenge when I really just wanted to understand. So, I learned from my friends in middle school who would say stuff about sex. They would say stuff like "You should do it so you're not the only person. Boys look at you better and you you'll be more mature and all this weird stuff**".**

Not Folding Under Pressure

I went to a predominantly white high school and these girls told me something I had never heard before. They said, "you should have anal sex because your parents won't be able to tell your hymen is broke." And I was just like, "What? We're 15? What are you talking about?" I thought that was so weird and stupid. But they said this because they knew if their mom found out they were having sex, they would be in trouble. They would say things to me like "you should have sex, so you won't be left out and you'll be more mature". My response to one girl was "Girl you crazy and you a ho!" I didn't care what boys thought about me because they were ugly anyway. My aunt used to say to me "If you let everybody touch you, when you get a husband, you're gonna be dirty and used up and he ain't gonna want you". I didn't want that to happen to me.

In the Relationship Field

I tried to wait until I was married to have sex. The first time I consented to sex was with the father of my three children. We got married when I was 18 and we had 1 child by then. We had 2 children by the time I was 21. Because I wasn't informed about sex, I did feel like it made me a little bit disadvantaged when it came to sexual experiences with my husband. I didn't know what to expect. As I got older, I learned.

My children's father was 8 years older than me, and he had been around the block and had sex. He was able to manipulate me and say the right things to get me to have sex with him. He was able to manipulate me because I didn't have anything else to go on. I was 15 the first time we had sex. One of the things he said was "Well, we're gonna get married anyway." He bought me a ring and he did go through with what he said but looking back on it I'm like *Girl you're so weak.* Throughout our marriage he put his hands on me and I finally got fed up and separated from him after about 7 years of marriage.

Betrayal

I started dating someone new after me and my children's father separated. We had plans to get married until one day a girl reached out to me and told me that she had been sleeping with him. I didn't say anything to him about it. He only found out that I knew because the girl told him that she talked to me. He was upset but I told him I didn't want to sleep with him unprotected anymore because he already had someone he was sleeping with unprotected, and I didn't trust him. Then he told me that he wasn't messing with her anymore and that's what got us back to being okay and sleeping together unprotected.

I was having stomach pains and I get cysts a lot, so that's what I thought was happening. I went to the doctor, and they let me know that it was chlamydia. It literally broke my heart because I wasn’t sleeping with anybody else. I just stayed at home. I was definitely pissed too because I already knew he was cheating. We talked about it, and I told him to just handle his business, but be safe when he came back to me. And his response was always “I’m not doing anything.” When I brought my diagnosis to his attention, he immediately tried to act like I was doing something and that hurt my feelings for him to think I’m that type of person to be so dirty. That was really hard on me because I trusted him, we had open communication. He could pretty much do what he wanted to do but he still couldn’t be honest enough to cover himself and protect me.

Even though I wanted to, I didn’t tell anyone about the diagnosis because I was embarrassed and nervous. I really felt like “you don’t care enough about me to the point where you would bring something home to me.” Then I was also embarrassed because there is such a stigma against people who have sexually transmitted infections. I did eventually tell my OBGYN because the diagnosis triggered BV and that was hard to get control of. So, I was honest with her, and I wanted to let her know that I wasn’t out here just sleeping with everybody, and her response was “I don’t care if you are, I just want you healthy.” She was so open, and I didn’t feel like she was judgmental. That was very helpful to me.

Picking up the Pieces

The entire experience of having an STI made me feel like I just needed to be more aware and more careful. I journaled a lot to help me get through the pain and embarrassment I was feeling. Music helped me too. With my partners now, I remember that just because somebody says they’re monogamous doesn’t always mean that. The other person is not in charge of your body and care, you are. So, if somebody goes out and does something, that’s on them. It can come back on you, but it’s on you to take care of your own. So now I’m not sleeping with anybody unless we go to the clinic together. I’m more of an advocate for myself and my body now.

I was kind of scared into not having sex and instead of scaring children, we need to give them something and to prepare them. Say “If this person says this, or guys will say this, but don’t listen to them. Counter what they say or wait until you’re actually ready.” I wasn’t ready when I had sex but everything, he said sounded good, so I did it. Education and being more informed about things and having a good support system helps because when you're educated about things, you can make better decisions. And then once you're educated, not only do you make those better decisions, but you also make sure you help other people like your children and family make better decisions as well.

My oldest daughter and her boyfriend are sexually active, but they want to wait until their 30s to begin having children. I’ve asked them “What makes y’all want to wait?” and my daughter says, “You always said wait until you’re ready.” I’m the type of mom that doesn’t want my children having sex, but if they choose to, they aren’t going to get in trouble. I would rather tell them so we can be prepared for things. My younger daughters aren’t interested in sex at all. I have a daughter who recently turned 15 and she such a good girl. She’s a lot like me when I was her age. I used to be nervous like *what if some grown man does to her what was done to me.* We’ve talked about it, and she says “Ain't no grown man gonna talk to me. I didn't want, nobody's weird dad speaking to me.” My daughter is strong and powerful because she has a mom that was honest with her about sex and relationships. When I look at my daughters, not only am I proud of them, but I’m also proud of myself because the reason why they have abstained from things and they know things is because everything that I went through and that I learned good and bad, I presented it to them.

Diamond's Story

Diamond is a wife, mother, daughter, and women's health worker in her 30s. She was raised by her mom, who had her first child at 14. Her mom did not talk about her teenage pregnancy often, but she was strong in her rules about not allowing Diamond to date until she reached a certain age. Diamond has a history of long-term relationships, but those did not necessarily protect her from contracting an STI. In the following story, Diamond talks about how she moved from being uninterested and afraid to have sex to learning how to have a healthier relationship with sex as a married woman.

Breaking the Cycle

My mom had her first child when she was 14. I think that was because she did not have anyone to tell her when to have sex and how to protect herself. She had been through a lot growing up. Her mom did not want her for whatever reason and the person that took care of her only saw her as another mouth to feed. She was abused, tortured, and even burned. My mom is who I think of when I think about what it means to be resilient. I often think about how she was a child out here flailing and nobody was like "let me tell this little Black girl this is how we do things". My mother did talk to me early, earlier than most kids about having a cycle. I think I was in second grade when she told me what a period was. She knew I would have my first period early because of her history. When she told me she just said "this is how you're going to become a woman. This is how you use the maxi pad. This is where they're located in the house if you need them." But I didn't have any indication that was how you then could get pregnant.

Middle School Maybe

I did not realize how sheltered I was. It took a lot from my friends for me to learn about sex. I remember maybe like 7th or 8th grade I was at a sleepover, and it was the first time I learned what oral sex was and girls were asking "Would you kiss the boy after he did this to you?" and I was like "Did what to you? What are y'all talking about?" and they all knew, and I didn't. I felt like I ding dong. I was like "Why would somebody do that to you?" I didn't even know what that was.

A Negotiation

In 9th grade, we were allowed to hang out with boys and go on dates and to the movies. But I still wasn't really thinking about sex. I had a consistent boyfriend around the time I was in high school. My mom was strong in her rules about me not dating. If was up to her I would not have dated until I went to college. So, I had to barter with her over multiple conversations for me to be able to date. I started off negotiating wearing makeup. Then I moved to dating. I was like "I have straight A's. I'm on student council. I do all these things. Why can't I have a male that's a friend? Why can't they call me on the phone?" Finally, she was like "Okay, you're right" and she allowed me to date. My dad kind of came back into the picture around this time and I remember him telling me "Your mom gets to make those decisions about makeup and dating. I don't get to weigh in on those. Whatever she says is what it is." And I remember thinking, what is the purpose here? You're going to come back into my life and not speak up for me or be a sounding board?

So, I started dating around 16 and that's roughly around the time I started having sex because I had a consistent boyfriend. I was afraid to be 14 and pregnant like my mother. But once I wasn't 14 anymore, I felt like I didn't have to worry about it anymore. I felt like if I got pregnant at 16 it would be different. I felt like I had enough knowledge to make a decision about having sex. I dated my high school boyfriend up until college. I later found out he identified as bisexual and that he had multiple partners. I was really scared when I found out because I thought I was going to have AIDS. I know now that is not accurate, but in that moment, I was scared and angry because I didn't think it was fair for him to hold that kind of secret.

Two Different Pages

I had the same boyfriend in college for almost the entire four years. I thought we were monogamous, but he was not monogamous at all. You had to check in the dorm with your ID. One night I was leaving the dorm and they gave me another girls ID instead of mine as I was leaving the dorm. I had to go back and tell them, "This isn't my ID." And they said, "Didn't you just left this room number?" I told them "Yes, but this isn't my ID." So, the other girl must have been there with him the night before and left her ID. I remember thinking to myself: Just how many girls are coming into his room? There were other times I would find panties in his room, and they weren't mine.

One day, my discharge was not appropriate, and I knew something was wrong. My mom wasn't the type of mom to hold my hand if I needed to go to the doctor. She gave me the insurance card and I had to take myself and figure it out. I had a history of yeast infections. For people who've lived like that and also have had bacterial vaginosis, they might not know that they have another issue. This time however, I knew I was experiencing something different. I went to Planned Parenthood and it felt judgy to me. I was very uncomfortable. I was thinking they were thinking I was promiscuous and wondering what I did bacterial vaginosis and trichomoniasis. Thankfully it was easy to clear up.

This Doesn't Happen to People Like Me

A little later, I had a genital wart. There were a lot of questions like "How long have you had this? Did you know it was raised?" I felt like it was hard to answer them because no one gave me the language to talk about all of the things about a genital wart. I was so disgusted by the whole experience because it was an external thing. For so long I had always thought only white people get warts because they get them on their hands and feet from going to the restroom without shoes or playing outside or other things like that. I judged myself and I was very frustrated and upset about the occurrence. I knew it was going to keep coming back every three to six months. I was fearful that I was going to be one of those people that had herpes on their mouth. That hasn't been my reality, but the thought was enough to make you want to make good choices if you're going to have sex. To go ahead and get STD screening.

Reflection and Recovery

I felt like during the relationship with my college boyfriend, I allowed stupid behavior to take over my brain for so long. I felt anger for allowing him to manipulate me. Asking me what I did and who I had been sleeping with. I hadn't done anything; I knew I had only been with him. I was scared because I thought I could trust him but for all I knew he could have had 25 partners at the time, and I had not the slightest idea. It was also bad because I still wanted to have sex with him because it was a good sexual experience even though he was bad for me.

I was really embarrassed and shameful. think I only told one friend because she had a really complex sexual history. She told me about when she got chlamydia from one of her partners. She was vulnerable with me about what she went through, so I told her about my experience. She was supportive because she had dealt with so much sexually and partners that cheated on her. But my other friends weren't having these kinds of issues.

I did have a really close guy friend who told me about his partner who had a history of genital warts. I didn't tell him my experience, but we had a talk about his comfort level of dealing with her and her sexual health. It was empowering to talk to him because I knew that I wasn't alone.

During my senior year, I participated in vagina monologues, and it helped me to heal from the situation with my ex. The *Vagina Monologues* is a theatre production that displays women's experiences of consensual and nonconsensual sex, reproductivities health, rights, and well-being, body image and a variety of other topics concerning women and bodily autonomy. This experience taught me that it was okay to go through things sexually that may be uncomfortable, nuanced, funny, hilarious. I learned sex is not always glamorized like we see on TV. It was okay to fumble.

The monologues had a small case of maybe 20. I was able to meet women who identified as queer and lesbian. I think they shared a lot of deep secrets about sexuality that I didn't even think about. One lady was like "I married my husband, and I realized now I don't want to be married to a man. I want to maybe be married to a woman." She was sharing this with us in confidence. I still have relationships with some of them until this day. Participating in the monologues let me know I wasn't alone. I learned that women have sex. People can enjoy sex. Being in this space with other women really took away that shame I was experiencing around the STI, and it helped me to heal. Shortly after the monologues I graduated and moved away. The monologues, moving, and creating distance helped me to cut ties with my college boyfriend because I had had enough.

A New Era

It was two years before I dated again because I did not want to get another STI or have issues with my sexual health because the STI experience I had really bothered me. I felt like I was scarred in a way that was uncomfortable. I made the decision that if I was going to get into a relationship, I'm going to use condoms and share my sexual history. I had a plan for going into my next relationship, I was not going to play the victim. I wanted to make sure in the future I could minimize risks if possible. I was fearful and I didn't want another STI and at the same time I was learning it was okay to love myself and choose myself first. My sexual health is important.

The next person I dated turned out to be my husband. He was a virgin, so I didn't have to worry about contracting anything from him. If anything, I was putting him at risk, it was the opposite of what I experienced before. I was very honest about my sexual history with him, and I did not hold anything back. I knew I would want to know those things if I had been in his position. He asked appropriate questions and I educated myself more. We don't talk to young girls enough about personal hygiene like wearing cotton underwear, not using fragrance soaps and how to clean your vagina properly. By this time, I was out of school, so I really took the time to be more knowledgeable and learn more about being good at personal hygiene.

Madison's Story [Participant authored introduction and subtitles]

Madison is a 26-year-old biracial woman who identifies as Black. When reflecting on her early years, she can't ignore the feeling that her body was almost corrupted by maturity before she was 10. Since being diagnosed with herpes simplex virus 2 (HSV 2) Madison has been on a journey toward self-acceptance, education and curating a life informed by Black feminist principles.

