SEXUAL WELL-BEING AMONG QUEER WOMEN OF COLOR

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ABSTRACT

Sexual well-being, a critical part of human life, is deeply connected to physical and mental health. Despite global initiatives calling for the inclusion of multidimensional approaches to sexual health research, the dominant discourse continues to be disease and deficit focused. While multiply marginalized groups are hyper visible in the sexual health research on risk and disease, they are rarely considered in the arena of sexual well-being. Importantly, despite sexual minority women being exposed to increased sexual violence and subsequent negative mental and physical health consequences, this makes them more, not less, worthy of attention regarding the sexual well-being. In resistance to narratives that pathologize marginalized sexualities, this project focuses on the sexual well-being of queer women of color (QWOC).

I designed and conducted a mixed-methods study using self-report, online survey methodology capturing cognitive and affective assessments of sexuality and sexual experiences, measures of health at the individual and structural level, and responses to open-ended survey items on their perceptions of each. Self-identified QWOC (n = 397) aged 18 – 78, *(*M = 28.61, SD = 6.64) living in the United States completed the study. This dissertation presents their survey findings in three stand-alone studies addressing separate but related content from these data.

Study I examined the relationship between self-rated health and sexual well-being. Compared to national norms, this sample of QWOC reported lower self-rated health scores and moderately high levels of sexual self-esteem. Multiple linear regressions showed self-rated emotional well-being and general health predicted all dimensions of sexual well-being except for sexual shame, which was only predicted by emotional well-being. Sexual pride was additionally influenced by income and identifying as a survivor of sexual abuse. Racial differences emerged

across dimensions of sexual well-being highlighting the need for intersectional and person-centered research that respects the heterogeneity of QWOC.

Study II focused on structural determinants of health and sexual well-being. I utilized a person-centered approach to identify profiles of sexual well-being across QWOC and then examined profile membership in relation to structural determinants of health. Latent profile analyses revealed three profiles of sexual well-being: low, moderate, and high. Most participants belonged to the moderate profile, with measures of sexual satisfaction, pride, self-esteem, and shame clustering together. Higher levels of positive sexual well-being measures were associated with lower levels of sexual shame. Structural determinants of health such as income and living in the south significantly predicted membership in the high sexual well-being profile.

Given the lack of agreed upon definition, Study III analyzed qualitative data to gain insight on conceptualizations of sexual well-being among QWOC. Open-ended responses to the question, "what does sexual well-being mean to you?" were analyzed using inductive content analysis. Responses (n = 346) revealed a multifaceted concept of sexual well-being involving three themes, 1) physical health and safety, 2) comfort, and 3) positivity. Findings inform a definition of sexual well-being by adding in-depth qualitative data from racialized and sexually marginalized women on how they define sexual well-being for themselves.

Taken together, these three studies offer an important addition to the extant literature on sexual well-being and on QWOC, a population that is often overlooked in research. This dissertation offers empirical evidence of the complex interplay between health, sexual well-being, and overlapping systems of power and oppression. These findings also identify the need for more research examining the strengths within marginalized populations and structural factors influencing sexual well-being.

This thesis is dedicated to queer women of color everywhere and the erotic power within us all.

"Recognizing the power of the erotic within our lives can give us the energy to pursue genuine change within our world, rather than merely settling for a shift of characters in the same weary drama." – Audre Lorde, Uses of the Erotic: The Erotic as Power

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INTRODUCTION AND OVERVIEW

Sexual health is a global health equity priority. Despite years of research efforts toward sexual health equity, persistent disparate outcomes among racially and sexually marginalized populations remain (Mahajan et al., 2021; Weinstein et al., 2017). To make progress in this area, it is imperative that health approaches incorporate a sex positive perspective (J. V. Ford et al., 2019; Gruskin & Kismödi, 2020). This dissertation answers the call by exploring the sexual well-being among a multiply marginalized population of queer women of color facing consistent health inequities.

Queer Women of Color

Throughout this dissertation, I use the term 'queer' intentionally. Queer is a term used to defy categorization and encompass a diversity of sexualities. Queer is inclusive of any and all sexualities that are systematically marginalized because of their resistance to heteronormativity, monosexuality, and binary gender constructs (Callis, 2014; Kolker et al., 2020; Worthen, 2023). Queer can also be used to describe fluid gender and sexual identities (Morandini et al., 2017). The word and identity have been reclaimed as empowering to some, but not all, members of the community and may still be used derogatorily by outgroup members.

Queer women of color (QWOC) are understudied in sexual health research. The perspectives and experiences of sexually and racially marginalized women are largely missing given that sexual health research is largely based on White, cisgender, heterosexual populations. Conversely, those with marginalized identities are hyper visible in the disease and risk focused research which labels racialized and marginalized sexualities as vulnerable to negative health outcomes. Together, there is a dearth of research examining the strengths and resistance among QWOC and this research is important, relevant and desperately needed.

Research consistently finds that QWOC face elevated rates of violence and encounter more adverse health outcomes compared to their white and heterosexual peers (Bostwick et al., 2019; Canan et al., 2021a, 2021b; McCauley et al., 2015; Walters et al., 2013). This heightened exposure to violence contributes to negative health impacts, such as increased incidences of sexually transmitted infections (STIs) (Holmes & Beach, 2020; Logie, 2015; Thoma et al., 2013) and unintended pregnancies (Tornello et al., 2014; Ybarra et al., 2021). Moreover, challenges in accessing affirming and competent healthcare, which are exacerbated by the intersection of multiple marginalized identities, further affect their sexual well-being (Gessner et al., 2020; Rice et al., 2019; Turpin et al., 2021). These findings highlight significant individual-level challenges that intensify sexual health inequities among QWOC. Although one approach is to delve deeper into oppressive aspects undergirding these inequities, an equally valid approach is taken here focusing on sexual well-being and how QWOC thrive in the face of these challenges.

Research suggests that focusing on sexual well-being and sex positive approaches may be more effective than infection and risk education (Ford et al., 2019). Methods that are holistic and affirming approaches to sexual health and incorporate sexual pleasure may increase adherence to treatment interventions and improve sexual health outcomes overall. For example, understanding and prioritizing sexual pleasure and education on sexual communication has been associated with decreased risk of sexual violence, better sexual health outcomes, and higher levels of sexual well-being (J. V. Ford et al., 2019; Sladden et al., 2021). QWOC could directly benefit from these interventions and must be a focus of sexual health research efforts.

Sexual Well-Being

Sex is a critical part of human life. Sexual behaviors and experiences are intimately intertwined with physical and mental health (Diamond & Huebner, 2012). In fact, the World

Health Organization's (WHO) definition of sexual health includes "physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity," and promotes positive approaches to sex that emphasize pleasure, respect, and consent (World Health Organization, 2006, p. 4).

While there is no agreed upon definition, sexual well-being is broadly defined as a subjective assessment of the physical, cognitive, and affective experiences of human sexuality (Lorimer et al., 2019). The lack of consensus around how to measure sexual well-being is a barrier to further studying, measuring, and creating interventions to actualize this important aspect of overall health, and sexual health in particular. Different studies and different contexts have used the term sexual well-being with a diversity of underlying measures of the construct (Lorimer et al., 2019). Recently, a promising definition and measure was presented by Mitchell and colleagues (2023) defining sexual well-being as: "sexual emotions and cognitions which include feeling safe, respected, comfortable, confident, autonomous, secure, and able to work through change, challenges, and past traumas" (Mitchell et al., 20223, p. 8).

Although published after the current dissertation research was designed and conducted, the work by Mitchell and colleagues aligns with the current study in its focus on sexual well-being as a multidimensional construct with positive, health enhancing components of importance. This definition was aligned with many of the findings in this project. My project adds to their definition with additional data from an underexamined population and in a different country with different sociopolitical impacts on health.

Intersectionality Theory

Intersectionality theory, developed by Black feminist scholars Kimberlé Crenshaw and Patricia Hill Collins, emphasizes the inseparability of multiple identities within social

phenomena and the interconnected systems of power and oppression that influence them (Collins, 2000; Collins & Bilge, 2020; K. Crenshaw, 1991; K. W. Crenshaw, 2006). This theory offers a critical lens for understanding how overlapping layers of discrimination occur across multiple identities (Bowleg et al., 2003; Settles & Buchanan, 2014) and is vital to public health policy and interventions (Bowleg, 2021; Merz et al., 2021).

To accurately understand the experiences of QWOC, this project was informed by the tenets of intersectionality theory (Buchanan & Wiklund, 2021). Experiences of sexual well-being do not exist in a vacuum and are shaped by structural and sociocultural processes (Higgins et al., 2022). QWOC are simultaneously marginalized by their sexuality, gender, and race. The experience of sexual well-being therefore exists within overlapping systems power and oppression founded in White, heteronormative patriarchy.

This detailed examination of how identities and social categorizations interact within and between individuals and institutions is a critical theoretical perspective for examining sexual well-being (Hancock, 2007). Intersectionality addresses how oppressive structures reinforce each other and create inequality, calling for transformative research practices (Buchanan & Wiklund, 2021; Cole, 2009; Collins & Bilge, 2020). Social justice is at the core of intersectionality (Buchanan & Wiklund, 2021; Cole, 2009; Collins & Bilge, 2020; Settles & Buchanan, 2014), making it essential for health equity research. As such, intersectionality theory informs this work by contextualizing the sexual well-being of QWOC within overlapping systems and sociocultural environments.

Embodiment Theory

Ecosocial theory explores the origins and dynamics of social inequalities in health (Krieger, 2001, p. 672). Social epidemiologist Nancy Krieger developed this theory, which

examines the effects of social, political, cultural, and economic processes on health's ecology and biology (Krieger, 2001, 2021). Krieger (2001) explains that health and well-being are influenced at multiple levels (micro to macro) of biological, ecological, and social organization within society. Health inequalities are generated through social, ecological, and biological mechanisms, with lived experiences shaping biological processes via embodiment (Krieger, 2001, p. 201).

Embodiment describes the reciprocal relationship between the body and its social context, linking environmental conditions (e.g., racism, poverty, pollution) to health outcomes (Krieger, 2001; Merz et al., 2021). Understanding embodiment within ecosocial theory provides insights into the dynamic interaction between the body and lived experiences, which is crucial for sexual health (Chmielewski, 2017; Piran, 2019). Similar to intersectionality theory, ecosocial theory necessitates the integration of social systems of power, privilege, and oppression into health equity research (Merz et al., 2021); as such, both intersectionality and embodiment theory are important frameworks for this project.

The Present Dissertation

This project shifts the focus away from disease and asks, what is good about QWOC's sexuality? What factors contribute to positive sexual well-being among those at the highest statistical risk of negative sexual experiences so that we might leverage these factors in service of attaining health equity? To address the gaps in the extant literature, the overarching aims of this research project are to examine (1) how sex is linked to health for QWOC, and (2) how QWOC experience sexual well-being.

This dissertation project is presented as three independent papers to achieve two primary goals. First, to examine sexual well-being in multiple and distinct ways to contribute to the current gap in literature. Second, to facilitate an effective publication and dissemination process.

The three papers explore how QWOC understand their health and sexual well-being, structural determinants of health and sexual well-being, and qualitative investigation of their personal definitions of sexual well-being. These three studies each offer a unique contribution to the literature, grounded in the understanding that health equity research is only as good as its implications across levels of practice and policy.

Study I investigated the relationship between self-rated health and sexual well-being. This study examined a multidimensional measure of sexual well-being involving separate validated measures of sexual self-esteem, sexual pride, sexual shame, and satisfaction with sex life. Self-rated health measures were used to ensure the internal state and experience of the participants were the focus rather than a researcher-imposed measure of health. Study I revealed that participants reported lower self-rated health scores compared to national norms and moderately high levels of sexual self-esteem. Multiple regression results highlighted the critical roles of emotional well-being and general health in predicting all dimensions of sexual well-being, except sexual shame. Notably, sexual pride was influenced positively by socio-economic factors (e.g., income) and identifying as survivor of sexual abuse. Differences by racial identity supported the need for intersectional research that respects the heterogeneity within QWOC communities.

Building on Study I, Study II explored the relationship between structural determinants of health and sexual well-being. Using latent profile analysis, a person-centered approach, this study identified three distinct profiles of sexual well-being: low, moderate, and high. The moderate sexual well-being profile contained the majority of participants, with around average scores across measures of sex life satisfaction, pride, self-esteem, and shame. The high sexual well-being profile was marked by higher levels of positive sexual well-being measures being

correlated with lower levels of sexual shame. This study examined neighborhood level factors such as median neighborhood income and home values based on participant zip code. Social determinants of health, such as state level policies and geographic regional sociocultural contexts, were considered. Results revealed that income and geographic region significantly predicted membership in the high sexual well-being profile, indicating that socio-economic context plays an unexpected yet vital role in shaping sexual well-being among QWOC.

Study III used qualitative data to further explore how QWOC conceptualized sexual well-being. Currently, there is no standardized, agreed upon definition of sexual well-being. This study addressed this by analyzing open-ended responses to the question, "What does sexual well-being mean to you?" Inductive content analysis revealed a multifaceted concept encompassing physical health and safety, comfort, and positivity. Resulting themes indicate the multidimensional nature of sexual well-being and reinforce the addition of sex positivity that distinguishes sexual well-being from sexual health. These qualitative findings provided insights into the personal and contextual factors that contribute to sexual well-being, providing a nuanced perspective that complements the quantitative findings of the previous studies.