Precocious Puberty

I grew up being so afraid and ashamed of my body. I started developing breasts when I was in about third grade, and I was always taller. This put signals and alarms in my parents' heads. My mom would tell me, "You're a big girl. You're thick." Her comments seemed shady to me because it seemed like she was trying to send a coded message that I could be smaller, but I was choosing not to do so. Then, I had my father saying "You need to stay covered. You're not safe going out like that." It was tough growing up with my white cousins always commenting on what my ass looks like and saying they wanted to look like me. A lot of these comments didn't really hit. It took me years to understand them as compliments. For so long I thought my body was bad and maybe later on people would catch up to me and it wouldn't matter so much.

I remember when I got my period. I was really young; I might have been in fifth grade. I needed a lot more support than I got. There would be times where I wouldn't have enough pads at school or a change of clothes. I needed someone to help me get prepared for those days and be aware of when my cycle was because I was not, and my mom did not have the time to help me mentally. She was more concerned about my younger brother and his needs. All of this added to my body shame. It was fucking terrible. Like figuring that out on my own. We had a conversation, and I was told I was now a woman because I started my period. I remember crying a lot because I was wanted to hang out with my friends. I didn't want to be a woman. My parents were excited for me, but I think they were scared by my reaction because I didn't know what starting my period meant. We didn't talk about sex. I literally thought I had cancer.

Waiting for Them To Catch Up

In high school I was proud that I was not having sex and that I was a virgin. I was like "I'm not interested in you guys. I value myself." I felt like if I found the right one, it would happen for me. I was raised Catholic and was very into Catholicism growing up. Catholicism indoctrinated me to stay chaste. I cared about having sex, but I wanted to do it "the right way.". We would go to these Catholic youth camps, and I wasn't sneaking having sex like other kids, so I thought I was better than them. I wanted to be associated with this moral hierarchy. On top of this, I had a lot of body shame and then couple that with race. I am a larger woman and although I'm extremely light, I was often the darkest person in the classroom. It's not like I was getting hounded to go to dances. So, the moral piece was also a way to protect myself because I wasn't getting approached.

Same Roof, Different Rules

Interestingly, I didn't get the sex talk, but my younger brother did. Condoms fell out of one of his bags, so my dad had a conversation with him, but I wasn't there for it. I felt like he had a lot more freedom than me. He was able to have girls over and no one even offered that to me. That bothered me and hurt me. But when I got to college having relationships with boys became a big deal for me.

Giving Up Control

Once I got to college I started to flourish. It seemed like everything as going well. I was more confident in my body, making friends, my natural hair. I was excited about growing into a woman, which I thought was having sex. By this point I thought being a virgin was the least cool thing. I had my list of things to do for school and for my social life and I could not wait to check sex off the list. I was like "Now's the time for me to allow myself to do this." I was also watching shows that made me think having a boyfriend and having sex is what college is. The content I was consuming definitely informed my decision to have sex. The media has a way of conditioning us that's a little beyond our control. I was waiting for the man to choose me. Catholicism taught me that. Once they did, I got a signal of validation and that was my sign. I wasn't getting to know people and dating or taking the steps that go into courtship.

Just as I started to harness control over my body, I was raped my freshman year. That experience woke me up to a lot of isms about gender. After this, sex became extremely scary for me. I tried to be resilient in that situation by becoming hypersexual. I thought I was picking cues of being a strong independent woman who is carefree and doesn't overcomplicate sex. It was like I was releasing my power.

It turns out that I found more empowerment through education. I started studying more about sexual assault, gender-based violence and intersectionality. These things that were truly where I found more power and met more women or femme identifiers who could speak on this and have shared experiences. Even still, I did not have enough education on consent. I was finding myself being assaulted quite a bit my first two years on campus. I think one of these experiences resulted in me contracting herpes simplex virus 2.

Reality Check

I still am not exactly sure how I got it. I can think of one incident where it may have happened. I was really sick and once I came out of the sickness and had taken all of the antibiotics. After this, I started having a reaction in my vaginal area and said to myself: This needs to be addressed. I went to the health clinic and upon a visual examination they told me "Yeah, that's definitely HSV 2." They still ran the tests. I remember was in class when I got the phone call confirming my diagnosis. When I returned to the classroom, I started crying uncontrollably so I had to leave.

Seeking Answers

After the diagnosis I spent days on the internet looking for Youtubers who might have been talking about and people just were not. It was a cue to me that society was not at a place where it was safe to talk about having an STI. I became so depressed. Not to mention HSV 2 is an autoimmune issue, so I had very little energy. It was difficult for me to physically move, and I made a lot of excuses to not have to move because I did not want to be limping around. I lived with my parents at the time, so I started staying in my room and sleeping a lot. I had mentally started to shame myself about how I contracted the STI. I thought I would be undignified and did not see a future for myself in a romantic way. I immediately began counting myself out of experiences that I am entitled to that had nothing to do with my diagnosis. I didn't think I would have sex ever again. A lot of my experiences had been non-consensual, so I felt very cheated that I didn't get a fair shot to learn. I did find one Youtuber that talked about having bacterial vaginosis. Although we didn't have the same diagnosis, just the representation of someone being transparent and vulnerable about her issues made me feel like I had a chance to be as vulnerable. There really is something about seeing someone who likes like you, who has had a similar experience with an STI.

Until this day, I've only had one doctor tell me I have HSV 2. I had almost wrapped up all of my medicine and I then I had another outbreak and I panicked. I thought I needed more medication because I was still having a flareup. I went to another doctor and they me it wasn't HSV 2, it was an ingrown hair. I felt instances like this led me astray because I would have to get another opinion. I didn't know if my diagnosis was real or not.

Wombman

I turned to spirituality and natural remedies to pull me out of my depression. I needed more structure and belief system because it can be dark when you feel that undesirable. I wasn't diagnosed as suicidal, but I did feel like if I can't be in a happy relationship and experience love and fulfillment with whoever I want, what's the point? I started getting into Yoruba religions and reading books about my body. I read the Sacred Woman Text which taught me about having a relationship with my womb, it was something I'd never heard of before. That's when I started actually caring about the maintenance and care of that space versus having it presentable. In a sense I was no longer objectifying myself. I now look at my body and my womb specifically as a whole functioning piece of nature versus a desirable object. The more I see myself as an all-encompassing human that has full range, the less scary it is to take care of myself and value my health. The book discussed diet, exercise, using crystals and stuff like that. I went vegan for a couple of months, and I thought I cured myself. So, I did a lot of self-education and learning to truly treat my body as a temple. Mindfulness and meditation were huge for me too. One day I discovered that my mom was diagnosed with the same STI as me when she gave birth to me. This changed my opinions on myself a little bit because I thought maybe this something I've always had. Me and my mom have never talked about the diagnosis. I mostly take responsibility for it though because I was having unprotected sex.

Overall, I try to be more educated about what my status is. I get tested for STIs more often than I go to the doctor for a regular checkup. I'm more worried about getting pap smears. I like to be in those spaces to learn more about my sexual and reproductive health.

Passing out Pieces

Until this day, my mom doesn't know about my diagnosis, nor does she know that I know about hers. One friend reached out to me to ask if she should tell her partner about her diagnosis. She is the only person I talked to about my diagnosis because when she disclosed to me, I realized I was not alone.

It is still more difficult for me to talk about the STI than my assault. There is a social responsibility to living with HSV 2. In most cases when I've disclosed my status, people don't have an issue with it. But there are times when people have a strong reaction. I used to not be able to handle those reactions but now I can. My reaction in those instances is usually "Oh, you don't have enough information on it." I'm now more informed about how a lot of systematic issues contributed to the circumstances that lead to me getting an STI. I believe that talking about it is a part of the solution. That is the first step.

Taylor's Story

Taylor is a 43-year-old mother of two daughters. She was raised by a strong Black grandmother and mother. Despite this, it wasn't until Taylor was 38 that she really began to work on herself. As she realized her marriage was about to end, she also started to recognize that she did not know who she was outside of her marriage. Since she decided to move forward from her marriage, she has prioritized making decisions to celebrate herself. The pages that follow details Taylor story of resilience and self-love as a young mom who was born to a young mom.

The Naivety of It All

My parents always told me I was beautiful, but I wasn't ever spoken to positively about my body. I wasn't fat, but I was always thicker for my age and my sister was very slim. So, I was embarrassed of my body. I never felt pretty, but I wasn't one of those girls who didn't feel pretty and sought the attention of boys to feel better. I wanted boys to notice me, but I didn't seek to sexualize myself. I did start masturbating at a young age, I didn't know where I got that from or why I was doing it, but I knew it felt good. I was also touched inappropriately when I was younger, but neither one of these things made me want to have sex.

In fact, I was very afraid of sex. Even the concept of sex I didn't really think about it. I lived with my grandma until she passed away when I was 11. My mom was a young mom, so she was very strict about sex. She had me and my sister at 15 and 17. Once we moved in with my mom after my grandmother passed away, my mom started having conversations with us about not trusting boys. She told us boys used her for sex. I remember her telling us "I had sex with your sister's father, I got pregnant. The next time I trusted a man was your father. I had sex with him and immediately got pregnant with you." At the time, that made perfect sense to me. I didn't question it. Now that I'm older I realize what she was saying was improbable. Even if I was to have sex, I don't think I would've been comfortable having a conversation with her about birth control because of how adamant she was about us not having sex. My. Mom would've probably beat our ass for asking to get on birth control. Our birth control was my mom telling us "You better not be out here fucking." My mom planted things in my head like "what people think of you is important". I grew up thinking that how people perceive you is of the utmost importance.

Virgin by Choice

My mom kept us in the house a lot, so I didn't have a chance to be around boys and be flirtatious. Most boys weren't interested in me, and I think that was because I was very vocal about being a virgin and remaining one. I felt like none of the boys in my town were worthy of my virginity. There was one guy that I dated in high school, but as soon as my mom found out that was over. I was also still very scared of sex, and I even more scared of my mom. Plus, I knew didn't want to be used for sex. There was one boy I thought about losing my virginity to. I thought I loved him. I invited him over one Friday night I knew my mom would be going out. I had heard all these things about sex being really painful and I had even seen his penis which wasn't small. I was nervous but my hormones were raging at this point, so I was like "Let's try it." He ended up not coming. The weekend passed and on Monday morning I heard that he had slept with a girl that was my friend. My first thought was Thank God I didn't lose my virginity to him, I would've been devasted. This experience confirmed for me, nope I'm not having sex; men are not to be trusted. I would let guys perform oral sex on me, but I would never return the favor or have vaginal sex with them. I stayed the course all throughout high school until I got to college.

If It Isn't Love

I lost my virginity my freshman year of college. I met my oldest daughter's father the first day of orientation. We had a quick romance because we got engaged over the Christmas break of my freshman year. We were married shortly after that and remained married for a total of four years. I didn't know a lot about relationships, and I thought he really loved me. Which he did, but to the point he was crazy about me and that became problematic. It was my first encounter with a committed relationship, and he was my first love. He would send me music and play Luther Vandross. He did a lot of things that I needed to feel secure and open that part of my body up. So, one day I was like I'm ready to have sex with him.

After we had sex, I remember wanting to get on birth control, so I made an appointment with the health department. I couldn't follow through with the appointment because my mom put the message in my mind that girls who are on birth control are whores. I was too embarrassed to go. I thought they would judge me. I ultimately ended up getting pregnant.

Thotting Across the Land

Once I got divorced from my first daughter's father, I felt like I had only seen and known one penis in my life. I wanted to know all the penises. So, I proceeded on to have sex with a few different people. I didn't give a shit about judgement. I probably had sex with like five guys over the course of six months. And that's an approximation because I honestly stopped counting. I was like "I'm not going to let a number judge me." I felt so oppressed in that marriage and relationship and I wanted to know more.

Over that six-month period, I had a one-night stand. I met a guy at the club, and he was very handsome. I took him home and things got hot and heavy. I don't think he had a condom, but I shrugged my shoulders and said "Fuck it." I was on birth control and my thought process was I'm not going to get pregnant and that's all that matters to me. I wasn't even thinking about sexually transmitted infections because he didn't seem like the type. He was a very clean looking young man, so I thought he took care of himself. We had sex and I never talked to him again.

A couple of months later I got into a relationship with someone I liked back in college. We started having sex. Initially it was protected but it eventually became unprotected because I knew we were going to be together. One day I went to the bathroom, and I was like "It really hurts to pee." It was a ton of pain. I had had yeast infections and thought that may have been it, but eventually it got so bad I was like I need to go to the clinic. I kept telling myself "This is clearly just a horrible yeast infection." At the doctor they were like "So we did a culture and its chlamydia and gonorrhea at the same time. It happens."

The Aftermath: Accountability or the Lack Thereof

My knee jerk reaction was "This man has given me gonorrhea and chlamydia." I was like "How dare you?" I had to figure out how to have the conversation with him because the doctors gave me medication and some to give to my partner. I was embarrassed. I was ashamed. I felt disgusted. Even though I wasn't a whore, I felt like one. I was too embarrassed to tell anyone but my partner. When I talked to him, I immediately told him "This is your fault!" Initially I was afraid to tell him because I thought he may leave. We talked through it though and I was just so embarrassed because I did not tell him I had sex with the guy from the club unprotected prior to getting in a relationship with him. I did not get tested between the two either. I was a single mom around this time and taking care of myself was my last priority, so it had to be something bad for me to pay attention. During the conversation he was like "It could have been me" and I was like "Yeah it probably is." I asked him if he protected himself with the last girl he was with and he said no. So, it could've been either of us. Thinking about it now, I feel very embarrassed by my inability to be accountable because it could have been me, but I allowed him to take the fall for it. We took our medication and we stayed together for about three years. I think him staying with me and being able to talk through it helped me. He really accepted me, it might have been because he thought he was the cause of it, but it helped me.

After our relationship, it took me about 3 years to get back into the dating pool. I became hypersensitive about my sexual health. I didn't play any games about my sexual health. I had a latex allergy, so I had to figure out how was going to have sex. I did a lot of research because I was really scared to get an STD again. I looked up the STI rates in the county I relocated to know how prevalent they were. When I started having sex again, we had to use lamb skin. I had to educate myself because the lack of education got me there in the first place.

Educating and Becoming My Best Self

After this relationship whenever I dated someone, if we did have sex, it was always protected. In between partners, every time I would get a full STI panel test: Hep B, Hep C, gonorrhea, HIV, everything. I was so adamant even up until my current boyfriend. We had been seeing each other a year before we started having sex. I told him "I need to see your test results and here are mine." I wanted to make sure I didn't get an STI again or catch something permanently. This experience made me make better choices.

I think it might have been helpful to have heard other women openly tell their stories in an empowered way before it happened to me. If I had a chance to talk to a group of young girls and I thought they would listen to me, I would tell my story. I've had a whole lot of self-realization. Statistically speaking, the probability of contracting an STI is so high for us. It does feel better when you have sex unprotected but there should be a commitment to keeping one another safe in addition to having sexual freedom. We should be having these conversations normally in our homes. I try to talk to my daughters about their bodies and let them know about their choices. I hope they hear me and listen to me in a different way because I'm trying to give them something different than what my parents gave me.

Kennedy's Story [Participant authored introduction and subtitles]

The following story describes Kennedy's life and her run ins with peer pressure, misguided love, and finding her true and authentic self. Her younger days were filled with lies, betrayal and cheating which lead to losses in friendship and trust. However, she still had the will to be someone, love someone and have that same love reciprocated. Kennedy didn't know that the love she longed for would come from a seed, her daughter–Baby Rose. Her seed gave her the ability to strive, move forward and discover what she can accomplish in this crazy thing we call life. Baby Rose never knew what she would be to Kennedy, but Kennedy will go to the ends of the earth to show her.

Not Being Me

I grew up with both of my parents in the house. My dad did go to prison for a while, but he was still extremely present, well as present as one can be from prison. They never give me a bird and the bees talk. We were told don't let an adult touch you, don't let an adult sit you on their lap, or if an adult tells you "Let's play a game and you can't tell nobody," that's not a game you want to play. That was the only sex talk I ever got at home. There were times when my cousins used to sneak into their parents' room or even go through my parents' stuff when they weren't home and find dirty movies. They'd watch them but I never wanted to. I was always the lookout person. I didn't want to get in trouble, but I wasn't going to let them get in trouble either.

I went to private school up until sixth grade and at that school there was no sex education. We learned about body parts and bones, but not specifically sexual education. I didn't have sex ed until I was in 7th or 8th grade in public school. I was super taken aback by everything I saw. I think the first picture they showed us was the bleu waffle or something like that — the vaginal disease where it's a whole bunch of bumps and discoloration. As a kid, I was like "Oh my God! That's what happens when you have sex?" They told us yes it could happen with unprotected sex, and you could get pregnant. It was so scary at the time. I didn't want a boyfriend or to even talk to boys at all.

When I was 13 or 14 my mom put me on Depo [Depo-Provera is a birth control shot]. She had done the same with my older sister. My mom told me "I had my baby at 16 and you not gonna have a baby at 16 so you gonna be on Depo at least until you get outta high school and graduate." I didn't understand what birth control meant but my mom said that's what I had to do so I did it. I never asked why. She said, "If you're gonna live in my house, you're gonna be on birth control." I was scared of getting put out, so I wasn't going to argue or fight because she was crazy. She wasn't going to put me out or beat me up. The depo made me super depressed. It also caused me to gain a lot of weight that made me insecure, and I felt like I wasn't pretty. I confided in my sister a lot during this time since she was on Depo too. But she didn't have any advice for me because she was scared of our mom too.

Trying To Fit In

When I got to high school, peer pressure and friends influenced me to have sex. All the other girls had a boyfriend and I thought I didn't have one because I was this fat girl or maybe because I wasn't having sex. My older cousin told me "Nobody loses their virginity to the love of their life. So why do you think that's gonna be a thing?" As a kid, I felt like she knew more than me. She had friends that had lost their virginities. And she knows more people than me. So, I thought clearly this is something she knows. My friends would tell me they lost their virginities and had sex with their boyfriends and then they started saying "I love you." Getting a boy to like you seemed like the thing to do. If I had gotten education a little sooner, I would have been prepared for the friends and peer pressure. I would have been like "Yeah, no. Did y'all see all them pictures?" Instead, I could have saved my opportunity for a special time.

My cousin convinced me sex wasn't that bad. So, one day I hung out with my cousin, her baby daddy, and his brother. Her baby daddy's brother kissed me. I thought it was cute and decided to hang out with him the next weekend too. The following weekend was my 15th birthday and this time when I hung out with him, we had sex. My cousin had told me "Even though you don't lose your virginity to the love of life, it's gonna be fireworks." It was not fireworks for me. While we were having sex, I remember looking out the window and watching a squirrel pass and wondered if it was watching me have sex. One thought was "I don't think I'm supposed to be paying attention to that squirrel." Another thought was "I'm so glad this squirrel can't talk because it would have told my mom and started thinking about getting trouble. So, I was like "We gotta hurry up because I have to go home." So, it was not magical or all it had been hyped up to be. So, I felt like sex wasn't for me.

I still thought we would be in love, and I would finally have a boyfriend since we had sex. It was probably two weeks later that he also took my best friends' virginity. I was so angry, and I felt extremely betrayed. I fought her in the neighborhood and at school. I got suspended for the fight at school which made me get beat by my mom for fighting my best friend at school.

I couldn't tell my mom why I fought her. My mom wasn't the most understanding and she can be impulsive. Like one time I was getting bullied at school and I told her about it in a funny way, but she didn't think it was funny. She went up to the school and we had to have a meeting with the parents of the girls who were bullying me. My mom instantly tried to fight their parents. She was calling them little bitches and all kinds of stuff. It was so embarrassing I was like "Mom, please stop!" It was the worst. So that's why I didn't feel like I could come to my mom about what really happened with my best friend.

After this, I didn't have sex again for a couple of years. Once I did start having sex again, it was with one person and it was pretty consistent, almost like every weekend. It was very basic we only did like two or three positions if that. In my head I thought "Maybe I'm lame, so he doesn't want to do anything else." I felt very inexperienced and insecure. I felt like I had to step my game up, so I started watching porn.

Discovering the Real Me

I had started watching porn and I wasn't as sexually experienced as my other friends. I began thinking that sex was supposed to be the way it looked on porn. This thought process turned me into a whore because in my head if I had more experience then I would look how porn stars look. To me, college was my time to explore. I didn't know any of those people and I knew I would never see them again after I graduated. I thought I would go back home then move out of state. I wasn't sleeping with everybody, but I definitely wasn't shy about it. I was trying to figure it out and get more experience. It kind of worked because there was one person in my building that was a regular hookup. He had way more experience than me and it helped me a lot. Even still I didn't feel like it was what I saw on porn. I always felt like I didn't know what I was doing. I realize that all went back to me feeling insecure as a person, not necessarily my performance in bed.

Dreams Not Yet Fulfilled

I did not move out of state after I graduated like I thought I would. I moved back home and started working at a restaurant. There I met my daughter's father. He was super attentive, always asking me if I was okay or if I needed anything. He made me feel like I could drop the guy I was still messing with from college and be serious with him. We dated for about two years, but he ended up getting caught cheating, so we broke up. Two months after we broke up, I found out I was pregnant. It was really stressful because we weren't together. I couldn't depend on him. Thankfully I had my mom and my sister to tell me I'm stronger than what I thought I was. I was working two jobs and I was able to move in with my mom, so I was able to save a lot. My mom was really my backbone, she helped me with my daughter. I honestly didn't think I was going to get through this tough time. I had to take it one day at a time and keep going for my daughter. I'm so glad I had my mom there for me through it all.

When I was about six months pregnant, I thought I had an STI, but it was a yeast infection and bacterial vaginosis. I cussed my daughter's dad out saying, "You gave me something because I'm having to get treatment." Then he admitted to sleeping with 3 other women while we were together. It turned out not to be an STI, but he admitted he was cheating like it was so normal. At that point, I made a decision not to continue a cycle of insanity. My parents stayed together for their children, and I was considering doing that for my daughter, but I didn't want to keep going through it with her dad. After a while you will end up feeling like less of a person and you keep accepting less each time.

A Minor Setback

I was diagnosed with an STI for the first time when I was 27. My then boyfriend went to Chicago for what was supposed to be one day but turned out to be four. Whenever we were supposed to talk at night while he was in Chicago, he would ghost me. He wasn't answering my calls or texting me back which isn't like him at all. He had a whole bunch of excuses saying his phone died or he left it. At the time, I thought something was going on, but I was like it can't be. He didn't go to Chicago often, so I thought "Who would he know there." We had sex right when he got back and a week later it burned when I peed, and I was itchy in my vaginal area. Something didn't feel right, and I didn't know what was going on. I told my ex-boyfriend about my systems, and he told me to try urgent care, but I didn't think they dealt with the issues I was having. Instead, I set an appointment at Planned Parenthood, but I told him I set the appointment up at urgent care. At planned parenthood, I got tested and they treated me presumptively. They gave me a shot in my butt and some pills to take as if I had already tested positive. A week went by, and they called me to tell me I was positive for chlamydia and gonorrhea. I felt like it was the end of the world. I was embarrassed. When I was leaving the appointment, I saw somebody I knew, and I thought they probably knew what I was there for.

Putting on a Mask

When they told me my results, I was livid. I call him and ask, "Are you cheating on me?" He says "No." I ask again "Are you cheating on me? Like please be honest because I'm being so calm right now, but I'm actually really pissed. So please be real with me." He said no again and asked why you say that. I told him "I just got a call that I have gonorrhea and chlamydia. So, who you been sleeping with." He hung up on me. I kept calling him all day and he wasn't answering. I texted him saying things like we need to talk, please call me, call me back, you need to explain this to me. No answer for like two days. Once he finally did get in contact with me, he told me he met a girl at the club when he was in Chicago, and they hooked up all weekend. Until this day I still feel like this story was a lie.

I told my younger cousin when I found out. We are really close we grew like sisters and people thought we were twins. When I told her she was so mad she was trying to hit him with her car. She was more upset than I was for real. I was upset but at the same time I had gotten the treatment, and I was not about to be with him again. I couldn't be worried about it because I didn't want it to stress me out our control my life. I was going to move on from him for a minute.

A Major Comeback

We broke up for about a month, but we eventually got back together. The kids were a big part of us getting back together. I still didn't trust him though. I was constantly going through his phone, trying to find out where he was at, and telling him we need to be in communication at all times. I'm not even that type of girl but I felt so insecure. I went back to planned parenthood to get condoms. They showed me the chart of effectiveness and how to put them on. We started using condoms because I was so scared. I was having flashbacks to middle school sex, and I could not have that. I did not want what they showed us on those pictures. A part of me felt like I wanted to go back to the college me and do me since I lost trust in him. But I was so scared of catching something else. I couldn't even try to talk to or be with anybody else. It was hard. This experience shaped me in a well needed way to be more cautious. If I get in another position where I'm having sex with someone regularly, would expect for them to tell me if they have other sexual partners and how many of them, they are having unprotected sex with. I would share the same in return. I would also let my partner know that we need to practice safe sex and use protection if we aren't going to be monogamous. I'm going to be more open and honest with my sexual partners in the future because its important.

During our one month break up I also started therapy. Even though my therapist was this little White man with glasses, I was very comfortable with him. I was able to talk through a lot of my childhood traumas and trust issues. Therapy was a real eye opener for me. I recently got a job in the healthcare field. My daughter was telling me that all the parents were going to career day at her school. I didn't want to go because I was a supervisor at a drug testing facility and that is a lame job. Kids didn't know what drug testing is. In that moment I thought *maybe I need to find something cooler to do.* So, I enrolled in school and applied for my current job. I also had to step my game up because I'm about to have two more children to provide for. When it comes to my children, I'm going to make sure they are educated on sexual health. Even though it's an uncomfortable topic, it's a conversation that should be had. I'm going to be real with my children because I want them to feel comfortable coming to me with stuff. I want to open that line of communication and make sure it remains open.