Together, these studies paint a comprehensive picture of sexual well-being among QWOC, illustrating how perceptions of individual health and well-being, social determinants of health, and personal conceptualizations interconnect. This integrated approach emphasizes the importance of considering mixed methods and multidimensional measures to fully understand and support the sexual well-being of QWOC. By synthesizing these findings, we can develop more effective, inclusive strategies to enhance sexual health outcomes and address the unique challenges faced by this population.

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STUDY I: SELF-REPORTED HEALTH AND SEXUAL WELL-BEING AMONG QUEER WOMEN OF COLOR

ABSTRACT

Sexual well-being is interconnected to overall health. Queer women of color (QWOC) are often described as a vulnerable population at risk for worse health outcomes. As resistance to narratives that equate queer sexualities with negative health, this study aimed to examine positive sexual well-being and health. A targeted sample of QWOC (n = 397) aged 18 – 78, *(*M = 28.61, SD = 6.64) completed an online survey of self-report measures of sexual self-esteem, sexual pride, sex life satisfaction, sexual shame and self-reported health. Descriptive analyses revealed that despite overall lower self-rated health scores from the overall sample compared to national norms, this sample demonstrated moderately high levels of sexual self-esteem. Results from multiple linear regressions showed self-rated emotional well-being and general health predicted all dimensions of sexual well-being except for sexual shame. Lower levels of sexual shame were predicted by higher levels of emotional well-being. Sexual pride was additionally influenced positively by income and identifying as a survivor of sexual abuse. Some racial differences emerged across dimensions of sexual well-being, particularly between Black QWOC compared to Asian QWOC, highlighting the need for intersectional and person-centered research that respects the heterogeneity of QWOC. These findings highlight the importance of considering the protective and sex-positive aspects of queer sexuality and the vital role of emotional well-being in sustaining self-esteem, pride, and satisfaction despite marginalization. This study highlights the complex interplay between health perceptions, sexual identity, and well-being, emphasizing the need for more inclusive and comprehensive research and interventions.

INTRODUCTION

Sexual well-being is a critical aspect of public health (J. V. Ford et al., 2019; Mitchell et al., 2021). Despite public health policy efforts and biomedical advances, sexual health inequities persist among racially and sexually marginalized populations (Mahajan et al., 2021; Weinstein et al., 2017). Queer women of color (QWOC) describe a heterogenous group marginalized by sexuality, gender, and race. Meanwhile, a paucity of research exists on the sexual well-being of QWOC. What is known, highlights significant inequities. For example, QWOC are exposed to more severe and increased rates of sexual violence compared to White heterosexual women (McCown & Platt, 2021; Reuter et al., 2017). Sexual violence increases the risk of sexually transmitted infections (STIs), unintended pregnancy, post-traumatic stress disorder (PTSD), poor physical health, substance use, disordered eating, and suicidal ideation (Chivers-Wilson, 2006; Dworkin, 2020; Roberts et al., 2020). Despite 25 years of sexual violence research, prevalence rates have remained stable, implying that new research methodologies and strategies are imperative (McCauley et al., 2019).

This study employs a new strategy by shifting the focus away from deficits and asks, what is good about QWOC's sexuality? How does a population among those at the highest statistical risk of negative sexual health outcomes experience sexual well-being? To address the gaps in the extant literature, this study examined the relationship between health and sexual well-being among a sample of QWOC in an effort to provide empirical evidence that might serve solutions for health equity.

Sexual activity is a health behavior, like exercise, diet, or substance use, with critical implications for mental health (Diamond & Huebner, 2012). Four decades of health psychology and public health prioritization little progress has been made in understanding the health relevant

socio-emotional processes around sexual experiences (Diamond & Huebner, 2012). Sexual well-being is a crucial area to explore because it captures the multidimensional aspects of sex and sexuality, related to but distinct from sexual health. Understanding how individuals experience sexuality and the relationship between health and sexual well-being is key to addressing health inequities.

Sexual well-being involves a common and critical health behavior – sex, which is intimately intertwined with physical and mental health (Diamond & Huebner, 2012). While there may be many factors that motivate sexual behavior, pleasure is a common reason why people have sex (Higgins & Hirsch, 2007; Zaneva et al., 2022). Sexuality research largely ignores racialized or marginalized sexual pleasure and remains predominately disease focused and deficit-based (Jones, 2019). This deficits focus that labels queer sexualities at risk or vulnerable to negative health outcomes contributes to pathologizing QWOC and ignoring and positive aspects of their sexual experiences (Mitchell et al., 2021; Perrin et al., 2020).

Sexual pleasure, sexual self-esteem, and sexual satisfaction have been associated with better physical and mental health (Andersen & Hill Collins, 2013; Wellings et al., 2019). This relationship is likely bidirectional, with people in better health engaging in more frequent sex (Lindau & Gavrilova, 2010). Self-rated health plays an important role in overall well-being and is predictive of long-term health outcomes above and beyond objective health measures or lifestyle factors (Wu & Zhang, 2023). In a large U.S. study on satisfaction with sex life among adults of unknown sexual orientation, higher self-rated health was associated with higher levels of satisfaction (Flynn et al., 2016).

Among sexually marginalized populations (i.e., lesbian, gay, bisexual, queer or LGBQ) research suggests increased mental distress and poorer general health among bisexual women

compared to lesbian women (Fredriksen-Goldsen et al., 2010). Sexual well-being disparities within marginalized groups have shown higher rates of sexual dysfunction in bisexual women compared to their lesbian-identifying counterparts (Lorenz, 2019). Understanding the relationship between health and sexual well-being is critical to addressing the needs of this population.

Some research suggests that proximal risky health behaviors such as substance and alcohol use contribute to increased risk for sexually transmitted infections in lesbian women compared to their heterosexual peers (Hegazi & Pakianathan, 2018). Differences in sexual health outcomes are also impacted by healthcare availability and access. For example, a lack of relevant and affirming sexual health knowledge and information particularly for multiple marginalized communities likely impacts sexual health inequities (Santos et al., 2017).

While most sexual health research continues to examine individual identities (e.g., looking at sexuality separate from race), there are some valuable intersectional exceptions. For example, Thorpe and colleagues examined sexual distress among Black queer women and found that evidence of decreased sexual distress and increased psychological resilience compared to Black heterosexual women (Thorpe et al., 2024). There are several investigations that focus on the cervical cancer and reproductive health experiences and disparate health outcomes among Black and Latina sexual minority women (Agénor et al., 2014, 2015, 2016). Other research suggests that multiple marginalized identities do not necessarily predict worse health outcomes in an additive, linear fashion (Hsieh & Ruther, 2016). Research that incorporates multiple overlapping identities reveals unique and ambiguous findings that call for further research.

PRESENT STUDY

There is an urgent need for sex positive and intersectional research that focuses on the health and sexual well-being of QWOC. Present research with large national populations often lack diversity, resort to comparing marginalized groups to dominant identities, and are predominately disease focused. Large, nationally representative studies require substantive funding, and these artifacts are a reflection of federal funding priorities. Given the limited literature on QWOC's sexual well-being this study sought to examine the relationship between self-rated health and sexual well-being. Self-rated or subjective measures of health and sexual well-being allow for the internal experience and participant perspective to be reflected. Self-rated health has been shown to be predictive of long-term health outcomes above and beyond objective health measures (Wu & Zhang, 2023). Given the available literature connecting overall health and sexual well-being in general population. I hypothesize that better self-rated health will predict higher levels of sexual well-being.

METHOD

Design

The goal of this study was to assess the relationship between self-perceived health and sexual well-being among QWOC. The present study was collected from a larger online study that explored health and well-being among a sample of self-identified QWOC. The larger study included several measures of beliefs, experiences, and attitudes around sex and sexuality as well as assessments of physical and mental health. Internet-based surveys have proven valuable in accessing populations that are typically difficult to reach, including sexual and gender minorities (McInroy, 2016; Mustanski, 2001). Although online research offers benefits such as speed, low cost, and the ability to target specific study populations, it also raises concerns about data

integrity (Belliveau & Yakovenko, 2022; Griffin et al., 2022). To ensure data integrity in this study, Prolific was used to verify that the online data collected was from genuine human participants. Prolific's registration process involves a four-step process requiring participants to verify their email, phone number, identity (e.g., via driving license or state ID card), and complete a trial study. Evidence suggests that Prolific delivers higher quality data compared to other online research platforms (Peer et al., 2021). This study was approved by the Michigan State University Institutional Review Board.

Participants were initially recruited via Prolific. Prolific only invited participants that met a specified demographic criterion (i.e., lived in the U.S., 18 years of age or older, self-identified as LGBTQ+, self-identified as a woman, self-identified as a person of color) based on their verified profile. The study was described as a survey focused on the sexual and mental health of queer women of color. Eligible participants were then directed to complete the survey via a link to Qualtrics. In Qualtrics, participants were required to submit their unique Prolific ID and pass a Completely Automated Public Turing Test to tell Computers and Humans Apart (CAPTCHA) to prevent bot participation (Pickering & Blaszczynski, 2021; Teitcher et al., 2015; Watson et al., 2018). Qualtrics also automatically disqualified entries from duplicate IP addresses and flagged rapid completions. In addition, the first author reviewed attention checks, redundant questions, and completion times to ensure data quality beyond the automated measures (Newman et al., 2021; Teitcher et al., 2015). Qualitative responses were mandatory, but participants could opt out of providing qualitative answers by typing a designated word such as "tooth." I screened responses for nonsensical content after data collection (Kennedy et al., 2020; Teitcher et al., 2015). Three participants were removed from analyses who identified racially as White.

Participants

Eligibility for this study was restricted to users that were already registered with Prolific and met the following criteria: aged 18 or older, self-identified as LGBTQ, self-identified as women, self-identified as belonging to a non-white racial group, residing in the United States, and possessing proficiency in written English. Screening of participants was based on their Prolific user profile data, with additional confirmation required that they identified as part of the LGBTQ community and were fluent in English. After verifying their eligibility and consenting to participate, individuals were directed to complete the survey. Data collection occurred in March 2023, and participants received a $10 compensation upon survey completion.

See Table 1 for sample descriptives. Participants were between the ages of 18 – 78, *(M* = 28.61, *SD* = 6.64). Most participants identified as Multiracial (*n* = 144, 36%), cisgender (*n* = 331, 86%), in a relationship (*n* = 226, 58%), and college educated (*n* = 177, 45%). Approximately 52% of the participants reported mono-sexual behavior (i.e., sex involving people of a single gender) in the past 12 months.

Table 1

Participant Characteristics (*n* = 397)

Characteristic	*% (n)*[1]
Age	
18 – 29	66 (264)
30 – 39	24 (94)
40 – 49	7 (26)
50 – 59	3 (10)
60 – 80	1 (3)
Cisgender [a]	86 (331)
Past Year Sexual Behavior	
Mono	52 (205)
Pluri	14 (55)
No sex	34 (133)
In a Relationship [a]	58 (226)
Childhood Sexual Abuse [a]	41 (163)

Table 1 (cont'd)

Race	
Asian	17 (68)
Black	27 (107)
Latine	18 (70)
Multiracial	36 (144)
Native/Indigenous	2 (8)
Education	
High School or Less	46 (183)
College Degree	45 (177)
Graduate Degree	9.3 (37)
Income	
≤ $9,999	46 (178)
$20,000-$39,999	21 (81)
$40,000-$59,000	14 (55)
≥ $60,000	19 (73)
Insurance Type	
Medicaid	25 (96)
Medicare	7 (28)
ACA	5 (19)
Uninsured	15 (56)
Employer or Private	47(178)

[1] Note. Column totals may not equal 100% due to missing data.
[a] Reflects the number and percentage of participants answering "yes" to this question.

Measures

Participant Characteristics

Participants self-reported several demographic variables and personal characteristics. Demographics included: age, racial identity, if they identified as a gender other than the gender they were assigned at birth (yes/no), education, and income. Participants were asked to report past childhood sexual abuse (CSA) prior to age 12 with the four-item Childhood Sexual Abuse Scale (Aalsma et al., 2002). The CSA scale consisted of items such as "I believe that I have been sexually abused by someone" and "Someone tried to touch me in a sexual way against my will."

Responses were coded as yes (1) or no (0) and had good internal reliability in this sample (α = .92).

Health

Self-rated health (SRH) was assessed with subscales from the RAND 36-Item Health Survey 1.0 (SF-36; (Hays & Shapiro, 1992; Ware et al., 1993). The SF-36 measured dimensions of mental and physical functioning, well-being, and disability across eight domains of health-related quality of life. All scale scores are transformed into a 0 – 100 scale such that higher scores indicated a healthier state (Hays & Shapiro, 1992). This study measured SRH using the following four subscales from the SF-36.

General Health. Personal evaluation of physical health was assessed with the five-item General Health scale. This scale includes a single measure SRH item, "In general, would you say your health is: Excellent (5), Very Good (4), Good (3), Fair (2), or Poor (1). Additional items included, "I seem to get sick a little easier than other people" and "I expect my health to get worse." Response options ranging from definitely true to definitely false on a 1-5 scale and were coded such that higher scores indicated that they evaluated their health as better overall. Reliability of this scale was good with a Cronbach's alpha of 0.84.