Jazmine's Story [Participant authored introduction and subtitles]

Jazmine is a mom of two holding it down while her boyfriend works out of state. Jazmine is a sweet individual who grew up with a perfect childhood. Once she got to high school, she became very interested in sex, but she didn't have enough support or courage to ask about it. Her mom wasn't the nicest at this time, which made her afraid to ask because she didn't want to get in trouble. In this story, Jasmine talks about the things in her life that lead up to her getting an STI from her boyfriend, how she overcame that experience, and how she feels today.

The Beginning

There would be people making comments about my body all the time. I wasn't the thickest, but I did have a butt. People would stay stuff about me eating a lot of cornbread and how I had a big booty. Little comments like that. It made me uncomfortable, but I never really said anything. This probably happened starting when I was 13 old. During that time, when I was leaving middle school and going to high school, we started talking about sex. Other girls were doing stuff, but I wasn't doing anything sexual. I took a health class in middle school where I was taught about STDs and to always use protection, but it went over my head a little bit. We mainly watched videos and people would be asleep. I wasn't paying it too much attention. Then at that time kids who were having sex were hyping it up to seem like it's cool. I started to get curious as any kid would, but I didn't feel like I could go and talk to my mom about this stuff. No adults in my family ever talked to me about it but I wish somebody did.

Curiosity

When I got to high school, people were hyping sex up even more. My friends were doing it and I wanted to see what it was like. I was 15 at the time, I had a boyfriend, so I decided to have sex. Once we did it, I said to myself "Oh this is it?" It was very boring and not what everybody was making it seem like, but I continued to have sex with him. We stayed together all throughout high school. I was just letting people influence me to do bad stuff. Me and my boyfriend did use protection because he had condoms. But if he didn't, I probably still would have done it because I didn't have anybody to tell me what to do or how to protect myself. It would have been much better to have the information about sex to come from someone close to me instead of some random person in class or from a boring video. I had a younger cousin who told me "If I'm ready to have sex, I'm going to tell my mom." When she told me this I was like "I wish I could do that", but I knew I wouldn't because she's not that type of person. I feel like I can't go to her because she is not going to try and help me, instead she will point out everything that's wrong.

A Bump in the Road

After I graduated high school, me and my high school boyfriend broke up. I began dating this guy who had been trying to get with me for years. There were times he would act weird which made me think he was cheating. He would say stuff like "I'm at the doctor's office with my baby mama" or "I'm going with my baby mama to get a costume with the baby." I'd be thinking, "He's probably cheating on me." Fast forward to one day I'm at school. I go to the bathroom and it's this clear fluid coming out of me. It was so much that I had to wear a tampon or a pad. I wasn't thinking anything of it. I told my mom there was something coming out of me, and she was like "You better hope you don't have an STD or something." I thought I might've been ovulating or something, so I told my really close friend who I trusted, and she was like "You need to go the doctor."

I made the appointment, got tested and the doctor confirmed I had chlamydia and gonorrhea. They gave me a shot in my butt or my hip but while she was doing it, I felt so disgusting. I was crying and my face turned extremely red.

Afterwards, I immediately called him spazzing because it confirmed he was cheating on me. He tried to tell me he wasn't not cheating on me, and I was like "Dude, I got chlamydia and gonorrhea and I'm only messing with you!" Then he kind of admitted to it, but I was done with him after that. Having sex with two women at the same time unprotected was a little too far for me. Just leave me alone. It especially hurt me because I didn't want him at first then when I finally gave him a chance this is what he did.

The Aftermath

I'm so glad I told my friend about the discharge I was experiencing because I probably wouldn't have gone to the doctor. When I told her about the diagnosis, she was supportive because I was very embarrassed about it. Venting to her about it was helpful but I told myself I would take it to the grave and never tell anybody else. I had a couple of friends who were open with telling me about their STI diagnoses, but I still didn't tell them what I had. I thought people would talk about me.

A Word of Advice

After this relationship, I was single for the longest. I didn't want to have sex. I was scared even though I had been treated. I just felt disgusting. I didn't have sex for a while, maybe like six months to a year. When I finally met someone new, he told me I needed to get tested before we had sex. I was shocked in a good way, and I told him that I would do that, and he needed to do the same. We exchanged results but I later found out that he sent me an outdated report. Luckily, I didn't catch anything. After this, I almost always used condoms with my partners. I was doing me, but I was going to be safe with it. One time, I was a little intoxicated and was about to have sex and I asked him "Do you have a condom?" he said, "I don't have one" and I told him "We aren't about to have sex." We did not have sex and he left. Every time I had a new partner, I would go to the doctor to get tested, whether we used a condom or not. I would always try to use condoms though. I started to care more about my body because having an STI can change your body. I stand my ground now, no matter who it is. Sex is a desire and it's very tempting. Plus, there's so many things out there that make you want to do it, things on television, music, porn. Stuff is out there that influences you to have sex, but they aren't really talking about being protected. So, you have to be strong minded when it comes to sex because one wrong move one time, you could end up with something for the rest of your life.

I want people to know they should be careful. STI's need to be talked about more in the household. Its good they teach you about sex in school, but I believe it is better when it comes from someone who loves and cares about you. As a kid, someone in my family talking to me about this would've let me know they cared, and I would have been comfortable being open and talking with them.

Candace's Story [Participant authored introduction and subtitles]

Candace is gay, Black, and proud. Now. She used to be a shy, naïve girl who questioned every aspect of her sexuality. Over time, with the support of a strong community, Candace became an unfiltered firecracker who loves to share her story with anyone who will listen.

Practices Makes Perfect

I never really had a birds and bees kind of conversation. I knew when I was younger that I wasn't straight. I mean I was kissing girls in fourth grade. There was one summer I went on vacation with one of my friends from Girl Scouts. We were watching movies and like some kissing scene came up and I don't remember like how the conversation got started, but basically, we came to the decision to practice kissing on each other. We practiced all kinds of kissing: just pecks, French kissing. We practiced like the whole scene in the movie where the characters are just relaxing and all of a sudden somebody just reaches over and starts kissing. We didn't get caught but nothing happened between us after this.

In middle school, my small little social circle talked about sex because one of our friends told us she lost her virginity. Even listening her share that experience, sex sounded so unpleasant. By this point I had seen dick pics and I understood the general gist of how sex is supposed to happen, but this was the first time I knew somebody that actually did it. She was able to share details of how it felt and that was my impression of how things were supposed to go.

Birth Control = Green Light

Late during my freshman year of high school, I remember asking my mom if I could get on birth control. I wasn't even thinking about pregnancy prevention or anything. I was thinking about the fact I had really terrible periods. My friends who were already on birth control told me it was helpful for periods so I asked if I could be put on it. One of my parents decided I couldn't be on it because they didn't want me to have the idea that I could be out there having sex now that I was on birth control. Instead, I was prescribed a different medication that is specifically for periods. The pills were really big, and I had to take two of them three times a day for the duration of my period. This was the only conversation we had within the household about anything sexually related.

I did talk to my older cousin about sex this same year. She was about three years older than me, and I had confided in her that I didn't think I was straight. She wasn't outwardly disapproving, but she implied that maybe I felt I wasn't straight because I hadn't had any sexual experiences with guys. So, she ended up hooking me up with one of her friends and I kind of went along with it because I thought maybe she was right. Her friend eventually became my boyfriend and that is who I lost my virginity to.

The Moment I Knew

I used to go to this youth group down the street from my house weekly. One day he convinced me to skip youth group and come to his house because his mom was working late. I went to his house, and we go straight to his room and get started. Within the first five minutes of us having sex, I wanted to find a way out of it because that shit hurt. I was thinking "If this is what everybody's been hyping up, I know I'm gay at this point." All of a sudden, we heard the garage come up and realized his mom is home. He throws me my clothes and I go hide in the closet. I eventually had to jump out the window. It wasn't a far jump, and his friend was there to catch me. It wasn't that far of a jump, and I didn't get caught but it was still so bad. We dated for about two years, but we only had sex twice.

I came out during my sophomore year of high school. My mom's reaction was like "Okay, anything else? Is that it?" She was fine with it, but my stepdad had a very different reaction. He told me "I don't care, as long as you don't bring any of that gay shit around me." Then they pushed the age that I could date up until I was 18 even though they originally told me I could date at 16. I didn't listen to them, but that was interesting.

Free for All

Once I hit college, I was more fully comfortable in my sexuality. I was still unaware and uninformed on a lot of things about life. I worked at the LGBT resource center on campus, and it was very resourceful for me. It's where I got a lot of my sex ed information. For example, I didn't know dental dams were a thing until college. I spent a lot of time in that office and that's where I learned a lot of my sexual information. It's where I learned how to actually put a name to how I identify sexually because I don't think I was fully prepared at home in that sense. I had to learn on my own.

My first couple of years I was a ho. I was out there experiencing all of the things I didn't get to experience in high school. I had limited relationship experience and when I got to college, I was getting a lot of new attention. I feel like if I had more discussions about sex and sexual health, I probably wouldn't have gone as crazy as I did. I was on again off again single but during my single phases I would find someone new and hook up with them. At one point one of my best friends said to me "Are you trying to hook up with every type of person you possibly can? You've hooked up with a white girl, a Hispanic girl, a Black girl, like you have no type. You're just out here adding names to a book." I was really leaning into having freedom and I felt a lot of things were in my face that I missed out on during high school. I definitely went overboard. There was a point where I had chlamydia and gonorrhea twice within a year. I thought I was doing something wrong like not getting tested as frequently as I should be. I had a blast and there's memories that I have for myself where I can say "Wow that was insane, but it was a great time."

Reality Check

The first time I learned I had an STI was during a new patient visit at a health clinic not too far from my college campus. I was going there so I could get a new prescription for migraines I experience. As a part of the visit, I peed in a cup and did a couple of other things that is required for new patients. While I was waiting for the doctor, this middle-aged white lady who had the biggest glasses and one of those librarian kind of haircuts came in and said "Excuse me miss, can you tell me again, are you sexually active?" I tell her yes, I am. She says okay then walks out. I sat there like, okay? She came back in and told me "According to your urinalysis it looks like you have chlamydia." I didn't know the difference between STI's, nor did I have any symptoms to help me differentiate so I asked her what it was. She explained chlamydia to me and then asked me "How many sexual partners do you have?

In that moment, I got pissed that she was assuming I had multiple partners. I didn't know if she made that implication because I was a college student, or because I was black. I got snappy with her, but I also couldn't pinpoint who or how long I had it because I did have multiple partners at the time. However, I only told her I had one, partially because I was embarrassed.

Dirty Laundry

She gave me the medication to get treated. I remember feeling so afraid because I knew I had to tell who I've been with that I tested positive for this. Nervousness about the reaction I was going to get overwhelmed me because it was four people, three girls and a guy. I didn't want any of them to be mad at me or look at me and be like "Oh you dirty bitch." In that moment it felt like the hardest thing to do. I might have caught an attitude at the doctor's office, but I was a crying mess when I got back to the dorm. I told my roommate because I was freaking out and she sat with me. We talked it through, and she was like, "Why don't you just type up, you know, whatever message you want to send, and I will push send for you. But you have to write it up."

I thought everyone would find out about my diagnosis because there were these anonymous social media pages that air everybody's dirty laundry. Getting an STD was one of the ultimate things to expose because not only was I have sex with whoever, but I also got an STD. There was also the finger pointing of who was the cause of STD. The guy's reaction was "Who you been fucking? You're a ho don't come to this party." He called me all types of names, but I didn't really care what he said because it's always been hard for me to take men seriously anyway. One girl didn't really care when I told her. There was worry in the back of my mind about if she would keep fucking with me after telling her, but we were pretty cool after and still had sex. I can't remember how the other two reacted.

Big Leo Energy

It was a while before I caught another STI, but when I did get another one, I was just like whatever. Everyone I deal with as an adult is very open. This may be a little crazy but the more recent times I've had STDs me and my girlfriend have had foursomes with our friends. So, it's like "Hey remember that night at the lake house? Yeah, one of y'all have something so go get tested because I just got tested and came back positive." Even if they were to have a negative reaction to me notifying them of a possible STI exposure I wouldn't take it too personally. I don't fear rejection or judgement as much as I did with my first STI. At the end of the day, I know I'm not having a whole bunch of wild unprotected sex with whoever, but whenever I've had an STI ironically, it's been from a man. My social circle now is super small which keeps chaos out of my life. If anything, negative or taboo or something you wouldn't necessarily want to be shared in the public were to happen, I'm not too embarrassed to share. Finding people of color within the LGBT community has allowed me to find comfort and confidence. My friends as adults aren't judgmental and even if they were going to judge me, I don't really care. As I've grown, I've grown to put less stock into how people view me because I know myself better now than I did then. I'm at a way better space confident and comfort wise to not let what others say affect me. If you want to judge me and say I'm dirty, guess what? You were rolling in the dirt with me. So, either you're going to handle it and I'm going to go ahead and take this medicine. I'm more open about this kind of stuff because it's not that much of a taboo for me because I've had STI's I dealt with them. Being able to comfortably talk about these things with your community is important for moving forward. The more we have these conversations, the more it will feel less taboo. Beyond conversations with your community, we also have to think about the discrepancies in the healthcare field and the statistics on care for Black women. The fact of the matter is we don't talk enough about Black bodies which is why we don't know enough.