Pain. Well-being and disability related to physical health were assessed with the two-item Bodily Pain subscale. Items included, "During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?" and "How much bodily pain have you had during the past 4 weeks." Response options ranged from none to very severe on a 6 - 1 scale with higher scores indicating fewer limitations due to physical pain. Reliability in this sample was good (α = .87).

Physical Function. Functioning related to physical health was measured with the six-item Physical Functioning scale. This subscale assessed to what extent health limits one's ability to engage in daily activities ranging from, "vigorous activities, such as running, lifting heavy objects, participating in strenuous sports" to "bending, kneeling, or stopping." The response scale ranged from 1 to 3, indicated a lot of limitations to no limitations at all, with higher scores indicating fewer or no health-related limitations in the activity areas. This scale had good internal consistency ($\alpha = .92$).

Emotional Well-being. Well-being and functioning related to mental health were assessed with the five-item Mental Health scale. This scale included items related to symptoms of anxiety, depression, emotional regulation, and psychological well-being (Ware et al., 1993). This scale asked participants to indicate how much of the time they have experienced certain states during the past four weeks, such as "Have you been a very nervous person?" and "Have you felt downhearted and blue?" with response options ranging from all of the time (1) to none of the time (6). After the recommended scale transformation, higher scores indicated that the participant felt calm, happy, and peaceful most of the time. Scale reliability was good in this sample ($\alpha = .87$).

Sexual Well-being

Sex Life. Subjective satisfaction with one's current sex life overall was measured by the five-item *Satisfaction with Sex Life Scale* (Neto, 2012). Items such as, "I am satisfied with my sex life" and "The conditions of my sex life are excellent," are rated on a scale of strongly disagree (1) to strongly agree (7). Averaged total scores ranged between 1 (very low satisfaction) and 7 (very high satisfaction). In this sample, the scale demonstrated high reliability ($\alpha = .94$).

Sexual Self-esteem. Evaluations of self-related to sexuality were measured by a total score from the 35-item *Sexual Self-Esteem Inventory-Short Form* SSEI-SF (Zeanah & Schwarz, 1996). This multidimensional questionnaire encompasses five facets of subjective self-esteem related to sex and sexuality: Adaptiveness, Attractiveness, Control, Moral Judgement, and Skills/Experience. Each subscale is seven items each and rated on a 1 – 6 scale. The skill/experience domain measured an individual's self-appraisal of their own sexual abilities and how they feel about their sexual experiences, for example, "I feel good about my ability to satisfy my sexual partner." The attractiveness subscale captures cognitions about their own body and physical attractiveness as exemplified by, "I am pleased with my physical appearance" or the reverse scored item, "I would like to trade bodies with someone else." The control subscale measures to what extent participants feel in control of their sexual behavior, thoughts, and feelings as captured by items such as, "I worry that things will get out of hand because I can't always tell what my partner wants in a sexual situation." The moral judgment subscale measured how much an individual believes their sexual behaviors align with their morals. An example of a moral judgment item is, "I never feel guilty about my sexual feelings" or the reverse scored item, "I have punished myself for my sexual thoughts, feelings, and/or behaviors." Lastly, the adaptiveness subscale referred to how much an individual feels that their sexual experiences contribute to their life or sense of self. An example of an adaptiveness is: "I like what I have learned about myself from my sexual experiences." Averaged total scores across facets could range between 1 (very low sexual self-esteem) and 6 (very high sexual self-esteem). Internal consistency was high in this sample ($\alpha = .94$).

Sexual shame and pride. Self-conscious emotions related to sexuality were measured by the *Sexual Shame and Pride Scale* (SSPS; Rendina et al., 2019). This measure consists of 16

items total, eight items measuring shame and eight measuring pride. Responses range from not at all true (0) to completely true (4). Examples of the items that measured shame include “I often feel embarrassed by the sexual activities I like” and “I tend to feel bad or dirty after sex.” Examples of the items that measured pride include “There are people with whom I regularly discuss my sex life” and “I am comfortable telling my partners what I want or need sexually.” Scores are calculated as average scores with higher scores indicating higher levels of either construct. Cronbach’s alpha for the shame and pride subscales in this sample were 0.88 and 0.91 respectively. This measure has established convergent and predictive validity (Rendina et al., 2019).

Analytic Method

I conducted all analyses in R v4.3.2 (R Core Team, 2023). I z-score transformed predictor and outcome variables to account for different scales. I examined visuals (i.e., boxplots and histograms) and Shapiro-Wilk normality analysis for preliminary tests of normality. Test of normality revealed sexual shame was visually right skewed and had a statistically significant Shapiro-Wilks test. For this reason, sexual shame was transformed into a dichotomous variable and analyzed via logistic regression. I conducted multiple linear regression analyses to examine the relationship between self-reported health and sexual well-being. All variables were entered in the model simultaneously to examine the unique association of each variable with each measure of sexual well-being adjusting for all other variables. I used the Breusch-Pagan test and variance inflation factor (vif) functions from the r package ‘car’ (version 3.1-2) to assess for heteroskedasticity and multicollinearity (Fox & Weisberg, 2018).

RESULTS

See Table 2 for means, standard deviations, and correlations.

I conducted multiple linear regression analyses for continuous outcomes and a logistic regression for the dichotomous outcome to examine the relationships between physical health and sexual well-being. Sexual well-being was measured by four separate but related facets encompassing cognitive and affective perceptions of sexuality and sexual experiences. Analyses included measures of perceived health as well as demographic variables as simultaneous predictors. Statistically significant results are presented by each sexual well-being outcome. Regression results are detailed in Table 3.

Table 2

Means, standard deviations, and correlations of study variables with confidence intervals

Variable	*M*	*SD*	1	2	3	4	5	6	7	8
1. Age	28.61	8.64								
2. Sex Life	4.06	1.74	.09 [-.00, .19]							
3. Self-Esteem	4.01	.90	.25** [.16, .34]	.48** [.40, .56]						
4. Pride	1.97	1.05	.18** [.09, .28]	.38** [.29, .46]	.68** [.63, .73]					
5. Shame	0.82	0.84	-.13* [-.22, -.03]	-.24** [-.33, -.14]	-.58** [-.65, -.51]	-.28** [-.37, -.19]				
6. General Health	57.14	22.43	.07 [-.03, .17]	.23** [.13, .32]	.40** [.31, .48]	.21** [.11, .30]	-.24** [-.33, -.15]			
7. Emotional Health	53.08	22.22	.23** [.14, .32]	.31** [.22, .40]	.47** [.39, .54]	.27** [.17, .36]	-.33** [-.42, -.24]	.45** [.37, .53]		
8. Pain	74.31	21.69	-.03 [-.13, .07]	.09 [-.01, .18]	.19** [.10, .29]	.02 [-.08, .12]	-.15** [-.25, -.05]	.55** [.47, .61]	.32** [.23, .40]	
9. Physical Function	83.95	21.79	-.04 [-.14, .06]	.10 [-.00, .19]	.23** [.13, .32]	.09 [-.01, .19]	-.17** [-.26, -.07]	.58** [.51, .64]	.25** [.15, .34]	.51** [.44, .58]

Note. M and *SD* are used to represent mean and standard deviation, respectively. Values in square brackets indicate the 95% confidence interval for each correlation. The confidence interval is a plausible range of population correlations that could have caused the sample correlation (Cumming, 2014). * indicates $p < .05$. ** indicates $p < .01$.

Table 3

Linear Regression Analyses with Physical Health Measures Predicting Sexual Well-Being Among QWOC

	Sexual Well-being													
Predictors	Sex Life					Sexual Self-esteem					Sexual Pride				
	*b**	*SE*	*t*	*p*	95% CI	*b**	*SE*	*t*	*p*	95% CI	*b**	*SE*	*t*	*p*	95% CI
Emotional well-being	0.25	0.06	4.30	< .001 ***	[0.13, 0.36]	0.32	0.05	6.23	< .001 ***	[0.22, 0.42]	0.17	0.06	3.01	.003**	[0.06, 0.28]
General health	0.21	0.07	2.84	.005**	[0.06, 0.35]	0.25	0.07	3.76	< .001 ***	[0.12, 0.37]	0.20	0.07	2.71	.007**	[0.05, 0.34]
Age	-0.05	0.06	-0.89	.376	[-0.17, 0.06]	0.13	0.05	2.42	.016*	[0.02, 0.23]	0.07	0.06	1.31	.190	[-0.04, 0.19]
Income	0.23	0.12	1.96	.042*	[-0.00, 0.46]	0.18	0.10	1.76	.080	[-0.02, 0.38]	0.35	0.11	3.09	.002**	[0.13, 0.57]
Black	0.00	0.16	0.00	.997	[-0.31, 0.31]	0.27	0.14	1.95	.052	[-0.00, 0.55]	0.33	0.15	2.18	.030*	[0.03, 0.64]
Latine	0.06	0.17	0.34	.735	[-0.27, 0.39]	0.36	0.15	2.43	.016*	[0.07, 0.66]	0.44	0.16	2.71	.007**	[0.12, 0.77]
Multi	0.01	0.15	0.06	.950	[-0.28, 0.30]	0.36	0.13	2.72	.007**	[0.10, 0.61]	0.38	0.14	2.63	.009**	[0.10, 0.66]
Native	-0.50	0.41	-1.23	.220	[-1.30, 0.30]	-0.10	0.36	-0.29	.776	[-0.81, 0.61]	-0.09	0.40	-0.24	.812	[-0.87, 0.69]
CSA (0=no, 1=yes)	0.18	0.10	1.75	.080	[-0.02, 0.38]	0.14	0.09	1.56	.119	[-0.04, 0.32]	0.29	0.10	2.92	.004**	[0.10, 0.49]

Race reference category was coded as 0=Asian; *b** = standardized beta coefficient; SE = standardized error. *p < 0.05; **p < 0.01; ***p < .001.

Sex Life. Emotional well-being, general health, and income level accounted for roughly 12% of the variance in satisfaction with sex life [$F(16, 360) = 4.20$, $p < .001$, adjusted $R^2 = .12$]. Findings showed that higher levels of emotional well-being, $F(1, 360) = 18.50$, $p < .001$, $\eta^2 = .05$, general health $F(1, 360) = 8.07$, $p = .005$, $\eta^2 = .02$, and income, $F(3, 360) = 2.76$, $p = .042$, $\eta^2 = .02$, positively influenced satisfaction with sex life.

Sexual Self-esteem. Emotional well-being, general health, age, and race accounted for roughly 31% of the variance in sexual self-esteem [$F(10, 376) = 18.30$, $p < .001$, adjusted $R^2 = .31$]. Findings showed that higher levels of emotional well-being, [$F(1, 360) = 38.87$, $p < .001$, $\eta^2 = .10$], general health [$F(1, 360) = 14.12$, $p < .001$, $\eta^2 = .04$], age, [$F(3, 360) = 5.87$, $p = .02$, $\eta^2 = .02$], and race [$F(4, 360) = 2.40$, $p = .049$, $\eta^2 = .03$] positively influenced sexual self-esteem. Results also showed significant differences by race. Results indicated Black identified QWOC ($M = 146.94$, $SD = 31.17$), [$t(392) = -2.90$, $p = .004$, d = -.45] reported significantly higher levels of sexual self-esteem when compared to Asian QWOC ($M = 132.84$, $SD = 27.03$).

Sexual pride. Emotional well-being, general health, income, race, and survivor status accounted for roughly 16% of the variance in sexual pride [$F(16, 359) = 5.44$, $p < .001$, adjusted $R^2 = .16$]. Emotional well-being, [$F(1, 359) = 9.07$, $p = .003$, $\eta^2 = .02$], general health [$F(1, 359) = 7.32$, $p = .007$, $\eta^2 = .02$], income, [$F(3, 359) = 3.97$, $p = .008$, $\eta^2 = .03$], race [$F(4, 359) = 2.54$, $p = .039$, $\eta^2 = .03$], and survivor status positively influenced sexual pride. Post-hoc contrast analyses further revealed that significant differences only occurred when comparing sexual pride scores between Asian ($M = 1.65$, $SD = .98$) and Black ($M = 2.16$, $SD = 1.02$) QWOC, [$t(390) = -3.15$, $p = .002$, d = -.49], and Asian and Multiracial respondents ($M = 2.0$, $SD = 1.11$), [$t(390) = -2.23$, $p = .026$, d = -.33]. Results indicate that Black and Multiracial participants reported significantly higher sexual pride compared to Asian QWOC in this sample.

Sexual Shame. Logistic regression results showed that only emotional well-being significantly predicted sexual shame (*AOR* = .61, 95% *CI* = .46, .79, I < .001). No other predictors or covariates were significant.

DISCUSSION

The purpose of this study was to examine how self-rated health impacts sexual well-being among QWOC. The present study findings indicate high levels of sexual self-esteem across participants and highlight the importance of emotional well-being across all aspects of sexual well-being in this sample. QWOC remain largely ignored in sexual health research. This is one of the first studies to examine self-rated health and sexual well-being among this population. Findings from this study can promote more comprehensive and inclusive research and interventions to reduce sexual health inequities and improve sexual well-being among this marginalized population.

Average scores of self-rated emotional well-being and general health in this sample were lower than reported norms for the general adult U.S. population (Ware et al., 1993). These findings suggest that QWOC may perceive their mental and physical health as below average. Mean scores on self-reported emotional well-being were closer to that of clinical groups reporting depressive symptoms (Mchorney et al., 1993). This finding aligns with research that shows increased prevalence rates of depression in LGBTQ populations compared to cisgender and heterosexual groups (Bostwick et al., 2019; Russell & Fish, 2016). Psychosocial factors such as minority stress and sexual stigma contribute to worse mental health outcomes among multiply marginalized communities (Andersen & Hill Collins, 2013; Brooks, 1981; Calabrese et al., 2015; Meyer, 2010). Further evidence suggests that bisexual-identified women and QWOC report CSA at higher rates than their heterosexual counterparts and experience worse mental health outcomes

(Bochicchio et al., 2024; Chapman et al., 2004). These data underscore the elevated mental health challenges faced by QWOC, aligning with existing research on increased prevalence rates of depression and adverse childhood events.

Despite lower self-rated health scores, the sample exhibited moderately high levels of sexual self-esteem. Higher sexual self-esteem among QWOC may be influenced by various factors. Research suggests that more frequent oral sex is linked to higher sexual self-esteem in heterosexual individuals (Maas & Lefkowitz, 2015). The direction of the link between sexual self-esteem and oral sex is unknown and may be that higher sexual self-esteem increases the likelihood of giving or receiving oral sex. Similarly, among queer women, common sexual behaviors such as oral sex (Bailey, 2003) may enhance sexual self-esteem by fostering positive sexual experiences and relationship satisfaction. These behaviors may buffer against the negative impacts of lower emotional well-being. Additionally, supportive networks are vital for maintaining self-esteem among multiply marginalized individuals facing sexual stigma, such as sex workers living with HIV (Kalemi et al., 2017). Supportive environments promote resilience and identity development, helping individuals navigate systems of oppression (Legate et al., 2012). The interplay of engaging in pleasurable sexual behaviors and having robust support systems highlights the protective and sex-positive aspects of the queer community and sexuality, underscoring their importance in sustaining self-esteem despite marginalization.

Sexual Pride

Sexual pride was significantly and positively predicted by higher self-rated emotional well-being. Sexual pride is a self-evaluative emotion that may be protective and promote resilience in the face of identity based oppression (Herrick et al., 2014). General feelings of pride, described as having positive self-oriented beliefs, have been associated with emotional

strength (Güsewell & Ruch, 2012). Feelings of pride have also been correlated positively with perceptions of social support (Tracy & Robins, 2007). Social support systems and engaging in social activism may promote both pride and emotional well-being.

Greater self-rated general health also predicted greater sexual pride. It makes sense that rating one's health as excellent could predict a more positive self-assessment of one's sexual confidence and skills, resulting in higher overall sexual pride. Greater sexual pride has been associated with an increased number of sexual partners, casual sexual encounters, and condomless anal sex in gay and bisexual men (Rendina et al., 2019). While these behaviors are often labeled solely as risk factors, particularly for HIV, it is important to consider the pleasurable and social reasons that people engage in sex (Jones, 2019). The nuanced relationship between sexual behaviors and sexual pride emphasizes the complex interplay between health risks, health perceptions, and sexual identity. Understanding these dynamics can help in framing sexual health interventions that recognize both the risks and the positive aspects of sexual behavior. Overall, the findings highlight the need for a balanced perspective that incorporates the diverse motivations and outcomes associated with sexual pride and behavior.

Higher income predicted increased levels of sexual pride. Higher income may provide QWOC greater autonomy and access to empowering knowledge and resources that support increased comfort with their sexual desire and feelings. Income may provide better access to resources that empower feelings of sexual pride but may also expose individuals to discrimination. Some research suggests that QPOC faced increased experiences of discrimination with increased socioeconomic level (Shangani et al., 2020). Further, at higher levels of income, the impact of experiences of heterosexism had stronger associations with symptoms of depression compared to lower income QPOC (Sutter et al., 2018; Sutter & Perrin, 2016). More

research is needed to examine the dynamics between experiences of discrimination and heterosexism and sexual pride. An inverse relationship between finances and sexual satisfaction was shown among married heterosexual Black women such that higher income predicted lower sexual satisfaction (Henderson-King & Veroff, 1994). This suggests that socioeconomic factors play a multifaceted role in shaping sexual pride and well-being, necessitating further investigation into the diverse experiences of QWOC across different income levels.

Significant results also indicated self-identification as a survivor of CSA predicted sexual pride. The implications of these results should be considered carefully. First, it is important to consider how CSA was measured in this study. The childhood sexual abuse scale (Aalsma et al., 2002) requires an individual to identify a behavior as sexual, against their will, and/or as abusive before the age of 12. Adult survivors of CSA may struggle to recall past events or label them as harmful, particularly when perpetuated within a family or close-knit community (Fivush & Edwards, 2004; Gobin & Freyd, 2009). The ability to recognize and identify as a survivor of CSA implies an extent of healing and processing of the traumatic past. This healing process may support a shift in identity from victim to survivor. Self-identification as a survivor is associated with post-traumatic growth and positive mental and physical health recovery and outcomes (Delker et al., 2020). Further, secondary findings from a study of college survivors of sexual violence found that identifying as heterosexual increased negative sexual self-schemas and decreased sexual arousal compared to non-heterosexual individuals (Lipinski & Beck, 2022). These findings suggest that a queer sexual identity may buffer against the deleterious impact of sexual violence. In conclusion, the ability to self-identify as a CSA survivor appears to play a crucial role in sexual pride and recovery, with the buffering effects of a queer sexual identity further enhancing resilience and positive sexual self-concept

Greater sexual pride was also significantly associated with racial identity. More specifically, sexual pride was significantly higher among QWOC identifying as Black or Multiracial compared to Asian QWOC in this study. Little research exists examining sexual pride among QWOC. In a rare and important study of the experiences of individuals that identify as both bisexual and biracial, Galupo et al., (2019) found several strengths and positive experiences related to dual bi identities. While not focused specifically on sexual pride, the ability of multiracial QWOC to navigate multiple identities flexibly may contribute positively to their sexual self-concept and pride (Galupo et al., 2019). This flexible navigation likely enables them to draw on diverse cultural and personal resources, enhancing their overall sexual well-being. Therefore, understanding the interplay between racial identity and sexual pride can provide valuable insights into the unique experiences and strengths of QWOC, particularly those who are Black or Multiracial.

Sexual Self-Esteem

Higher sexual self-esteem was predicted by higher self-rated emotional well-being and general health. It makes sense that rating one's health as excellent and endorsing feelings of calm happiness could predict more positive self-assessment of one's attractiveness, skills, and sexual agency, aspects of sexual self-esteem. In this study, sexual self-esteem was measured as a total score by averaging responses across five subscales: Skill/Experience, Attractiveness, Control, Moral Judgment, and Adaptiveness with higher scores indicated higher sexual self-esteem. Self-rated health likely impacts these dimensions in different ways. Some processes may be related to individuals who rate their emotional and physical health better having more positive body image which in turn is related to sexual self-esteem regardless of objective measures such as body mass

index (Hannier et al., 2018). Or perhaps, better mental health supports a sense of control and agency over sexuality even when holding multiply marginalized identities.

There were also significant results for age and race. Sexual self-esteem increased with age and was significantly higher among QWOC identifying as Multiracial or Latine. These findings align with longitudinal research that has shown overall self-esteem to increase from adolescence through middle adulthood (Orth et al., 2018). Self-esteem then remains constant until declining around age 90 (Orth et al., 2018). Some evidence has revealed differential declines by race, suggesting that self-esteem declined faster in Black individuals when compared to White individuals (Shaw et al., 2010). Taken together, sexual self-esteem captures an individual's sense of self and self- perceived value as a sexual being and dynamically interacts with psychological and identity-based factors.

Sex Life Satisfaction

Results showed that changes in sex life satisfaction were significantly associated with emotional well-being and general health. This relationship highlights the interconnectedness of physical and mental health with sexual satisfaction. Individuals who report their overall health as very good or excellent are more likely to report increased interest in engaging in sex, as well as more frequent and satisfying sexual experiences (Lindau & Gavrilova, 2010). Additionally, better perceived health status was related to receiving and performing oral sex with the past 90 days for women regardless of age, relationship status, or sexual orientation (Herbenick et al., 2010). These findings suggest that engaging in sexual behaviors that are perceived as pleasurable and intimate can contribute positively to one's health perceptions. For QWOC, women, engaging in common sexual activities like oral sex (Bailey, 2003) may support positive sexual interactions and satisfying relationships resulting in greater satisfaction with one's sex life overall. These

behaviors may mitigate negative consequences of discrimination on overall emotional well-being.

Sexual Shame

Results showed that changes in sexual shame were significantly predicted by self-rated emotional well-being. It is unsurprising that better mental health is associated with lower feelings of sexual shame. This finding is aligned with a study of sexual minority men that indicated effects of sexual shame on compulsive sexual behavior were better explained by the relationship between sexual shame and emotional dysregulation (Cienfuegos-Szalay et al., 2022). Similarly, higher levels of internalized heterosexism and shame predicted worse symptoms of depression and anxiety among a study sample of sexual minority youth (Puckett et al., 2017).

Even at lower levels on average in this sample, self-rated emotional well-being was negatively associated with feelings of sexual shame. Holding all other variables constant, emotional well-being was the only significant factor that predicted sexual shame. Notably, self-identifying as a survivor of CSA was not significantly related to sexual shame. It may be that other cognitive and affective processes that promote resilience and positive self-schemas after traumatic events are buffering against expected negative health outcomes (Chivers-Wilson, 2006; Lipinski & Beck, 2022, 2022; Van Bruggen et al., 2006). Another study showed shame partially mediated the relationship between traumatic experiences and mental and physical health outcomes in an LGBTQ sample (Scheer et al., 2020).

Shame is an important concept to further understand given how this negative self-evaluation interacts with healing after traumatic events. These findings underscore the crucial role of mental health in influencing sexual well-being and highlight the need for interventions that prioritize emotional health to mitigate sexual shame.

Limitations and Future Directions

Although this is one of the first and only studies to examine self-rated health and sexual well-being among QWOC, it is not without limitations. First, this study was cross-sectional meaning that a causal direction between predictors and sexual well-being facets cannot be determined. The interaction between well-being and health are complex, not well understood, and likely bidirectional. The present study examined how self-rated health predicted sexual well-being. Future research is needed to look at the reverse direction of this relationship and identify how sex and sexual well-being impact health (Gianotten et al., 2021). To further a strengths-based and sex positive approach to sexual health, more attention needs to be paid to how sexuality positively impacts physical and mental health. Second, this study measured sexual well-being based on four self-reported measures of sexual self-esteem, sexual shame, sexual pride, and sex life satisfaction, none of which have been validated explicitly with QWOC populations. This limits sexual well-being to these dimensions potentially not covering all that defines the whole construct. With the lack of an agreed upon definition of sexual well-being, varying definitions and measurement hinder empirical progress toward truly understanding the phenomena. This study was one of the first to utilize these measures among QWOC adding important information about how QWOC internally value and experience sexual well-being. Third, mental and physical health were measured as self-rated perceptions rather than objective symptom or diagnostic assessments. While self-rated health has been associated with accurate predictions of mortality and health functioning, these findings will not generalize to clinical assessments. Fourth, this study sample was predominately young and educated and thus not necessarily generalizable to all QWOC. It is imperative that research examine sexual well-being

and health across the lifespan, particularly when considering the impacts of hormones, menopause, and overall aging on sexual functioning.

Future research is urgently needed to conduct longitudinal studies with diverse and representative samples of QWOC using a validated and comprehensive measure of sexual well-being. Longitudinal studies will help to illuminate the directionality of interactions between health and sexual well-being across the life span. More inclusive research samples with more representative samples of different age groups and education levels will support better generalizability of findings. Lastly, the field is in desperate need of a comprehensive multidimensional definition and measurement of sexual well-being. Future research should aim to achieve consensus on these constructs to facilitate empirical progress and a deeper understanding of how sexuality positively impacts physical and mental health.

Conclusion

The purpose of this study was to examine how health impacts sexual well-being among QWOC. Despite overall lower self-rated health scores from the overall sample compared to national norms, this sample demonstrated moderately high levels of sexual self-esteem. Self-rated emotional well-being was significantly predicative across all aspects of sexual well-being. These findings highlight the importance of considering the protective and sex-positive aspects of queer sexuality and the vital role of social support in sustaining self-esteem despite marginalization. This study highlights the complex interplay between health perceptions, sexual identity, and well-being, emphasizing the need for more inclusive and comprehensive research and interventions. Future studies should prioritize longitudinal designs, objective health assessments, and the development of a multidimensional definition of sexual well-being. Such efforts will facilitate a deeper understanding of how sexuality positively impacts physical and

mental health, ultimately aiding in reducing sexual health inequities and improving well-being among QWOC.