I recently had another STI, and it helped me to navigate more boundaries within my current relationship. We now know that if we want to have certain fantasies knocked off our bucket list we need to all get tested and be sure we are good before we get tested. One thing that is in the back of my mind when I get an STI is how it is going to affect my fertility. Until this day I don't know where my fertility stands but I know I want to have kids in maybe 3 years, and I am getting older. It is already going to be a long process because I will have to do IVF or get a sperm donor and I have PCOS. This last STI caused me to start thinking about how I need to begin getting my body right because it will be time to start trying soon. When I think back, I credit a lot of the fantasies I have to my lack of sexual experience earlier on. Now I have the opportunity to explore them, and I have explored some, but I know how to go about it in a healthy way and not be ashamed of exploring those pieces of me. There are risks with STIs and then there's risks PCOS and my fertility, but I can now make informed decisions. Before, I couldn't make informed decisions because nobody was talking about these things, I had to figure out a lot by myself.

Lashawn's Story [Participant authored introduction and subtitles]

Lashawn is 48 years old; a mother of 3 adult children and one granddaughter. Her story chronicles her journey and the challenges she went through with having parents who were not very present. She wound up pregnant at 17, but by putting God first and having a supportive village, she has been able to overcome many of the struggles she faced. Lashawn has learned to never let any obstacles stop her from getting where she wants to be. She wanted to share her story because it may be young girls out there who are experiencing what she did and telling her story may help them.

Broken Pieces

My godmother, godsisters, aunts, and uncles really had a huge impact on me growing up because they helped raise me. My mom had me in her early twenties when she had me, but she acted like an older mother instead of a young mother. She was also very strict. One time I ran away because I wanted to go outside and play with my friends, but she wouldn't let me. My mom didn't trust me to do anything so that's why I started sneaking and doing things. That night I ran away I snuck out. My great uncle Larry found me in someone's backyard before the night was over. He was a big part of my life, an inspiration to me. He was someone I looked to as a father. When he found me, he was upset with my mother because he felt like she always wanted to party and didn’t allow me to be a kid. That night he told me “I want you to do better with your kids.” He knew how my mom always men had around me, staying over and things like that.

Despite the fact I watched my mom do grown things in front of me, she never really talked to me about sex. I did learn about sex a little bit when we had sex education in gym class. They told us we should use a condom because there are diseases you can catch. The adults who helped raise me tried to talk to me at sex, but by that time I had already started having sex. I tried it for the first time when I was 13. I saw others doing it, so I wanted to try it even though I was young.

When I started having sex, I was scared to tell my mom. She figured it out though because she thought I had gotten bitten by something, and she took me to the doctor. The doctor told her it was a hickey and that I was probably trying to have sex or that I had already had sex. My mom seemed to be in denial because she responded “Huh?” Then the doctor asked if she had talked to me about sex. She told him no and the doctor told her she needed to talk to me because I was probably trying to experience sex. The doctor also told my mom that I probably needed birth control. He tried to tell her, but she ignored that. When we left the doctor, my mom asked me “Are you trying to have sex? Are you thinking about it” I told her yes and she told me “Well don’t do it” instead of putting me on the pill, giving me protection or teaching me what to do since I was thinking about it. She basically told me I better not do it and threatened me. Her telling me not to do it made me more curious, so I started experimenting. I had also seen my mom with different men so I was thinking “Oh well shit, that must be the thing.” She wasn’t really a good example, so what could she really say to me?

I Had To Grow Up

I ended up getting pregnant with my daughter at age 17. I had met a guy at a party with my friend. I hung out with him the next day we talked and then had sex. We did use protection, but it came off some kind of way and it was stuck in me. I knew instantly I was pregnant because I had to get in the tub to dig the condom out. Shortly after, it was confirmed I was pregnant. My great Uncle Larry was one of the first people I told. When I told him he said “I'm not mad at you, I'm not disappointed in you. You was looking for love in the wrong places and you wasn't getting it from your parents like you should have been. I love you and I support you no matter what decision you make.” And from their point on, I knew no matter what, he would be there for me. He was.

My mother had just had a stroke when I learned I was pregnant, so I couldn’t tell her right away. When she did find out she tried to take me to the abortion clinic, but it was too late. So, I had my baby. Me and the dad didn’t really have a relationship, we were young and messing around. I didn’t feel anything for him like that because he was out there messing with different women. I knew he wasn’t going to step up, be responsible, and take care of what he laid down and made. It was a game to him, so I had to take on the responsibility of taking care of my daughter. My dad came around after I had my daughter like “Oh you got a baby?” and I told him “Yeah, you weren’t around to teach me nothing about these men, so I ended up finding out the harder way and learning on my own.” My parents were so busy doing them they weren’t concerned about me enough. I was running to men looking for love. A little over a year after my first daughter was born, we had another child together. Once he didn’t want to accept our second child, I got over him quick. I tolerated too much from him. He felt like he could keep doing me how he wanted. I realized one day he didn’t have anything to offer me in the first place.

Unfortunate Incident

Moving forward I tried to be more cautious. I didn’t want to just pick up anybody, so I tried to let the relationship come to me. I started dating someone I went to elementary school with, so I had known him for a long time, and I trusted him. We lived together and I thought it was just me and him dating. When I was about 8 months pregnant, I felt funny in my vagina area. When I peed, it felt itchy and scratchy, and I had a funny discharge. I thought it may have been the baby, but I was like “Nah, something doesn’t feel right down there.” I told my best friend what I was experiencing, and she asked me if I went to the doctor to get any help. I made a doctor’s appointment, and my best friend took me. The doctor checked me out and told me I had trichomoniasis. She checked to make sure the baby was okay and then she gave me a prescription to treat it. I had to take the pills for about a week or a week and a half to clear it up.

In Need of Help and Guidance

Unfortunately, by this point my child’s father had been killed by a drunk driver around the same time. He didn’t even get to see her birth. I couldn’t even express how I felt to him because he was dead. I was so mad I couldn’t go off on him. I was actually extremely depressed because I had never caught anything. I was always cautious about what I did. I never slept with multiple partners because I’m very protective of my body. He was evidently still fucking around even though he told me he had stopped all of that. I had to grieve, talk to God, and just deal with it to get closure. I feel like that helped. God forgave me and I forgave him even though I was hurt. I was shocked for the doctor to even tell me that I had an STI. I tried to be in denial, but I had to accept it and get help.

I was also worried about the health of my child. I thought maybe the STI would send me into labor earlier. I was stressed and depressed from so much worry. I was hoping the pills would work because I was going into the last month of my pregnancy and was close to having the baby. That could have really done something to my baby and out her life in danger. I thank God my baby came out all right and that my health was okay. My baby was my blessing in all of this.

My doctor at the time was also a really good doctor. This Black woman doctor was my provider through all of my children. She was a very caring and compassionate doctor. She was very concerned about my health, wellbeing, and home life. She would say “Hey (insert name) you gotta come to your visits so I can do your wellness check.” I received prenatal pills and very detailed instructions for at home care. She definitely was there for me.

Excel to Better

After this, I had to find a way to move forward so I could raise all my children. They didn’t have anybody else but me. I got a lot of help from churches in my community. Relationally, I started being more cautious and watching who I involved myself with and protected myself. I didn’t get involved with a lot of people or go to bed with anybody. If I did, I stuck with one person. I wore protection and got the birth control shot to protect me. I didn’t want any more kids or diseases. I honestly wasn’t doing a lot of dating because I had kids to raise so I didn’t have time. I had to be a mother; I didn’t have time to do me. I chose to be a different type of mother than my mom. I didn’t bring men around my children because they will try to hit on your kid or screw them. I pretty much watch what I did once I had them. You have to watch what you do around your children because they have impressionable eyes. I didn’t have the best example with my parents, so I chose to be a different type of mama.

Kese’s Story

The Start

My mom was one of those moms who didn’t sugar coat anything. She was straight from her hip. She told us about diseases and germs. My mom taught her children to come to her if we were having sexual desires and things like that. She was very strategic about how she taught us about the way of life. Unfortunately, I never really got the opportunity to make decisions about sex for myself because I was raped. I hid it from everyone for a long time. They eventually noticed because every time the person who assaulted me came around; I would run away. One day I tried to run away, and my mom was like “No you need to talk to me because you were afraid, and I need to know what’s going on.” I told her what happened, and she never had him over the house again. She called his mother, who was a friend of the family to let her know what happened, and she only said, “Sorry he done that.” But she didn’t want us to press charges. Nobody did and I feel like he got away with it. This incident kept me away from sex for a long time. I was ashamed of my body and ashamed to tell anyone.

It All Came Crashing Down

When I was 17, I met a guy and I thought he was really nice at first. You know how they baby and sugar you and sweet talk you. I kept telling “My mom always told me I have to protect myself.” He would say “Oh it’s not going to be like you think. You don’t trust me?” and things like that to convince me to have sex with him. He was all up in my face, and he never told me he was dating anybody else. Now I know I shouldn’t have trusted his behind at all. We dated for about 3 months, and we did have sex. Once he got what he wanted he turned out to be something not nice because we did not talk after we had sex.

Double the Surprise

About 8 months after we had sex, I was really excited to become an auntie. My twin sister was pregnant, and I had been taking care of her. I started experiencing pain in my side one day, so I went to the doctor. They ran some tests and told me I was pregnant. I had no clue. I was seeing a therapist and taking psychotropic medicine, so I was still having my period and everything.

They did some more tests and the doctor told me “You have trichomoniasis.” I said, “What’s that?” He didn’t tell me, but he gave me some pills to take. There I was 18, about to be a first-time mom and they didn’t explain anything to me. I was concerned because I didn’t know if trichomoniasis would hurt the baby or if I would lose the baby. There was so much I didn’t know. I was scared to pieces and they just pushed medicine on me without specifically telling me why I needed to take it. It was not a good feeling at all because I didn’t know anything.

The pills were big horse pills. They had never even asked me if I had trouble swallowing pills. When I kept throwing them up, I finally asked a lady at the doctors what trichomoniasis was and she said “oh, that's a woman's disease and a man had to have sex with you within 24 hours and having sex with someone else.” Then I thought to myself, he didn’t even care enough about me at all, like he had sex with someone else before me within a 24-hour session. That’s nasty!” I didn’t understand why he wanted to be with me if he was with somebody else.

I called to tell him I was pregnant, and he was like “It’s not mine.” I said, “I ain’t been with nobody but you. What you mean it’s not yours?” He was insistent that it was not his child. He even started a rumor telling people that I was lying. I was like “Oh no, no, no.” I wanted to hurt him really bad.

I didn’t share any of this with my mom at first because I felt like she would be disappointed in me. She told us about safe sex, and I didn’t want to tell her I messed up. She eventually finds out and she did not say what I thought she would. I thought she would cuss me out or throw me out the house, but she didn't do that. She was very encouraging and supportive of me. My mom was there for me and every teared I cried. When I wanted to hurt my child's father, she told me it was going to be okay. She reminded me that hurting him was not of God. I told my twin sister about my diagnosis because she's always been my support system. She comforted me and let me know that I wasn't alone.

Dark Times

I had my baby shortly after I went to the doctor because I was so far along. My mom thought I was experiencing postpartum depression, but I was just depressed all around. I had to raise my baby by myself. His dad was nowhere to be found and didn't want anything to deal with me. I was already feeling bad about my body and this situation made it worse. I tried to commit suicide because I this situation re-hurt me. I was devastated because I tried to trust somebody after being hurt from the assault when I was younger. I was committed but I had my twin and my mom to help with my baby.

Power in My Voice

There were two main things that helped me to keep getting up each day during this difficult time. Knowing my son loved me with everything in him and having a strong Black mama. My mom had an organization called Single Mothers of Color. The women in that group were very profound in how they talked to me. They taught me things I would need to know as a young Black mother. They came to my aid to help me, and they were very resourceful. Many of the things I needed, I had because of them. I don't believe in sex because I don't want to be hurt. I would be open to having sex again when I get married. Then I will have a right to do whatever I want to do to him. Despite all that I have been through I still choose love. My heart and ability to care for others is what I love most about myself. The women in my mom's organization taught me how to fight, speak up and advocate for women who can't advocate for themselves. Since then, I've worked with different organizations. In my work with these organizations, I started to see other women in situations similar to mine where men didn't want to claim their babies or with catching STI's from someone that claimed they loved them. I always try to give them encouraging words or a smile and I tell them "It was a dark point in my life where I wasn't as happy as I am right now" and they ask me to share. I tell them "No, I don't mind sharing if you want to listen." It gives me strength to be able to tell my story because I'm giving someone else strength and letting them know their voice needs to be heard.

Epilogue

As I reflected on my story, I realized that I've never dealt with the pain of what happened to me. I've been in several therapy sessions to help me since I came to this realization. I hadn't talked about this in years and had suppressed all of my feelings. Talking about it has been such a relief. There were some real supportive women in my group therapy sessions who told me I wasn't by myself, and they told me that it is okay to cry and that maybe I'll be crying some more tears. The women were very open and honest, and they were not ashamed, and I liked that because they were themselves. They were real and they didn't hide anything. Like we keep masking our faces to pretend we're okay all the time and sometimes we're not. I learned it was okay to cleanse out what's going on so I will be resilient to bounce back and be able to share my love with someone again. I'm going to keep going to therapy and go to classes to learn how to feel comfortable dating. A group that I'm familiar with in the city is doing monologues like the vagina monologues where I would be able to share my story. I want to be brave enough to do it. I haven't gotten there yet, but I am trying to overcome the pain.

Monique's Story [Participant authored introduction and subtitles]

Monique was born to a young mom, and she did not want to follow in her footsteps. A lot of what Monique learned about sex, dating, and relationships came from her exploring to figure things out/ For her, sex ed wasn't taught only in school. But also, through life experiences. After all she's gone through, she has learned that her sexual experiences never had to define her. In this story, you will see how Monique built herself into the wife and mother she is today.

Curiosity

The internet taught me a lot for me to be so young. I was too young to learn some of the stuff I did. I had heard about sex at school, and I decided to do an internet search. I got curious and proceeded with that curiosity. I was trying to figure out exactly what sex was, how you have sex, or what it consisted of. I was exploring and trying to figure out where I was with it and if I was supposed to be doing it. Of course, I found out that it is not okay for a child. But that's how my journey started.

In my household, sex was like a bad thing. Any sexual words were a no-no and met with "Don't say that that's a bad word." I actually never got the sex talk. It was treated as a secret sacred thing. It was an adult thing that only adults could talk about. I have this one memory embedded where me and my mom were passing through the hallway and she looked over her shoulder as I was walking past and says, "Monique, you know what sex is?" At this time, I was 9 and I said, "Yeah of course." My mom replied "Oh, okay" and went into her room. We never talked about it again. That was the extent of my sex talk. Maybe like two weeks later I started my period, so I did get the period talk. I was told "You're becoming a grown woman. Be careful with your body." None of the conversation consisted of sex. So, I was always trying to explore my sexuality. Masturbation was a big thing with me, and I would sneak to do it. I wasn't exploring with other people, but I was trying to figure out what my body did. I would see these things on the internet and think oh I can do that to myself.

I think my aunt and my mom were trying to prevent any kind of exposure to a sexual life. My mom had me at 13 and my aunt had my cousin at 14. We couldn't wear short shorts or tank tops. We always were supposed to hide our bodies. Everything was sexualized. We couldn't say certain words and we had to say vagina does not play words for it. We couldn't get too close to our neighbors they would not allow us to be alone with other kids at all.

I was actually scared to have sex for a while because my mom was a young mom. I watched my mom grow up I was scared to really have that life that she had. I wanted more for myself and it kind of just threw sex out the window I guess you could say; if that's the sacrifice I have to make to have a good life. I always said that I would have myself together before I can provide for someone else. So, because, my mom couldn't really provide everything for me. And because she made that choice when she was so young that she couldn't give me everything that I needed. I thought sex = baby and I just wanted my child to have everything that they needed.

Exploration

I didn't start dating guys until I was about 20. Most of my life I considered myself a lesbian. I felt like because I could do certain things to my body a different gender than me couldn't do the same things I could. I could please myself as a woman so I thought women should know how to please women. So that's where my interest in girls stemmed from. Then I had one friend I would experiment with because I wasn't allowed to have guy friends and she wasn't either. The only option we both had was girls.

My interest in men came about after an unexpected incident. I was hanging with some girl friends from work and some guys they knew. One of the guys put something in our drink. It was wild and that was my first experience with a guy. It wasn't a positive experience because they took my choice away. I started to question myself and everything I knew about my sexual life before. I wondered what I had really been doing. So, I opened myself up and thought about if I liked the experience with the guy and if it was something I would do. The first time I was under a strong influence so I had to figure out if it was something I would do in the front of my head as opposed to the back of my head. I started exploring my "straight life" and it was a roller coaster. Within two years of time, I had dated as many men as I dated women in all of my 20 years of dating girls. I became the most promiscuous person I knew. It was like a fast track to nowhere.

There was this guy that I would see at the store all the time when I was dating girls. He would always tell me how beautiful I was and that one day I would like guys. I always told him I had a girl. But when I did start liking guys, he was the third person I told. From there we started talking and hanging out. He invited me over to his apartment and we had sex.

Realization

Maybe three weeks after we had sex, I was in a car accident. I had to go to the hospital, and they tested me while I was there. I went home without the results. A month after the accident, I got a call saying, "I don't know if you know but your results came in and you do have gonorrhea." I was thinking to myself, I never had any symptoms so what are they talking about. I asked them "Are you sure you got the right person?" and of course they told me my information. The rest of the day was so weird. I literally held myself and cried. I envisioned my whole body turning brown or green. I felt disgusting, I felt nasty. I literally screamed that to myself.

At this time, I was very sexually active, so I didn't know who gave it to me. I had to call maybe four to five people. I was telling them "I don't know when I got this or what happened. I don't know if it was you or if it was someone else." I got called so many names and I got into so many arguments. It was devastating. It took a hit on everything— my confidence, my womanhood. I wanted to stop my whole entire life. It was literally a sexual shock to me. I didn't know I was susceptible of getting it or that it would actually happen to me. I used to think "It's not going to happen to me." In all my years of dating girls I didn't think it would happen because I thought everyone took care of their body, especially the people I was talking to. I didn't think I was that bad of a judge of character. Then it did happen to me. I felt nasty. I felt like I shouldn't have been doing what I was doing. I shouldn't have even had to call that many people. Because I didn't know who it was, I felt like less of a woman.

After I got the results, I went to the doctor and got retested and they told me I didn't have gonorrhea. Then I started to figure out what happened. While I was in the hospital getting treated for my car accident, they gave me a pill that treats gonorrhea as well. A month after I got my results, I called the guy from the store. I said "Hello" and no one responded. Then I said "Man, you need to go to the doctor." All of a sudden, his baby's mother answered the phone and said, "You got gonorrhea too?" In my head I was like dang it. I had a feeling it was him, but I didn't want to know. His baby mother continued "Yeah you you're not the only one. It's like four other girls." We had a conversation and she told me he had been going around knowingly untreated. For some reason he didn't want to get treated and he had been doing that for almost two years. That whole conversation hurt.

Rebuilding

I don't think I trusted the same after this situation. I literally didn't trust anyone. I no longer felt the need to show my body so much. I didn't feel the need to give my body to the world. I started a rule where I was not having sex with anyone unless they were my boyfriend. That got a little tricky because men are deceitful, and I would be lied to. They would call me their girlfriend only because they wanted to have sex. After a couple of these experiences, I started having multiple boyfriends. I remember one time I had like three boyfriends at one time. I wasn't sleeping with all of them. I would only sleep with one guy at a time so at least if I did get something, I would know who to go to and cuss out. I was also strict about wearing condoms whereas before it was more so like let's just get to it. At one point I did start sleeping with a married man unprotected. For some reason with him I was only worried about not getting pregnant, so we just pulled out. But I was faithful about getting tested every month just because you never know. If it could happen once, it would happen again.

It was just the simple fact that I couldn't really put all of my eggs in one basket because I didn't know where all their eggs were. I felt like if guys aren't serious then why should I be. I had never felt that way or been that type of person, but guys made me that way. I put up a lot of walls and it wasn't easy to get me in bed.

Knowledge

Once I met my now husband, I knew he was giving me all of his eggs. I told him he was going to have to come with some TNT because my walls are high. He told me verbatim "I'm going to blow them down." He made a lot of my worries and feelings of not being able to trust go away. Despite this, I still I still have the memories of how I felt and what people said to me when I called them about my gonorrhea results. Even though I'm married with a child now, I don't think I've ever fully rebuilt it. There was never a time for me to talk about that experience. Maybe if there was a support group or other people that I could talk about it with that had been through the same thing that could've encouraged me at that time that it was something I could move past. Now I've managed to repair my life. I make it a priority to respect my body, I take care of it to the fullest extent, and I know here my body goes and where it should not go but feeling like less of a woman is embedded in me. If I would've been able to get support at the time it happened, I probably wouldn't feel the way I feel now. The situation was definitely a "you live, and you learn" experience. I want to pass on my experience and not keep it to myself as a lesson learned. Even to my son so that not only he can have knowledge but so that anybody he's with will also have information.

Bou's Story [Participant authored introduction and subtitles]

Not allowing your experiences to define you is what Bou is all about. Bou is 22 and figuring it out. In the pages that follow, she walks us through her experience with sex and the traumatic events that followed. Despite the difficulties she faced, she managed to bounce back. Her experience has inspired her to do more research in reproductive science that will hopefully lead to the development of programming designed to educate other Black women on their bodies in relation to sex and diseases.

Where It All Started

Having African parents who are also very religious has affected me entirely. I had to learn a lot on my home because there were certain things my parents would never talk about. We never talked about boys, and we don't talk about sex. We never even had a conversation about periods. I remember when I got my first period, I had actually been bleeding for three days but I just thought something was wrong and I didn't tell anybody. Then finally one day my cousin was doing laundry and she asked me had I been bleeding. I told her yes then she explained that I had my period. I did not know what she was talking about because a period had never been mentioned to me. At that point none of my peers in school had experienced their period either. I remember vividly calling my mom and telling her I started my period. She asked, "Are you okay?" I told her yes and that was the last thing she ever said. She never said anything else and there was no conversation.

Even when I got to middle school and I started to like boys, there was no conversation. I would have my little crushes and stuff, but I didn't know how to say anything because those conversations weren't allowed in the home. My dad was pretty strict too. There were times when he would come up to my school for different activities or see me talking to boys in the neighborhood and he would get really upset. I remember this one time a boy that was strictly a friend gave me a hug and my dad lost his mind! He was like "Why are you hugging boys?" Then my mom was very verbally abusive, and she said a lot of negative things about me and my sister's image which caused me to look at myself in a negative way when I was younger. We were so scared to have conversations about our feelings with our parents. We tried to be tip top and act like boys didn't exist or like sex wasn't a thing.

Navigating My Education

Over the years, I started to learn more about sex in school. Once I got to middle school, there were so many girls at my school and from my neighborhood who were pregnant, so I knew they were having sex. They were being very careless about it too. Sometimes they would have sex in school, it was a major thing. Constantly we would have officers coming in because students would get caught having sex in locker rooms and classrooms and stuff. It was very ghetto and very terrible. We were all from a predominantly Black neighborhood and we didn't have anybody guiding us. The gym teacher was the health teacher, and they would try to teach us but as soon as one sexual term was said everybody in the class lost it. I vividly remember those classes being a joke. Nobody took it serious and nobody learned anything. I vividly recall several times the teacher would walk out on our class. He hated teaching it because nobody was processing it. Besides by this point a lot of kids were already having sex and some of them were pregnant.

A lot of what I saw with my classmates confused me because I didn't have education on sex at home. When my middle school friends would tell me they were pregnant I was confused about how it happened. I didn't understand the process or what they had to do with a boy to get pregnant. Even though I was curious about the things my friends were doing, I did not have the room to sneak around and explore like them. My African parents viewed the people in the African American community as if they were heathens or their enemies. They did not allow me to hang out with the kids in my community because they thought I would start doing what the other kids were doing. If I wanted to play outside, I had to be in by a certain time. I wasn't allowed to stay the night at anybody's house. Sometimes I wasn't allowed to go to friend's birthday parties and if I was my parents would accompany me for an hour or two. We wouldn't stay long.

Adolescence

Once I got to high school, I did start to get sneaky. I went to an early college program that was on a college campus, so I was around college students. During this time, I was exposed to things like sex and drugs on an entirely different level. Since I was on a college campus, I wasn't in class from 7:00am to 3:00pm. My parents thought I was on campus all day studying but I had breaks in between classes that I used to hang with friends or boys. When I had my first experience with a boy in college, I came back and told my friend that I kissed him, and he wanted to take it further. She asked me if I knew about condoms or sexually transmitted infections, and I told her no. My friend was very educated about sex because her parents had conversations with her about it. She was sexually active, and she knew how to protect herself.

Since I didn’t know much about the boy, she told me I needed to go to the clinic and get tested. When she told me this, I felt like I was about to die because I thought something had happened. I told her I couldn’t go to the clinic because I was still on my parents’ insurance, and they would know I was up to something. She was like no “There’s spaces you can go where your visit won’t be reported to your parents.”

I took my friends advice, and we went to the clinic together. This doctors visit was officially educated on sex and my sexual health. By this point I was 17 years old. The doctor cancelled the rest of her appointments and sat with me for like two hours to explain every aspect of sex. The doctor was a white woman, and I was surprised that she was so patient. She told me “You cannot be out here doing anything, and you don’t know nothing.” It was so much information I left the appointment like “Whoa.” Shortly after this conversation with the doctor, I had vaginal sex for the first time. Prior to this my sexual experiences mostly consisted of oral sex. Because of the talk with the doctor, I made it a point to get tested regularly.

Even though I was at early college high school, I still lived at home with my parents until my senior year and had influence from my friends in my neighborhood. So much of this time felt like had the devil on one shoulder and an angel on the other. It was a constantly back and forth battle with myself. On one hand, I had friends from early college who were able to help educate me on sex and what healthy relationships looked like. On the other hand, I had friends from my neighborhood who would think that any attention from a boy meant he loved her. They kind of glorified abuse.

S.E.X.