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STUDY II: STRUCTURAL IMPACTS ON SEXUAL WELL-BEING AMONG QUEER WOMEN OF COLOR

ABSTRACT

There remains a dearth of research focused on the sexual well-being of multiple marginalized groups. This study is the first to identify profiles of sexual well-being among queer women of color (QWOC) using a person-centered approach (latent profile analysis, LPA). Latent profiles were then examined in relation to structural determinants of sexual well-being, including region, state political majority, and neighborhood level poverty measures. The first aim was to examine subjective measures of sexual well-being, focusing on cognitive and affective dimensions of sexuality. Self-identified QWOC (n=397), aged 18 – 78 (M = 28.61, SD = 8.64), responded to an online confidential survey. Three latent profiles of sexual well-being emerged: low, moderate, and high. Most participants clustered within the moderate profile, with average scores across all measures of sexual satisfaction, pride, self-esteem, and shame. Higher levels of positive sexual well-being measures were associated with lower levels of sexual shame. These findings provide empirical evidence on how QWOC perceive and evaluate their sexuality, contributing to the limited research in this area. Income significantly predicted profile membership, aligning with existing research on the relationship between socioeconomic conditions and sexual well-being. Surprisingly, U.S. region also predicted profile membership, with over half of the high sexual well-being profile members residing in the South. Findings underscore the need for continued research on how structural determinants impact the sexual well-being of QWOC. Despite increased exposure to sexual violence and health disparities, QWOC can experience high levels of sexual well-being. This study highlights the importance of

examining both strengths and vulnerabilities within marginalized populations and calls for further research on structural factors influencing sexual well-being.

INTRODUCTION

Sexual well-being is a critical aspect of public health (Jones, 2019; Mitchell et al., 2021). The subjective assessment of the physical, cognitive, and affective experience of human sexuality, sexual well-being is important to overall health and quality of life. Similar to other aspects of health, sexual well-being is influenced by structural and sociocultural processes (Higgins et al., 2022).

Queer women of color (QWOC) are exposed to multiple layers of marginalization and discrimination based on their gender, sexuality, and race. Racism, heterosexism, and sexism are deeply embedded into the fabric of society shaping systems and policies that impact the environments in which we live. Marginalization and discrimination are powerful social determinants of health that impact health above and beyond genetic risk factors and healthcare access. Inclusion of how structural factors impact health are imperative to public health solutions for health equity (Braveman et al., 2011). Intersectionality theory is vital to understand how overlapping systems of power and oppression impact public health outcomes (Bowleg, 2021; Merz et al., 2021).

Unfortunately, research on sexual well-being is limited. Moreover, research questions and study samples are predominantly White, cisgender, and heterosexual. Little attention is paid to the intersection of gender, race, and sexuality. When marginalized populations are considered in sexual health research they are labeled as vulnerable populations associated with increased sexual risk. Little research exists examining how social determinants of health impact the sexual

well-being of QWOC. The present gap is limiting research and clinical understanding of the needs and strengths among QWOC.

Research consistently shows that QWOC experience increased rates of violence and more negative health outcomes compared to their white and heterosexual counterparts (Bostwick et al., 2019; Canan et al., 2021a, 2021b; McCauley et al., 2015; Walters et al., 2013). This increased exposure to violence causes negative health outcomes such as higher incident rates of sexually transmitted infections (STIs) (Holmes & Beach, 2020; Logie, 2015; Thoma et al., 2013) and unintended pregnancy (Tornello et al., 2014; Ybarra et al., 2021). Additionally, barriers to access and availability of affirming and competent healthcare at the intersection of multiple marginalized identities further impact sexual well-being (Gessner et al., 2020; Rice et al., 2019; Turpin et al., 2021). These findings illustrate significant challenges at the individual level that exacerbate sexual health inequities among QWOC.

Social determinants of sexual well-being

The geographic context where people live is one kind of social determinant of health. Regional or state-level policies around gender affirming care and reproductive health contribute to sexual health inequities particularly in states with excessive restrictions such as southern states in the U.S. (Guttmacher Institute, 2024; Human Rights Campaign, 2024). Other socio-cultural factors such as higher levels of religiosity and related attitudes toward marriage equality (Jelen, 2017; Wormald & Lipka, 2016) maintain discrimination and stigma that negatively impacts sexual well-being of QWOC in this region. Evidence suggests that in states with limited gender and sexuality based protections, sexual minority women have reported poorer self-rated health outcomes compared to heterosexual women (Gonzales & Ehrenfeld, 2018).

Sexual violence not only has immediate physical and psychological effects but also significantly impacts lifetime earnings. Survivors of sexual violence often face substantial barriers to educational and career attainment. Research shows that sexual violence can lead to decreased educational achievement, interrupted educational trajectories, and lower career aspirations, ultimately affecting lifetime earnings (Barrett & Kamiya, 2012; Loya, 2015). Survivors experience worse negative mental health issues, such as PTSD and depression, which can hinder academic performance and job retention attainment (Kearns & DiRienzo, 2023; Letourneau et al., 2018).

Healthcare services are one way to address the negative impacts of sexual violence. Sexual health services can vary wildly based on region or state to differently impact the sexual well-being of QWOC depending on where they live. Dominant beliefs informed by religion even at the structural level impacts policies and laws despite the U.S. proposing separation of church and state. This is seen explicitly in state level policies that prohibit or restrict abortion and other reproductive health necessities (Lorimer et al., 2019; Mitchell et al., 2023).

Income inequality is well established as a social determinant of overall health (Bor et al., 2017; Pickett & Wilkinson, 2015; Wilkinson & Pickett, 2006). The impacts on sexual well-being are no exception. Lower income levels and economic instability often correlate with reduced access to healthcare services, including sexual and reproductive health services, leading to poorer health outcomes. This economic disparity can exacerbate vulnerabilities to sexual violence and exploitation, particularly among marginalized groups.

The need for strengths-based approaches

Notably, the aforementioned evidence about social determinants of health is often reported in a negative risk framework. Deficit-based approaches are defined by their

conceptualization of a population or individuals in terms of their problems and limitations (Dinishak, 2016; G. P. Green & Haines, 2016). A deficit based framework contributes to pathologizing queer and racialized sexualities and ignores ways in which communities perceive their own health and well-being (Bryant et al., 2021). In terms of sexual well-being, a focus on risk conceptualizes QWOC solely by their deviance and disease risk. Research and subsequent public health policy and messaging impacts the beliefs of patients, providers, and researchers effectively upholding the oppressive systems that in turn contribute to the very health inequities sexual health research is investigating (Fahs & McClelland, 2016).

The integration of systems of power within sexual well-being could be taken further, particularly when considering resilience. Resilience is a term to describe a process or ability to adapt and overcome adversity (Bowleg et al., 2003; Goodkind et al., 2020; Masten, 2018). Dominant use of resilience in psychology and health literature tends to emphasize individual strengths, and thus, problematize failing as an individual deficit (Bryant et al., 2021; Dinishak, 2016; Goodkind et al., 2020). The mainstream use and application of resilience theory in clinical research can contribute to blaming individual behavior or choices for their subsequent health outcomes and ignoring the powerful sociocultural and political forces impeding the health of some and facilitating the health of others. Resilience is often measured by an individual's capacity to overcome adversity. This viewpoint overlooks community-based strengths and ways in which oppressed communities can be bolstered against oppression through collective resistance (Bryant et al., 2021; Goodkind et al., 2020). Structural level impacts must be explored to examine buffering or protective factors as well.

PRESENT STUDY

To that end, this study examined a multidimensional measure of sexual well-being among QWOC. Understanding the contextual factors created by systems of power and oppression that interact with health is imperative for health equity. Understanding sexual well-being among QWOC is vital for sexual health equity. This study aimed to 1) identify levels of sexual well-being among a sample of QWOC, and 2) examine how social determinants of health impacted their sexual well-being.

METHOD

Design. Toward these aims, I used data on perceived physical and mental health, as well as attitudes, beliefs, and experiences of sex and sexuality included in a larger online study. Online surveys have demonstrated their utility in reaching populations that are often underrepresented in research, particularly sexual and gender minorities (McInroy, 2016; Mustanski, 2001). While online research methods offer rapid distribution, cost-effectiveness, and targeted access to specific populations, they also pose significant risks to data integrity (Belliveau & Yakovenko, 2022; Griffin et al., 2022). To mitigate these risks in this study, Prolific was employed to ensure that data was collected from verified human participants. To register as a study participant on Prolific, you are required to verify your email address, phone number, identity (e.g., via driving license or state ID card), and complete an internal trial study**.** Research has shown that Prolific provides superior data quality compared to other online research platforms (Peer et al., 2021).

The survey was hosted exclusively on Prolific, requiring that participants access it through the platform and submit their unique Prolific ID numbers within the survey. The survey was then completed on Qualtrics, where additional internal data quality measures included a

Completely Automated Public Turing Test to tell Computers and Humans Apart (CAPTCHA), a common technique for preventing automated responses (Pickering & Blaszczynski, 2021; Teitcher et al., 2015; Watson et al., 2018). Qualtrics' internal systems further screened out duplicate IP addresses and flagged suspicious completion times. Furthermore, the first author manually reviewed attention checks, redundant questions, and survey completion times to ensure high-quality data beyond the automated measures (Newman et al., 2021; Teitcher et al., 2015). Qualitative responses were mandatory, with participants given the option to opt out by typing a specified word such as "tooth." Qualitative data was also screened for nonsensical responses (Kennedy et al., 2020; Teitcher et al., 2015). A total of three participants were removed from analyses because they identified racially as White only. This study was approved by the Institutional Review Board.

Participants. Participants were exclusively recruited from Prolific and the survey was only visible to Prolific participants who met the inclusion criteria (i.e., 18 years old and older, identify as LGBTQ, identify as women, identify as members of a non-white racial group, reside in the United States, and have a proficiency in written English). The study, advertised as a survey on the sexual and mental health of queer women of color, was only visible to participants who matched demographic filters based on their Prolific registration. Participants were also asked to reconfirm their LGBTQ identification and English fluency. Upon affirming their eligibility and agreeing to the informed consent, participants were invited to complete the survey. The survey data was conducted in March 2023, and participants were compensated $10 upon its completion.

Measures

Demographics. Participants self-reported their age in years, if they identified as a gender different from their sex assigned at birth (yes/no), race, personal income, and highest level of

completed education. Participants ranged in age from 18 - 78 with over half of the sample under the age of 30. Participants on average were 29 years old (*SD* = 8.64) and predominantly identified as cisgender (14% identified as a gender other than their gender assigned at birth). This sample of QWOC was 36% Multiracial, 27% Black, 18% Latine, 17% Asian, and 2% Indigenous/Native American. Most of the sample reported completing high school or less (46%) or a college degree (45%) with a small percentage reporting a graduate degree (9.3%). Almost half of the sample (46%) reported an annual personal income less than $10,000.

Sexual Well-Being. Sexual well-being was measured by four separate, but related dimensions represented by currently available and validated scales.

Sex Life Satisfaction. Subjective satisfaction with one's current sex life overall was measured by the five-item *Satisfaction with Sex Life Scale* (Neto, 2012). Items such as, "I am satisfied with my sex life" and "The conditions of my sex life are excellent," are rated on a scale of strongly disagree (1) to strongly agree (7). Total scores are averaged with a total possible mean score of 7 and higher scores indicate higher satisfaction. For this sample, Cronbach alpha was 0.94.

Sexual Self-esteem. How participants evaluated their sexuality was measured with total scores of the 35-item *Sexual Self-Esteem Inventory-Short Form* (SSEI-SF; (Zeanah & Schwarz, 1996). This multidimensional questionnaire encompasses five domains of subjective self-esteem related to sex and sexuality: Adaptiveness, Attractiveness, Control, Moral Judgement, and Skills/Experience. In the short form version, each subscale is seven items each. The skill/experience domain measures an individual's self-appraisal of their own sexual abilities and how they feel about their sexual experiences, for example, "I feel good about my ability to satisfy my sexual partner." The attractiveness subscale captures cognitions about their own body

and physical attractiveness as exemplified by, “I am pleased with my physical appearance” or the reverse scored item, “I would like to trade bodies with someone else.” The control subscale measures to what extent participants feel in control of their sexual behavior, thoughts, and feelings as captured by items such as, “I worry that things will get out of hand because I can't always tell what my partner wants in a sexual situation.” The moral judgment subscale measures how much an individual believes their sexual behaviors align with their morals. An example of a moral judgment item is, “I never feel guilty about my sexual feelings” or the reverse scored item, “I have punished myself for my sexual thoughts, feelings, and/or behaviors.” Lastly, the adaptiveness subscale refers to how much an individual feels that their sexual experiences contribute to their life or sense of self. An example of an adaptiveness is: “I like what I have learned about myself from my sexual experiences.” Responses ranged from strongly disagree (1) to strongly agree (6). A total scale score of the SSEI-SF was utilized by averaging subscale scores. Internal consistency was good in this sample ($\alpha = .94$).

Sexual shame and pride. Self conscious-emotions related to sexuality were measured by the *Sexual Shame and Pride Scale* (SSPS; Rendina et al., 2019). This measure consists of eight items measuring shame and measuring pride. Responses range from not at all true (0) to completely true (4). Examples of the items that measured shame include “I often feel embarrassed by the sexual activities I like” and “I tend to feel bad or dirty after sex.” Examples of the items that measured pride include “There are people with whom I regularly discuss my sex life” and “I am comfortable telling my partners what I want or need sexually.” Scores are calculated as average scores with higher scores indicating higher levels of either construct. Cronbach’s alpha for the shame and pride subscales in this sample were 0.88 and 0.91

respectively. This measure has established convergent and predictive validity (Rendina et al., 2019).

Neighborhood Level Income. Neighborhood level income was measured by the median home value and median household income at the zip code level. I utilized the R package 'zipcodeR' (Rozzi, 2021) which pulled 2020 data from the data.census.gov database to connect zip codes to federal census data.

U.S. Region. The U.S. Census Bureau categorizes census data into four geographical regions: South (Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia), West (Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming), Midwest (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin), and Northeast (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) (U.S. Census Bureau, n.d.). Participant's zip code data was utilized to identify a U.S. state, and states were categorized into one of the four U.S. census bureau defined regions.

Political Climate. The political climate in which a participant lives was measured at the state level. Zip code data was utilized to identify a U.S. state. States were coded as Democrat or Republican based on the number of votes for each political party in the 2020 presidential election as officially designated by the Federal Election Commission (Albers, 2020/2023; Federal Election Commission, 2020).

Statistical Analysis

Latent profile analysis (LPA) is a person-centered analytical approach utilized to uncover within group heterogeneity. Sub-profiles emerge based on similar scoring across several variables of interest. In this study, profiles emerged from four factors of sexual well-being. I conducted all analyses in R v4.3.2 (R Core Team, 2023). I conducted LPA to identify profiles based on sexual well-being using the tidyLPA R-Package (Rosenberg et al., 2018). All four measures of sexual well-being were scaled to have a mean of zero and a standard deviation of 1 to address differences in scoring and for ease of interpretation.

To determine the best fitting LPA model, several standard criteria were considered. Error prediction and model fit were assessed by Akaike's Information Criterion (AIC), Bayesian Information Criterion (BIC), and sample size–adjusted BIC (adjusted BIC) values. In each of these criteria, lower values are indicative of better fit. Next, I used significant p-values ($< .05$) from bootstrapped likelihood ratio tests (BLRTs) to determine whether the k profile model was a better fit compared to the k-1 profile model (Dziak et al., 2014; Tofighi & Enders, 2007). Additionally, I assessed the entropy of each model. Entropy indicates accuracy of profile membership, with values approaching 1.0 indicating better fit (Celeux & Soromenho, 1996). Finally, I assessed the interpretability of profile membership to identify the model with the best fit to the data (Hipson, 2019). Additionally, the distribution of individuals in each profile, distinctness between profiles, theoretical interpretability, and parsimony were used to select the best fitting model (Nylund et al., 2007; Spurk et al., 2020).

Finally, I utilized Kruskal-Wallis tests followed by Dunn’s tests with Bonferroni post hoc adjustments to examine how profiles differed based on the above mentioned measures of structural determinants of health (Dunn, 1964; Kruskal & Wallis, 1952).

RESULTS

Latent Profile Analysis Results

Due to different scoring scales across measures, all variables were z-score scaled before fitting. Results of the fit statistics of the LPA analysis are in Table 4. While the BIC, adjusted BIC, entropy, and BLRT indicated preference for a five-profile model, this produced profile groups that had too few participants (n = 18). I examined four and three profile models for interpretability. The four-profile model had preferable fit statistics compared to the three-profile model however, the four-profile model included groups that were too similar and difficult to interpret. Despite the five-profile model demonstrating the best statistical fit, the three-profile model was ultimately the most interpretable with satisfactory sample sizes for each group.

Table 4

Latent Profile Model Fit Statistics

Number of Profiles	Akaike Information Criterion (AIC)	Bayesian Information Criterion (BIC)	Sample Size Adjusted BIC	Log Likelihood	Integrated completed Likelihood (ICL)	Entropy	Bootstrapped likelihood ratio test p-value
1	4521	4553	4527	-2252	-4553	1	NA
2	4164	4216	4175	-2069	-4286	0.754	<0.01
3	**4062**	**4133**	**4076**	**-2013**	**-4246**	**0.753**	**<0.01**
4	4014	4105	4032	-1984	-4229	0.771	<0.01
5	3962	4073	3985	-1953	-4205	0.787	<0.01
6	3962	4094	3989	-1948	-4262	0.757	0.257

The three-profile model yielded clearly distinguished response patterns across sexual well-being measures as shown by Fig. 1. The mean scores and number of participants for each sexual well-being measure by profile are presented in Table 5.

The low sexual well-being profile (n = 94; 24%) was the smallest of the groups and included participants whose reported levels of sexual self-esteem were 1.3 SDs below the total

sample mean, sexual pride 1.0 SD below the sample mean, sexual shame 0.8 above the sample mean, and satisfaction with their sex lives 0.8 SD below the sample mean.

The moderate sexual well-being (n = 179; 45%) was the largest of the groups and included participants reporting levels of sexual self-esteem around the sample mean, sexual pride 0.2 SD below the sample mean, sexual shame 0.2 SD below the sample mean, and satisfaction with their sex lives around the sample mean.

The high sexual well-being profile (n = 124; 31%) included reported levels of sexual self-esteem 1.0 SD above the sample mean, sexual pride 1.0 SD above the sample mean, sexual shame 1.0 SD below the sample mean, and satisfaction with their sex lives at 0.9 SD above the sample mean. Demographic characteristics of each profile are presented in Table 6.

Figure 1

Z-scores of Sexual Well-Being by Latent Profile

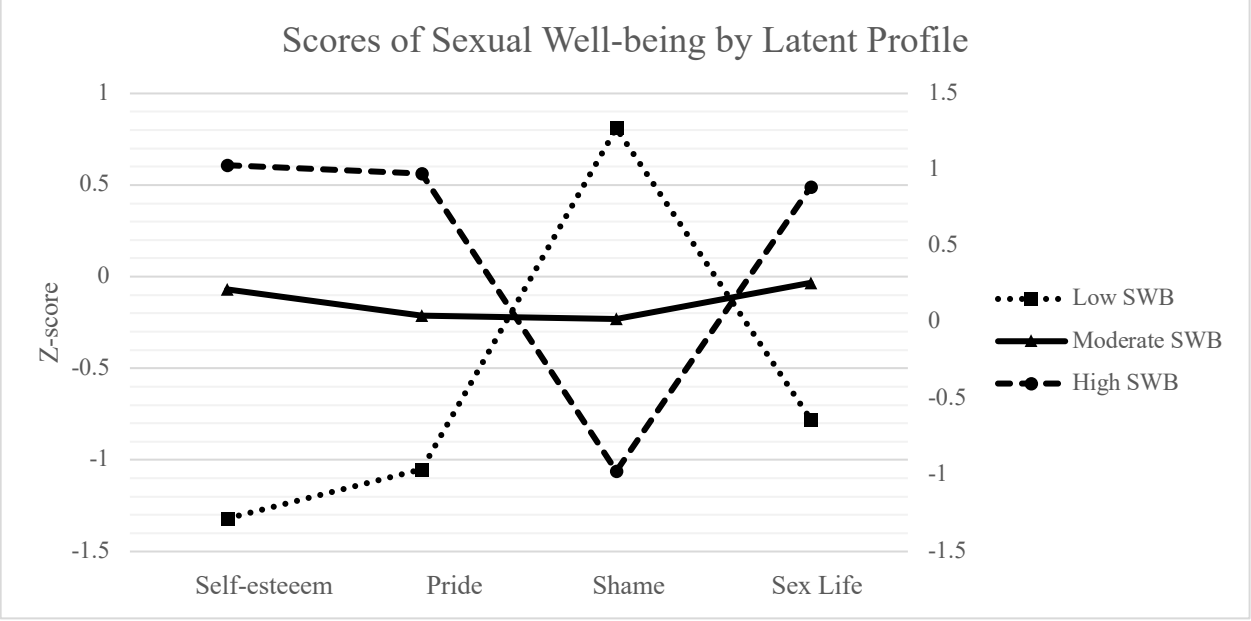


Table 5

Statistics of sexual well-being dependent upon membership in the 3-profile solution

Profile	*n*	Sexual Self-Esteem		Satisfaction with Sex Life		Pride		Shame	
		M	*SD*	*M*	*SD*	M	*SD*	M	*SD*
Lo	94	2.84	0.48	2.79	1.40	0.99	0.74	1.65	0.90
Mod	179	3.98	0.44	3.80	1.56	1.74	0.74	0.76	0.63
Hi	124	4.96	0.46	5.39	1.28	3.05	0.62	0.28	0.53

Table 6

Profile Descriptive Characteristics

Characteristic	**Low SWB**, *n* = 94[1]	**Moderate SWB**, *n* = 179[1]	**High** SWB, *n* = 124[1]
Age	25.95 (6.22)	28.64 (8.52)	30.60 (9.83
Transgender	17 (19%)	22 (13%)	16 (13%)
Race			
Asian	19 (20%)	38 (21%)	11 (8.9%)
Black	18 (19%)	49 (27%)	40 (32%)
Latine	13 (14%)	35 (20%)	22 (18%)
Multiracial	40 (43%)	54 (30%)	50 (40%)
Native/Indigenous	4 (4.3%)	3 (1.7%)	1 (0.8%)
Education			
High School or Less	49 (52%)	82 (46%)	52 (42%)
College Degree	37 (39%)	81 (45%)	59 (48%)
Graduate Degree	8 (8.5%)	16 (8.9%)	13 (10%)
Income			
≤ $9,999	61 (66%)	79 (45%)	38 (31%)
$20,000-$39,999	19 (21%)	38 (22%)	24 (20%)
$40,000-$59,000	8 (8.7%)	20 (11%)	27 (22%)
≥ $60,000	4 (4.3%)	37 (21%)	32 (26%)
Region			
South	37 (41%)	75 (44%)	66 (57%)
West	25 (28%)	51 (30%)	25 (22%)
Midwest	15 (17%)	22 (13%)	17 (15%)
Northeast	13 (14%)	21 (12%)	7 (6.1%)

[1] Mean (*SD*); *n* (%)

Indicators of profile membership

I used Kruskal-Wallis tests to analyze how profile membership was associated with structural level factors. Statistically significant Kruskal-Wallis test results were followed by pairwise comparisons using Dunn's test with Bonferroni adjustment to determine which groups differed from one another.

Income level was significantly different across the three sexual well-being profiles, χ^2 (2, n = 397) = 33.2, p < .0001 as seen in Fig. 2. Membership in the high sexual well-being profile was associated with higher income. Post-hoc pairwise comparisons using Dunn's test with a Bonferroni adjustment indicated personal income were significantly different between the low and moderate groups (p < .001), the low and high groups (p < .0001), and the moderate and high groups (p = .028). Each level of sexual well-being was significantly predicted by income, with higher income predicting higher sexual well-being. There were also significant differences in region of residence across the three sexual well-being profiles χ^2 (2, ˆ = 397) = 6.79, p = .033 as seen in Fig. 3. Members in the high sexual well-being profile were more likely to live in the South. Post-hoc pairwise comparisons using Dunn's Test with a Bonferroni adjustment indicated region of residence was significantly different between the low and high SWB profiles (p = .044), but not between the low and moderate (p = 1.0) or moderate and high (p = .127) profiles.