I met my first boyfriend on the college campus I was at for high school. He was the first person I had vaginal sex with. So, I did wait a little longer than a lot of my peers. Me and my boyfriend’s schedules aligned pretty well so if we had a large break in between classes, we would go back to his house and kick it. I was definitely taking advantage of the freedom I had because my parents thought I was on campus studying. Once we were about three years in, I had a feeling something was going on, but I could never catch him. I knew his schedule pretty well so I would call him, he wouldn’t answer but the excuses he gave me weren’t adding up. It drove me insane.

During one of our breaks from class, we went back to his place and had sex. Afterwards he pulled the condom off and I saw a little blood on the head of his penis. I had never ever seen that happen before. I was like “What the hell?” I looked at him and he looked nervous. I asked him “Why are you bleeding?” He said, “Maybe we were being too rough or something.” He tried to play me like I was crazy. I told him “You’re playing with me. Is there something you need to tell me?” He laughed and told me I was crazy. Anytime a man tells you you’re crazy, you’re not crazy. “I’m not crazy! We’ve had sex how many times?” Again, we were three years in, and we had sex often. There had never been blood before. The blood made me scared because I thought he might have had HIV or AIDS or something. It was one of those moments where I thought my life is over. He got real defensive asking “Are you trying to imply I’m cheating on you. I’m not doing anything, that’s crazy. We had rough sex just leave it alone.” I told him “Okay if it’s nothing I’m going to go get tested and if something comes back that’s going to tell me all I need to know.” He tried to convince me not to get tested, but the next day I made one and I didn’t say anything to him about it.

Where Shit Gets Real

This wasn’t my first time getting tested because even with my boyfriend or in moments of celibacy, I made sure I got tested often. I didn’t have symptoms, but I still went to the appointment. Two days before my birthday I got a call back from the clinic. I was confused on why they were calling me back because I had never gotten one any of the other times I got tested. The lady on the phone told me I tested positive for chlamydia. My first reaction was “What?” I knew what chlamydia was, but I still didn’t understand. The lady was like “I’m so sorry” she heard me choking up on the phone and this was someone who I had seen often to get tested. She knew me and she knew the relationship. She told me to come in right then if I could so she could get me pills to get me and my boyfriend cleared up.

I had this feeling of betrayal because by the book they say if you are getting tested every three months, after every partner, using protection, and limiting yourself to one partner and your partner isn’t sleeping with other people, you should be good. I thought I had been safe. I was doing those things. I was as safe as safe could get. I felt so embarrassed and disgusting in that moment. I will never forget it. I was so upset because I was doing my part. He wasn’t doing his part. He didn’t consider me when he was out there being trifling.

I called him and I was going off! I don’t even remember what I said but I’m sure I called him all types of names. He crossed a huge boundary of mine. He finally admitted he cheated, and he apologized. I went to the clinic, and they told me I had a yeast infection too. I got even more upset. I had to stay there for hours because my blood pressure was too high. That was the highest it’s ever been. The doctor told me if it didn’t go down, I would have to go to the emergency room. I sat at the clinic crying, pissed and distraught. I vividly remember the nurse telling me “I’ve been through this before. He probably didn’t mean it boys are young and stupid.” Even though she probably didn’t mean any harm, I still found her saying this to be a little harmful because he knew what he was doing. The nurse continued to try to calm me down and I told her we had only had raw sex like once or twice our entire relationship. She reinforced the importance of using protection and being aware of what my boyfriend was doing. Once I left the clinic, I made sure he got his pills. I felt so terrible because it was two days before my birthday, and I felt lots of shame. We associated STIs and STDs with being unclean, so I felt dirty too. I didn’t realize how common they were, so I did pride myself on the fact I had never gotten one then I got it. It was a humbling experience for me because I realized it could easily happen to anyone at any given moment.

Coming Down

I started getting tested so frequently the doctor had to tell me to stop coming in unless I got a new partner. I became obsessed with getting tested because I was so scared. I also didn’t feel comfortable having sex anymore either. I left him for some time, but I did go back. I didn’t trust him though. We would fight about every little thing. I was insecure. I would go through his phone, and he was still cheating. I was 19 at the time so I give myself grace, but I was still dealing with the bullshit. Since I didn’t trust him, I could not have sex because my body would not respond to him. We would spend the night together still, but my girl just wasn’t getting wet for him. I was just so scared he was going to give me something again and I didn’t feel comfortable pleasing him or letting him use my body. He cheated and crossed a boundary so miss girl didn’t want to work with him anymore. That would cause a lot of fights between us and stuff. Sometimes I would try to get comfortable to have sex with him, but I would make him stop cause I would think about him cheating. I just didn’t know how to leave, because no one had ever talked to me about relationships. I tried dating but I couldn’t see anyone else because I didn’t know what they would do to me.

The Road to Healing

Talking about is what helped me to move forward. Speaking with friends who had similar experiences where they were doing everything by the book, but had a partner that crossed the boundary, cheated, and brought an STD back provided me a sense of relief. I was not the only girl who did everything by the book and still got messed over. For the longest I refused for people to know I had chlamydia at one point. I would not talk about it because I was so ashamed. Then I got to my current college and my friends were very open about having chlamydia. Some shared how a boy had given them HPV and they had seen genital warts before. I didn’t know we could talk so openly about stuff like that, and we weren’t sitting there judging each other for it either. I’m seeing more people around me display transparency and be open with others, which helps the people around them show up for themselves. I finally told two of my closest friends my ex gave my chlamydia, and they were like “Girl I had that twice from my ex.” I never told the full story but hearing their experiences made me more comfortable talking about the fact I once had chlamydia. I think it’s important to create spaces that are safe for Black women to talk about their sexual health. We are hard on ourselves, and society is 10 times hard on us than other women. So, creating safe spaces to feel validated and be educated are important. I’m only able to tell my story because I intentionally put myself in spaces where Black women are my safety net, they see me for me. Education is also key. What we choose to learn, take in, and engage with matters. I wish I would’ve met a Black woman who has had an STI and learned how she continued with her life. We need to have more conversations and get rid of ideologies define you by your STI status. Society associate STI’s with shame, embarrassment, and guilt and it shouldn’t be that way because then people hide it.

The more comfortable I got speaking about it the more I was able to see how common it was, especially on college campuses. It happens and it could easily again be me. I’ve heard stories where friends have gotten uncurable STI’s because their partners stepped out. This is why cheating is now a non-negotiable dealbreaker for me. I feel like if you can violate me in that way, you do not care about me in any other way. The STI experience with my ex-boyfriend made me real strict on what I will not deal with in a new relationship.

I recently started a new relationship, and it has also helped me move along. We have transparency and conversations about boundaries, non-negotiables, and getting tested for STIs. Sometimes the conversations are uncomfortable. But being able to make sure we are on the same page about what is and isn’t acceptable in our dating relationship has helped me to get past the fear of potential catching something or viewing all males in the same light. I’ve learned to honor my boundaries. I can have fun and enjoy sex too as long my partner and I create conditions where it is safe for me to do so. I’m glad I’m 22 and figuring it out now. There’s still more to experience, but I think the majority has passed. I’ve learned and grown from it. I’ve done a lot of research and reading. I want to turn my experience into some good that will contribute to reproductive justice.

Leslie’s Story [Participant authored introduction and subtitles]

Leslie’s sexual experience began with assault. She believes that this experience ushered her into a whirlwind of sexual experiences and a life that she did not necessarily see for herself. She is mother of three wonderful daughters, but she always wanted to be married before she had children. In her story, she shares some of the adversities she's experienced, how she overcame them, and the lessons she's learned along the way to becoming the strong and resilient woman she is today. Leslie hopes that her story gives other women the courage and confidence needed to open up and start their healing journey.

Lost Little Girl

My mom didn't know how to explain certain things to me. She would always use the wrong terms. It was always don't let nobody touch your pocketbook and that was just that. She never really sat me down and talked about sex, nothing like that. My dad was a pastor so in church I heard stuff like, "Your body is a temple" all the time. But my dad wasn't the type to sit us down and talking about things like that. I don't think he would've had too much to say because in our household it was mom's role to do that. What we learned in school was cut and dry. "Don't have sex or you'll catch an STD." So, I basically learned stuff on my own. I had a lack of education that I wish I would have got it from my mom rather than in the streets. I would've saved so much heartbreak, STDs, all of that.

****Trigger Warning****

When I was twelve years old, I was raped and that kind of put me out there. I was raped by my nephew, and he was like 17 or 18. I guess I didn't tell because I didn't want to get him in trouble. Since I didn't know anything about sex I was like "It kind of hurt, but it kind of feels good." I wanted to learn more, so shortly after that's when I started being sexually active and having consensual sex around 13 or 14. My mom eventually found out about everything because I wrote it in my diary. I feel like they basically blamed it on me because it was really swept under the rug. Even until this day no one has ever talked about what happened. I basically pushed it to the back of my head like nothing ever happened.

Tribulations

By the time I was 18, I was staying with my boyfriend. I had just graduated high school and I saved up for an apartment. We started off using condoms but after a month we weren't. He clearly wasn't using them on other people either. One day it was not feeling right down there. I smelled really bad. No matter how much I took a shower, washed, changed my panties, I had a bad fish odor. After about 3 days it made me go to the doctor because I knew something just wasn't right. They told me it was gonorrhea. I still stayed with him and about a month or two later I had trichomoniasis. This was a guy I was with for like two and a half years. I'm not going to lie; I went to the health clinic maybe like eight times within that two and a half years we were together. A few times it was probably gonorrhea and chlamydia. Each time, I had to take white pills and do a pelvic exam. The clinic I went to would talk to you and your partner together if you both were there and give you both medicine. They'd give me condoms too, even though my boyfriend at the time wouldn't use them. Even though he kept burning me, I felt like there was no point in using them. Maybe I just didn't want to believe he was sleeping around even though we kept having to go to the clinic.

When You Trust Too Much

The first time when I had gonorrhea, I was shocked, mad, and scared. I was just like "why?" I trusted him. I told him but it was just like you burned me let's take the medicine. That's it. I never had a voice that people listened to, so I didn't think that this situation was any different. I did start talking to other guys, not having sex with them, but it just made me feel better. If he could get girls, I could get guys. Toward the end of our relationship, we stopped having sex. Because he cheated, I just couldn't touch him. Eventually I got tired and fed up, so I left him with the clothes on my back even though it was my apartment. It was so embarrassing I never told anybody about all the times I caught stuff. I did have a couple of female friends at the time, but it was too embarrassing for me to sit there and talk about something like that.

I had my last STI in December of 2020. I was having some bleeding and I had that smell again. I had the feeling I was pregnant because I hadn't had a period in over a month, so I thought I might have been having a miscarriage. I went to the emergency room, and they told me I was six weeks pregnant and that I had trichomoniasis. I found out about both at the same time. I didn't treat it like a big deal, and I already knew if I said something he was probably going to blame me. He was a lady's man, and I knew something wasn't right, but I never had any proof that he was cheating. Stuff just wasn't adding up. I didn't say anything to him though. I just let it go.

I've dealt with most of these experiences on my own but maybe if there was a support group out there to talk about things like this it would have helped me. If there was a group of Black women that were going through the exact same thing I was going through, maybe I would have been inclined to listen and hear because they know exactly how I'm feeling. If they made it out, they could help me.

Overcoming the Past and Looking Forward to the Future

I have been holding this embarrassment in for years. If it were five or six months ago, I probably wouldn't have told my story because I just wasn't ready. But I am finally ready. I've been putting myself out there and looking for resources. I started reaching out to people. Me and my mom started talking a little more and it's nice to have somebody there to listen. I'm also in therapy.

I've also been abstinent. I don't want to be sexual with anyone and I don't think about it. That's a big change for me. I've been feeling like I wanted to be abstinent for a while but now I'm finally standing on it. I hope that abstaining from sex will help me have a clearer mind. Going to bed with people can cloud your judgement. I feel me being abstinent will help me make better choices. The past year or so, it's been better for me. I'm not stressed out; I'm not going back and forth to the doctor. At times I do get lonely and wish I had someone but then I think back like Leslie, look at what you just went through. Is it really worth it? And at the end of the day, I say "no." I want better for myself, and I know the change starts with me. I have to start doing things differently and I have to start thinking differently.

Destiny's Story [Participant authored introduction and subtitles]

Destiny has struggled with her self-esteem and self-worth for a significant portion of her life. There were times when Destiny made bad decisions because her issues with self-esteem and self-worth made it difficult for her to say no to people. She was a people pleaser. At 23 years of age, she's only recently started to learn how to love herself. Although Destiny is still working on loving herself, she told me that she has come much further than what she once thought she would. She hopes that sharing her story will encourage other women.

The Beginning of the Storm

My mother was very big on calling me and my sisters beautiful. She would affirm us and tells us we were smart too. I accepted the praise, but I had a difficult time accepting the beauty aspect. I was always on the heavier side, and I didn't feel like I fit into the guidelines of how beauty is portrayed in the media. My mom made sure to educate my siblings and I on sex. When we were younger, we were told "These are your personal parts, don't show them off to other people. You keep them private." Once we got older, especially after we had our periods, she started to get into the specifics and talked to us about sex. She told us "Sex is very sacred. Your vagina is like your sacred haven, and you don't want to defile or disrespect it. You should only have sex with your one partner after you get married. If you happen to choose to not wait until you get married, please be very careful. It only takes one time to get pregnant. Use protection because you can get diseases." She specifically told me a story about my sister's father where he was non-monogamous and had given her an infection. When she told us this, she emphasized that even if you are not cheating or being polygamous, you still need to be careful because you don't know what your partner is doing. She wanted us to be careful.

My dad, on the other hand, left when I was five but when he was around, he was a good dad. After he left it was very limited contact. It took four years to even get a phone number to get ahold of him. I felt like he didn't want me and that was really hard.

Even though my mom talked to us about sex, I still lived a very sheltered life. I was barely allowed out of the house, but I would still have crushes. I remember one time I told my sister about a crush who lived across the street from us: "This is one of my deepest darkest secrets. Don't tell nobody. Pinky promise." Immediately after she went inside and told everybody, including him. Then I guess they started dating. I felt betrayed by her. And after that there would be these different neighborhood friends that I was actual friends with, but I found attractive. I'd tell my sister and she would be like "Oh well, I got a crush on him too" They would always like her and want to be with her so in a sense I felt like I was unwanted in this case too.

A Hopeful Experience

I had one neighborhood best friend that my sister did not "date". We became friends because we would see each other at the soup kitchen or after school program. His two brothers and his sister would come to my house and beg my mom for me and my siblings to be able to come outside. We were best friends, but we also had chemistry because it was always flirty talks with us. When we were in middle school, there was a period where I thought we were "dating." I say dating with quotes because it was only for about a week. Once we made it official, there was a terrible snowstorm, and we did not see each other for a week. When I finally saw him at the soup kitchen, he was telling people he didn't have a girlfriend. It seemed like he was avoiding me. This experience caused me a little trauma, but we still stayed friends. A couple of weeks before my 16th birthday we had sex for the first time. I waited older than my two sisters and it was with somebody I really did care about. Me and the guy never got in a relationship, and I think it was because we didn't want to ruin our friendship.

The Decline

After this, I pretty much allowed people to use me like a tool. I was like a doormat, and I had a hard time telling people no. I think the trauma from my dad leaving caused me to feel like the guy will be around for what he wants, but after he's done, he's going to leave. Then when they'd leave it was whatever, no big deal. I wasn't really making good choices. I was making very bad choices. I would barely know a person and still be intimate with them. I was having one-night stands. Since I felt I unwanted, I felt like "How is my vagina any kind of sacred ground? I'm not amounting to anything. Hell, my dad didn't even want me." Sometimes I would think "Oh we're flirting and talking. That's dating" and it's not. Nothing was made official or anything. I wasn't doing further research and I was letting people play with my mind. I didn't have many positive moments in relationships.

While I wasn't making great choices. I ended up getting pregnant with my daughter. I had sex with my daughter's father once. I use marijuana for medicinal purposes to help with my multiple sclerosis and I would purchase it from him. He was also my sisters next door neighbor. I found him attractive, and I tried talking to him to get that relationship to develop but then he got incarcerated. A few months later I was sitting on my sister's back porch, and I saw his silhouette. We wound up having a one-night stand and then we lost contact. I didn't know I was pregnant for a while. I was spotting each month and I thought it was PCOS because it runs in my family. Plus, I thought we used protection, but I was half sleep and intoxicated so he probably took it off. I found out I was pregnant the same day I took my driver's test. I was having labor contractions and I was producing colostrum. After I passed my test, I told my mom. Her eyes got big; her jaw dropped. She didn't believe me I had to pull one breast out and show her I was producing colostrum. The next day I was admitted to the hospital and when I got discharged with my daughter my chart and my discharge papers said I had trichomoniasis. The doctors told me I had bacterial vaginosis, but that was all they told me, and they gave me treatment for that and trichomoniasis through an IV. My mom, sister, and mom's boyfriend were in the room when they told me that, so maybe the doctors didn't want to announce I had trichomoniasis in front of everybody. I respect them for that. I do feel like at some time later when it was just me, they could've came told me.

I knew I had gotten it from my child's father because the day I had her he was around his girlfriend, and she sent me messages saying "Be careful he gave me trichomoniasis. He's giving it to other people because he's not taking his medicine." I remember being angry and upset because if he knew he had it, why wouldn't he get treatment so he wouldn't transmit it to other people. I felt like that was selfish. But if they didn't know, it gave more awareness and concern to me to make sure that if I am being out there, I need to make sure I'm getting tested.

I was also shocked and concerned about how trichomoniasis may affect my daughter. I didn't know if I gave it to her or if I could give it to her. I did research and learned that I couldn't give it to her. Since it was an STD at first, I thought it couldn't be cured and that I was going to be stuck with it forever. Then I did more research into it, and I learned it's just an infection that could be cleared up with medication.

My Break Away Moment

After this I wasn't having sex really. I abstained because I didn't feel like it was much of a purpose, and I wanted to be a good model for my daughter. If I wasn't doing anything, how can I get anything? So, I knew as long as I wasn't doing anything, I should be okay. I learned to be more cautious and not to be so naïve. When I did start back dating and having sexual relationships, I was sure to use protection. Nobody said it better than the way Alicia Keys said it. This was another lesson learned and life is a bunch of lessons. You either learn from it or run from it. I choose to learn from not only my past but other people's past. Yes, this was a downfall. It sucked that it happened, but at least I got it taken care of and now I know what not to do. Test before you have sex or use protection if not both. When I got with my fiancé, I was still regularly testing for STI's, not only for my health but for his because we both have illnesses that will never go away. We have been together four years now and being with him and being around his family has greatly impacted me and my self-esteem. I've learned not be treated like a tool, how to speak up for myself, and how to say no without feeling guilty about it.

NikAsia's Story [Participant authored introduction and subtitles]

As a child, NikAsia was seemingly innocent and well behaved, full figured and a good girl. She was 18 years when she finally had sex, and now 4 kids in, she was diagnosed with genital herpes. The following story details how NikAsia, handled this devastating news, whom she had in her corner, and her plans to learn and grow from it.

Womanly Little Girl

I remember one time when I was about 12 years old, and I went to the store with my cousin who is one year younger than me. The guys were cat calling us and one of them said to my cousin "Ooh girl you pretty, how old are you?" She said 11. Then he looked at me and said, "Dang baby you sexy." That really affected me because he called my cousin pretty and me sexy. He was looking at her face but looking at my shape. Yes, I was 12 years old, but he saw that my body looked like was about 16 or 18. I felt like I had to work my body since I wasn't pretty. I became a tease, and it wasn't a good thing. I would wear tight pants and short shirts and present myself like I was doing stuff, but I wasn't doing anything. I just wanted the attention.

For the longest I thought sex was going to hurt and I don't like pain. Before I started my cycle my parents sat me down and told me what to expect. I knew that I would go into the bathroom and see blood. I think they told us at school too, so I was already familiar with what my parents were saying. In that conversation they told me if my mom wasn't around when I started my cycle my dad knew what to do. They told me not to be embarrassed to tell them and not to freak out. When it came to sex, they told me my first time was going to hurt. "Don't get it twisted. You see it in movies, and they are enjoying it and stuff. No, it's going to hurt" they said. My mom was real about it. My parents wanted me to wait until I was married, but my mom told me that if I was in the mood and I started petting and feeling, I needed to let them know before I decided to have sex. She also told me I had to use protection.

I'm Not Ready Yet

I don't know if my mom intended to scare me away from sex, but her telling me it would hurt stuck with me. My friends were having sex though. I remember double dating with my friend at my boyfriend's house. My friend and her boyfriend were in the guest room and my boyfriend said to me "You know what they in there doing." I said no and asked him if he wanted to watch TV to change the subject. He was like "How are they at my house and we not doing nothing, but they are." And I was like "I'm not ready, I'm not trying to" and I was okay with that.

I finally had sex when I was 18. I felt like I had been a virgin forever so the first few times I had sex I just wanted to get it over with. My parents' conversation definitely prepared me and I'm thankful they sat me down. Even though they told me to let them know before I decided I wanted to have sex, I did not do it. I was sneak, but I had always been a good girl, so I was too embarrassed to tell them.

This Is What I Waited For?

When I first started having sex, I always made my partners use condoms. But by the time I was about 26, they were not required at all. As I got older, I started to get persuaded by them saying "Oh, it's going to feel better" or "We ain't gotta use that" and I just became okay with it. I wasn't sleeping with a lot of people, but I didn't use protection with the people I was sleeping with. I was trying to solidify relationships through sex.

About two years ago, I noticed I had some itching in my vaginal area and I noticed a bump. I thought it was a hair bump. I went to the doctor, and she looked at it and told me it was a genital wart. Immediately I was like "Wait what?" because at this point, I had been celibate for almost a year. During my last pregnancy I had decided that if I man wanted to have sex, he was going to have to marry me. The doctor said "I can almost guarantee this is warts. She did a swab, ran some tests, and told me to come back in a week. At this point I was dazed and confused. The doctor told me there was no way to pinpoint when I contracted it. I have multiple sclerosis and at the time I was breastfeeding, so I wasn't taking my multiple sclerosis medicine.

The doctor explains I could have had it for years, but it was only flaring up because I wasn't taking my multiple sclerosis medicine. I went the next week to follow up and the doctor told me "Ms. Williams, this is herpes." I said "What?" and she said, "You have genital herpes." I just said "Okay, what now?" The doctor gave me medicine to get rid of my flareups. I had to take it for 10 days and was instructed to come back if I had another flare up. I was confused and I thought "there's nothing I can take daily to prevent this?" But I wouldn't let myself google it because I was going to freak out and get false information. The doctor told me it was a good thing I wasn't looking online for answers because it would have been a lot of misinformation blended in with the truth. She told me to call or email her anytime. She was very supportive.

A Friend Indeed

Initially I thought I would never tell anyone about my diagnosis. I have a best friend and a cousin who are both registered nurses. I wouldn't allow myself to tell my best friend, I was too embarrassed. I was embarrassed to tell my cousin to but to prevent me from going on Google trying to find information I told her. I said "This is where I am, and what it is. You can judge me if you want but tell me what you know about herpes." It was a blessing because she told me "It's not the end of the world. There are ways you can manage this infection and cope with it." She was a lifesaver and someone for me to talk to about it.

I also told a dear friend I recently reconnected with. I don't remember what made me tell her, but I'm very thankful that I did. When I told her she said "NikAsia, that's okay." She told me that it's not a dealbreaker. She said, "I feel like if I met someone, and he told me had had herpes, I would be okay with it." I was like "Keisha you're lying?" and she was like "No, that's not the end of the world. On the right medication you can successfully have relations and not spread it." I didn't know that there was a way for me not to pass it. This was probably like four months past my diagnosis. I don't feel like my doctor did me justice or told me everything I needed to know. But I didn't know what questions to ask. I feel like she wanted me to know if I wasn't having a flareup then I didn't need any medicine. I wanted to know if there was anything I could do to prevent flareups from happening. But I didn't want to worry because I knew that God did not give me a spirit of fear.

Knowledge Is Power

When I first learned of my diagnosis I was crushed, I was broken inside but when I really thought about it, it was me and how I was moving and not wearing protection. At that moment I had to come to grips with it. It was a lot of emotions, but I got through it by understanding and accepting that it was what I was doing and that it could be so much worse. I'm very strong in my faith and I trust God. I go to church four days a week almost every week. I could have been dying or have a baby that wasn't going to get to know me past three months. So, I told the Lord "I thank you. However, you had to humble me. This is what you chose to do, and I believe that you don't put more on me than I can handle." I'm going to keep moving forward by becoming more knowledgeable.

Can't Stop Won't Stop

I recently found out I contracted herpes from my last son's father. I got a text from my son's father's wife saying "I'm Derrick's wife. He has many children. Your baby is probably one of 30. He gets with women and makes babies and doesn't take care of them unless you're sleeping with him. I don't know what he came to visit you and tell you but be careful. He does have herpes." I was devastated and thrown off because how could he do that to people? We had been together on and off for four years. Thankfully while I was pregnant with our child, I didn't have any flare ups and I had to have a section. I've only had that one flare up when my son was about 18 months old. God has been with me the whole time because I couldn’t imagine having a baby and passing herpes to him not even knowing I had it. Sometimes I feel like I’m dirty so the best thing for me to do is stay celibate so I’m not putting someone in harm’s way. I have five children that I am responsible for, I have to speak up and be in the forefront for them. So as far as a love life and getting remarried that can way. It’s been that way for so long and it’s for the best. I feel like I can’t hurt anybody and can’t spread anything and I’m okay with it. It’s just my new normal. I don’t want it to always be, but that’s where I am right now.

At the end of the day, I am owning this. I played a huge role in this. I definitely did not see it happening, but if I'm 100% honest with myself, I wasn't trying to prevent it. This is the conversation and things that we don't talk about regularly. Everybody just says, “Oh yeah, you gotta go to the clinic and get that shot and then you'll be all right.” But what happens when the shot doesn't help when the shot doesn't take it away? And these are the conversations that we don't have. But, back to me personally, I'm accepting it. I'm moving forward, and I'm gonna educate myself and protect myself and anyone else that I get involved with, I won't let it get me down.

Summary

Although the stories shared in this chapter were unique to each woman, the narratives contained many similar elements. Throughout the process of completing the interviews, restorying them, and reflexively journaling it became clear that there were some shared experiences besides the acquisition of an STI among the participants. Their narratives demonstrate how these pivotal experiences have impacted the ways they manage their sexual health.