Figure 2

Ratio of profiles by income category

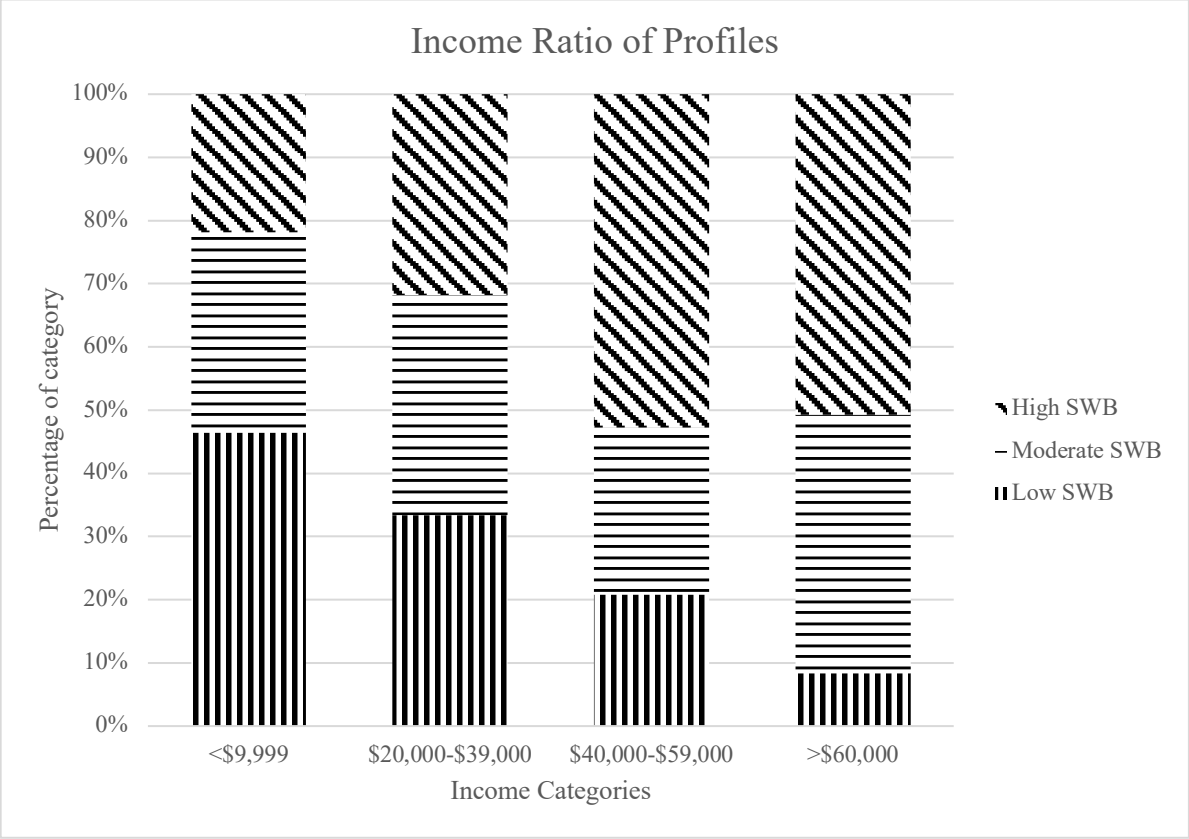
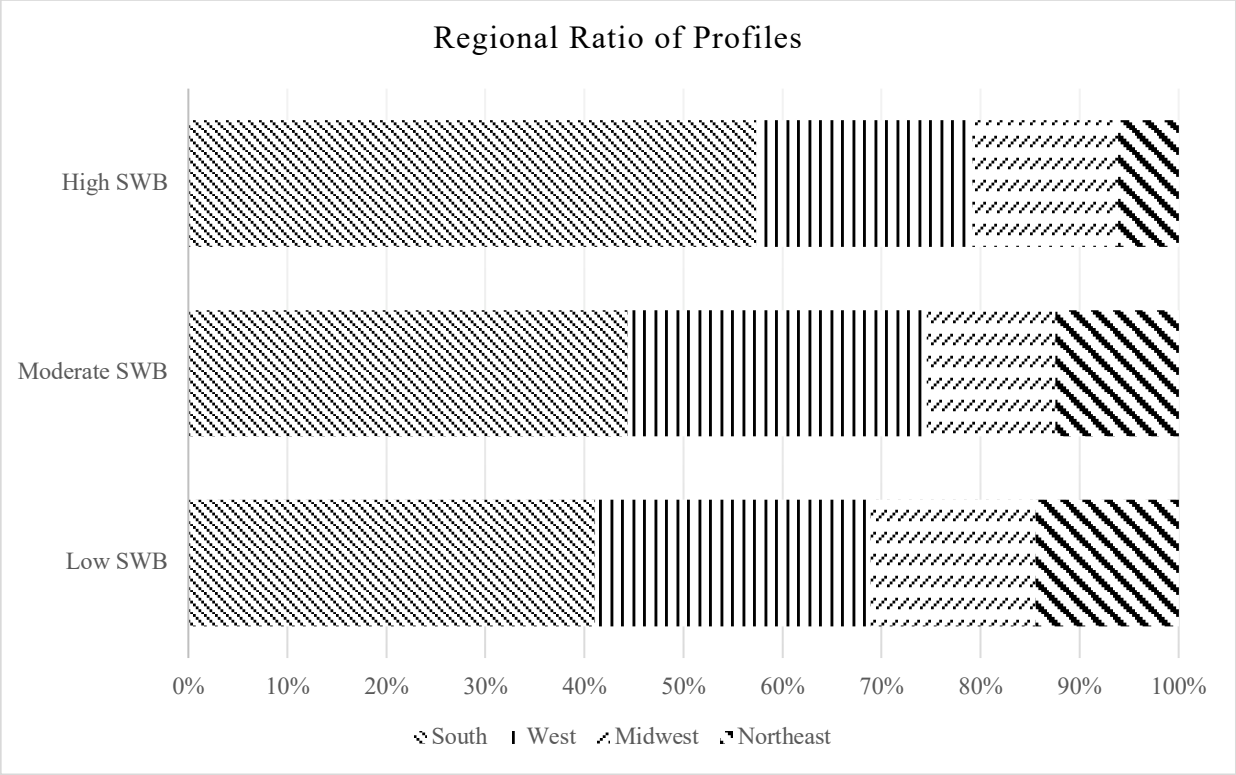


Figure 3

Ratio of profiles by region of residence



There was no significant effect of profile membership on state political climate (χ^2 (2, n = 397) = 3.07, p = .216), median home value (χ^2 (2, n = 397) = .382, p = .826), or median household income (χ^2 (2, n = 397) = 2.82, p = .244).

DISCUSSION

This study is the first to identify profiles of sexual well-being among QWOC. Using a person-centered approach (LPA), I explored how profile membership was associated with structural determinants of sexual well-being i.e., U.S. region, state political majority, and local median household income and home value. This study examined a multidimensional measure of sexual well-being and used a person-centered approach to deepen the understanding of

contextual factors created by systems of power and oppression that interact with health. QWOC are a population that has received little attention in the existing literature thus far and their inclusion is imperative for health equity.

The first aim of this study was to examine subjective measures of sexual well-being and determine how cognitive and affective measures of sexuality and sexual experiences coalesce in a sample of QWOC. Based on the measures utilized, the sample as a whole reported average sexual self-esteem (M = 4.01, SD = .90), above average levels of satisfaction with sex life (M = 4.06, SD = 1.74), average levels of sexual pride (M = 1.97, SD = 1.05), and below average levels of sexual shame (M = .82, SD = .84). There is little to no research examining these facets of sexuality among QWOC. These findings offer empirical evidence of how QWOC perceive and evaluate their own sexuality. These findings add empirical data to current research findings that are ambiguous and often compare queer sexualities to heterosexual samples. In these comparison studies, research is mixed on whether there are disparate levels of sexual functioning and satisfaction based on sexual orientation or behavior (Björkenstam et al., 2020; Flynn et al., 2017; Henderson, 2014; Lorenz, 2019).

I identified three latent profiles that distinguished between subgroups of participants based on their sexual well-being. Most participants belonged to the moderate sexual well-being profile, those who showed moderate levels across all four factors of sexual well-being. Overall, measures of sex life satisfaction, sexual pride, sexual self-esteem, and sexual shame clustered together indicating that higher levels of one positive measure of sexual well-being were associated with higher levels of other positive measures. Conversely, higher measures in positive sexual well-being clustered with lower levels of negative sexual well-being measure (i.e., sexual shame).

Identifying latent profiles reveals heterogeneity within a sample that is most often generalized as a homogenous group and compared to white, cisgender, and heterosexual peers (Bauer et al., 2022; Vigil et al., 2023). Person centered analyses allowed the data to reveal how participants might cluster together rather than researchers applying arbitrary distinctions of groups by race, ethnicity, or gender. This sample of QWOC represent a diverse group that clustered into three distinct profiles of low, moderate, and high sexual well-being. These findings promote measurement of a person's experience rather than assuming a singular experience based on identity(s).

The results of the LPA in this sample demonstrate QWOC can and do experience high levels of sexual well-being as measured by a balance of sexual self-esteem, pride, shame, and satisfaction with their sex lives. The increased exposure to sexual violence (Bostwick et al., 2019; Crump & Byers, 2017; Flanders et al., 2019; McCauley et al., 2015; Walters et al., 2013), higher incidence rates of STIs (Holmes & Beach, 2020; Logie, 2015; Thoma et al., 2013) and reproductive health risks (Tornello et al., 2014; Ybarra et al., 2021) faced by LBQ women compared to heterosexual women is well documented. Research on sexual violence and disease prevention are important aspects of creating solutions for gender and health equity and more research is needed on the structural aspects that create and maintain these inequities. Health inequity solutions will not be found at the individual level. Continued research that elucidates how interlocking systems of power, privilege and oppression are needed to create the solutions for the aforementioned sexual health inequities (Romanelli & Hudson, 2017; Vigil et al., 2023).

Given the lack of research on sexual well-being in racially and sexually marginalized populations, these findings demonstrate how cognitive and affective aspects of sex and sexuality contribute to sexual well-being. The three-profile model clearly demonstrated that the four

separate measures of sexual well-being (sexual self-esteem, sexual pride, sexual shame, and satisfaction with sex life) clustered together into meaningful profiles. Unsurprisingly, negative appraisals or shame around sex and sexuality was associated with lower levels of satisfaction with one's sex life and lower levels of self-esteem. The low and high sexual well-being profiles were inversely related showing a clear relationship between these measures.

The second aim of this study was to examine how structural determinants of health might impact the sexual well-being of QWOC. In this sample, income was significantly predictive across all three profiles of sexual well-being. This finding aligns with other research based in predominately White, cisgender, and heterosexual samples that have significant correlations between socioeconomic conditions and financial stress and sexual well-being (Higgins et al., 2022; Hill et al., 2017; Ji & Norling, 2004; Wikle et al., 2021). In this sample, higher income predicted membership into the high sexual well-being profile. For sexually and racially marginalized women, higher income may allow for better access to care, particularly in a multi-payer mixed healthcare system such as in the U.S. where you can pay for higher quality care. Higher income has been associated with increased likelihood of having health insurance, a decreased burden of healthcare costs and better sexual health outcomes in LGBTQ populations (Green et al., 2022). Increased access to resources related to sexual health likely impacts overall sexual well-being, particularly in this healthy, younger sample.

It is important to note that in the U.S., there is no amount of income or education that is completely protective from systemic oppression and harm. For example, one of the biggest health inequity gaps is consistently between Black and White reproductive complications and birth outcomes (Hoyert, 2023). State level research on birth data from California exposed that Black people giving birth at the highest level of their income distribution had worse birth

outcomes than White families at the lowest income bracket (Kennedy-Moulton et al., 2022). New York City rates of severe maternal morbidity revealed Black birthers in New York City were three times more likely to face severe maternal morbidity rates than non-Hispanic White birthers even when controlling for education, neighborhood poverty, and pre-pregnancy obesity (Angley et al., 2016). Notably, Black patients with a college degree actually had higher morbidity rates compared to those who never graduated high school of any other race (Angley et al., 2016). A patient's income alone does not change the paucity of training in LGBTQ health (Caceres et al., 2020; Committee on Understanding the Well-Being of Sexual and Gender Diverse Populations et al., 2020; Davidge-Pitts et al., 2017; Yu et al., 2023) or persistent implicit biases of clinicians (Burke et al., 2015; Khan et al., 2008; Maina et al., 2018; McDowell et al., 2020) within the U.S. healthcare systems.

U.S. region significantly predicted profile membership, but in potentially surprising ways. In this sample, over half of the high sexual well-being profile lived in the southern region of the U.S. The South holds most states that have refused Medicaid expansion (KFF, 2024). Without Medicaid expansion, individuals that fall between income requirements for Medicaid and the Affordable Care Act are left uninsured. After Roe V. Wade was overturned in 2022, many states enacted their own abortion policies, the most restrictive were predominately in the South (Guttmacher Institute, 2024). None of the southern states (exceptions include: Delaware, Maryland, and Virginia) have laws that protect LGBTQ individuals from discrimination (Movement Advancement Project, 2024). In every other state in the South, a person could be terminated from employment, denied a bank loan, or refused service in a restaurant or doctor's office on the bases of their sexual orientation or gender identity. The findings that show the majority of the high sexual well-being profile to live in the South is surprising considering the

state-level restrictions around accessible healthcare, reproductive health, and protection against discrimination in the South (Guttmacher Institute, 2024; Human Rights Campaign, 2024).

On the other hand, 58% of the U.S. Black population lives in the south (Frey, 2019). The state of Texas, the southern state where a majority of this sample was most likely to live, is 40% Hispanic according to the 2020 census (U.S. Census Bureau, 2020). Living in predominately Black or Latine neighborhoods might buffer against broader state level policies. In the north or west regions of the U.S. there may be more liberal policies and cultural norms that translate to LGB enclaves and community but that are majority White. Pervasive White supremacy within queer spaces (Lanzerotti et al., 2002; Logie & Rwigema, 2014), organizations that aim to serve multiply marginalized communities (Christensen et al., 2023), and pride parade events are well documented (Smith, 2020). Perhaps the higher POC populations in the South offer greater likelihood of communities that are both POC and LGBTQ so that QWOC have more opportunities for spaces that share all of their identities. National statistics suggest that one in three LBTQ adults live in the South, more than any other U.S. region (Movement Advancement Project, 2020). High centrality of both racial and sexual identities has been associated with better mental well-being in QPOC (Oyarvide Tuthill, 2021).

Interestingly, the state level political majority was not predictive of sexual well-being profiles among this sample. This is surprising due to mainstream Republican political party stances on reproductive health, marriage equality, and gender affirming care. This may partially be explained by the young age of this study sample (M = 28.61, SD = 8.64), which is around the median age of women in different-sex marriages but younger than the median age of 31 for women in “same-sex” marriages (Payne & Manning, 2021). This sample is also younger than the most recent statistics around U.S. fertility rates indicating the median age of giving birth is now

30 (Morse, 2022). Younger age may be associated with being less likely to be concerned about marriage or starting a family and thus being less impacted by state policies impacting reproductive health or marriage equality. This sample may also not be engaging in sexual behaviors that could result in pregnancy (i.e. depending on activity and/or gender of sexual partners) making state politics around reproductive injustice namely, abortion bans, not as impactful or salient for them personally. Even so, we would expect the lack of state level protections against LGBTQ discrimination and religious rhetoric tied to negative attitudes around marriage equality to have adverse impacts on mental and sexual well-being (Jelen, 2017; Wormald & Lipka, 2016).

Surprisingly, the relationships between sexual well-being and median household income and home value were also not significant. These findings are surprising given past research on sexual health risk and neighborhood level measures of income or poverty. Sexual health research investigating structural level factors have shown associations between neighborhood disadvantage (e.g., most often measured as low income), younger sexual onset and increased likelihood of pregnancy among adolescents (Cubbin et al., 2005; Decker et al., 2021). It may be that younger sexual onset does not necessarily translate to poorer subjective sexual well-being later in adulthood. Age of sexual onset is unknown in this sample; however, a majority of the sample did report lower income level. In the realm of LGBTQ health, most neighborhood level studies focus on increased incidence of HIV among MSM (Brawner et al., 2022; Frye et al., 2017).

However, while public health researchers label sexually active adolescents and MSM having condomless sex as negative health risks, they largely ignore other, potentially affirming, reasons why people engage in sexual behavior. Subjective measures allow for the participants to

report their affective or cognitive reactions to their own experience. The current study measured subjective sexual well-being as an important outcome for well-being overall, which also allows participants to articulate if and how the median income of their zip code may or may not impact their sense of sexual well-being.

Limitations and Future Directions

Despite being one of the first studies to use a person-centered approach to examine sexual well-being among QWOC, this study is not without limitations. As a cross-sectional study, data is limited to one point in time and thus cannot be causal. Additionally, sexual well-being is likely dynamic across the lifespan (Sladden et al., 2021) and future longitudinal studies are needed. Despite the relatively young age of the majority of the sample in this study, data trends showed that sexual well-being increased with age. The data was also all self-report measures. Although self-report measures allow for examination of an individual's internal state or perceptions of their own experience, it is potentially limited by social desirability bias or memory constraints. The present sample may also over represent individuals with sex positive attitudes due to self-selection bias toward responding to a sexual well-being survey (Strassberg & Lowe, 1995). There is an urgent need for future sex-positive research particularly to see how sexual well-being continues to change with age, longer term queer relationships, reproductive experiences, and hormonal changes across the lifespan.

The measures of structural determinants of health were limited to zip code data in this study and warrant expansion to effectively understand the impact on the lives of QWOC. Additional systems of oppression that may be impactful and should be included in future studies (e.g., measures of food insecurity, neighborhood level violence, systemic racism measured by Black/White incarceration ratios, racial segregation, and graduation rates are structural

determinants of health in the U.S.). Health equity depends on research that can better understand the roles of structural oppression and systems-level impacts on health and sexual well-being in particular. Further, data based on zip codes might establish artificial neighborhood boundaries and are unlikely to reflect the complete spectrum of the self-identified local contexts and social dynamics present in those areas (Decker et al., 2018).

Conclusion

Little is known about the sexual well-being of QWOC. While research suggests this population is systematically exposed to greater incidences of violence and negative health outcomes, there is a lack of understanding of positive, strength-based aspects of queer and racialized sexuality. This study identified three latent profiles of QWOC classified as low, moderate and high sexual well-being. Income and region of residence significantly predicted profile membership, with those with higher incomes and those living in the south experiencing the highest levels of sexual well-being. These results highlight the importance of examining how structural factors support or hinder sexual wellness. This study highlights the need for additional studies examining neighborhood level impacts on sexual well-being among multiply marginalized groups. Specifically, more strengths-based and qualitative research is needed to understand the protective and beneficial aspects of sexuality.

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STUDY III: *PLEASURE, JOY, AND TRUST*: SEXUAL WELL-BEING IN THEIR OWN WORDS

ABSTRACT

Sexual well-being is emerging as a vital dimension of public health. Overlapping but distinct from sexual health, sexual well-being expands on sexual function and behavior to incorporate aspects of sex and sexuality that are positive, pleasurable, relational, and psychological. Sexual pleasure is important to understand due to the vital role it plays in determining sexual behavior, a critical health behavior. Sexual well-being has been defined in various and sometimes conflictual ways creating a challenge in its measurement, assessment, and intervention. This study informs a definition of sexual well-being by adding in-depth qualitative data from racialized and sexually marginalized women on how they define their own sexual well-being. The present study examined qualitative data from a larger online study on sexual well-being among queer women of color (QWOC). The open-ended response from one item asking, "what does sexual well-being mean to you?" was analyzed using inductive content analysis. Responses (n = 346) revealed a multifaceted concept involving three overall themes, 1) physical health and safety, 2) comfort, and 3) positivity. Clinical implications include how sexual well-being can be conceptualized and understood within and across multiply marginalized populations.

INTRODUCTION

Sexual well-being is emerging as a vital aspect of public health. Sexual well-being is related but distinct from sexual health and expands beyond sexual function and behavior to incorporate aspects of sex and sexuality that are positive, pleasurable, relational, and psychological. The definition of sexual well-being has been defined in various and sometimes conflictual ways creating a challenge in its measurement, assessment, and intervention. This study adds empirical evidence toward operationalizing a definition of sexual well-being by adding an in-depth understanding of the lived experiences of how racialized and sexually marginalized women might define sexual well-being.

Sexual well-being is a global public health priority. Since 1975, the World Health Organization (World Health Organization, 2006) has brought together a group of interdisciplinary scholars to define sexuality and sexual health as a part of their process to develop shared definitions in service of realizing global health related priorities and goals. Their latest working definition of sexual health is defined as:

> "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006, p. 5).

This holistic definition of sexual health broadly encompasses the physical, emotional, mental, and social aspects of sexual behavior and emphasizes pleasure and positive well-being. The WHO emphasizes that sexual health is defined as more than the absence of disease or

dysfunction yet, the present state of sexual health research is largely disease and deficit focused (C. L. Ford et al., 2019).

Defining Sexual Well-being

Sexual well-being is a distinct yet related concept with conceptual roots in general well-being. The social sciences have worked to describe the phenomenon of "being well" and articulate the human experience beyond simply the absence of illness or disease. Despite 30 years of empirical and theoretical research, there is no scientific consensus on an agreed upon operationalized definition of well-being (Magyar & Keyes, 2019). The two leading perspectives on the study of well-being are hedonic and eudaimonic frameworks. Hedonic approaches focus broadly on measures of pleasure and happiness as measured by an individual's balance of positive and negative affect and life satisfaction (Bradburn, 1969; Kahneman et al., 1999). Eudaimonic approaches measure well-being by factors of external functioning and cognitive appraisals of self-actualization (Ryff & Keyes, 1995; Waterman, 1993). These two approaches are often contrasted against each other as one defining well-being as an individual's subjective perspective of their own experience based on internal factors (hedonic) while the other defines well-being as distinct from happiness and defined by self-actualization (eudaimonic). Given the complexity of the phenomenon, it is likely that well-being is a multidimensional concept that involves both eudaimonic and hedonic factors (Ryan & Deci, 2001).

Well-being is a broad and multidimensional concept that despite centuries of research still lacks a clear and practical definition (Jarden & Roache, 2023). It is challenging to assess a concept that is unclear or undefined. Given the available frameworks of well-being we can extrapolate to understand sexual well-being as a similar concept. In a parallel process to the research debates around well-being, sexual well-being reasonably involves multiple facets such

as sexual satisfaction, sexual dysfunction, and a balance between positive and negative beliefs and experiences of sex and sexuality. Similarly to well-being, sexual well-being lacks an agreed upon definition. This paper will first review the available definitions of sexual well-being and identify common indicators across conceptualizations.

In a 2010 meeting of the WHO, members attempted to define sexual well-being and ultimately decided that more research is needed to identify the appropriate "culture- and context specific" indicators related to well-being (World Health Organization, 2010). Provisionally, the WHO report indicated that, sexual well-being could include measurement broadly of "self-perceived sexual health", involving factors such as comfort and satisfaction with sexuality and identity as well as perceived abilities to maintain or improve one's sexual health. Sexual well-being involves capturing the subjective balance between positive and negative elements of sexuality such as satisfaction and experiences of discrimination or violence (World Health Organization, 2010).

The 2014 edition of the American Psychological Association (APA) Handbook of Sexuality and Psychology (Tolman et al., 2014) published a chapter on sexual well-being defining the concept based primarily in terms of subjective sexual satisfaction (Byers & Rehman, 2014; Lawrance & Byers, 1995). Lawrance and Byers (1995) define subjective sexual satisfaction as the subjective evaluation of one's sexuality, sexual functioning, response, frequency of sexual activity, and satisfaction with sexual partner(s). This concept of sexual well-being acknowledges the significant impact of romantic and sexual relationship dynamics and the interaction of both individual and dyadic factors contributing to sexual well-being above and beyond the characteristics of the individual alone (Byers & Rehman, 2014; Lawrance & Byers, 1995).

A literature review by Lorimer and colleagues (2019) examined publications that focused on sexual well-being to determine how the term is being defined. Their review found that out of 162 published articles that utilized the term sexual well-being, only 10 offered an explicit definition, or operationalized the concept of sexual well-being (Lorimer et al., 2019). Further, they found many studies utilized the term sexual well-being when only looking at one facet such as sexual satisfaction or sexual function and used the terms interchangeably (i.e., sexual well-being as sexual satisfaction). Of the 10 studies that included any definition of sexual well-being, 59 dimensions were identified and categorized into three main dimensions, individual cognitive-affect, interpersonal, and socio-cultural (Lorimer et al., 2019). Their review confirmed a continued lack of consensus around a definition and offered an overall definition of sexual well-being as all three of the aforementioned categories with the addition of an individual's ability or freedom to achieve well-being (Lorimer et al., 2019).

In another narrative review of the literature, Higgins and colleagues (2022) examined research addressing the impact of socioeconomic inequity on sexual well-being. The authors defined sexual well-being as physically and psychologically positive sexual experiences that "intersect with other key elements of sexuality" (Higgins et al., 2022). Unlike in the Lorimer et al., (2019) rapid review, Higgins et al., (2022) utilized a broad array of search terms to capture articles under the umbrella of sexual well-being and found that most of the studies focused on subjective views of one's sexual functioning and satisfaction (Higgins et al., 2022). The different language used to describe between these two studies reflects the ambiguity of the field for an agreed upon definition and measurement of sexual well-being.

Sundgren and colleagues (2022) published a review evaluating the existence of any quantitative psychometric assessments of sexual well-being. Their review included 88 studies of

which less than half (31%, *n* = 28) included an explicit definition of sexual well-being (Sundgren et al., 2022). The earliest measure was from 1979 and the authors noted that most quantitative measures were not theoretically grounded (Sundgren et al., 2022). Overall, the measures identified by Sundgren et al. (2022) included a total of 29 of the 59 dimensions proposed in the Lorimer et al., (2019) rapid review. Despite the range of dimensions included across studies, the majority of measures were still heavily focused on sexual function and satisfaction (Sundgren et al., 2022). Notably, only two of the included articles sampled lesbian, gay, bisexual, queer (LGBQ) or transgender or nonbinary (TNB) participants (Sundgren et al., 2022).

Finally answering the decades-long call to create a measure of sexual well-being, researchers from the United Kingdom (UK) developed such a measure for inclusion in a national survey on sexual attitudes and lifestyle (NASTAL; Mitchell et al., 2021, 2023). Mitchell et al., (2023) developed a quantitative measure of sexual well-being through rigorous conceptual work, qualitative research, cognitive interviews, workshops, and online testing. After multiple online tests and retests, confirmatory factor analysis finalized a 13-item measure that captures seven domains: sexual safety and security, sexual respect, sexual self-esteem, sexual resilience, sexual forgiveness, sexual self-determination, and sexual comfort (Mitchell et al., 2023). Ultimately, Mitchell et al., (2023) defined sexual well-being as: "sexual emotions and cognitions which include feeling safe, respected, comfortable, confident, autonomous, secure, and able to work through change, challenges, and past traumas."

Across these diverse definitions of sexual well-being, a few commonalities exist across concepts. Multiple dimensions of sexuality are implicated, with most current conceptualizations acknowledging the subjective nature of cognitive and affective aspects of sexuality and sexual experiences. An important motivation for engaging in sexual behavior, pleasure and satisfaction,

are also incorporated across conceptualizations of sexual well-being. Additionally, many definitions allude to the interconnection of social context, such as poverty, gender, disability, or relationship structure with sexual well-being (Higgins et al., 2022; Lorimer et al., 2019).

Importantly, none of the available definitions of sexual well-being were developed with a focus on marginalized sexualities. Definitions that relied mostly on subjective sexual satisfaction (Lawrance & Byers, 1995) were originally developed for heterosexual couples. The development of a comprehensive, quantitative measure of sexual well-being is a positive step toward the effective inclusion of sexuality as a vital aspect of public health research. While the Mitchell et al., (2023) measure included non-heterosexual individuals, the relatively small representation of non-heterosexual identities led to categories being collapsed or omitted from analysis in the development and validation of their sexual well-being scale. Existing definitions of sexual well-being lack explicit input from marginalized sexualities.

A small study of Mitchell and colleague's short version sexual well-being scale was found to have good psychometric properties in a sample of transgender adults ($N = 111$, trans-women $n = 22$) in Poland although the authors mention limitations that prevent full validation and a need for further study (Gerymski, 2020). The Polish sample of women was comparatively small, a barrier to generalizability. Additionally, they did not indicate the inclusion of participants that identified as non-binary or other genders than man/woman. Emerging research suggests nuanced similarities and differences between body perceptions and sexual well-being between binary and non-binary transgender individuals (Kennis et al., 2022) that warrant further study and inclusion of racially marginalized trans people.

Sexual well-being is underexplored in sexually and racially marginalized groups. Plurisexual (i.e., bisexual sexual orientation or sex behaviors with more than one gender) women

are more likely to report experiencing interpersonal violence (IPV), lifetime incidence of sexually transmitted infections (STI), and unintended pregnancy (Flanders et al., 2019; McCauley et al., 2015; Walters et al., 2013). Population level sexual health inequities reveal disparate incident rates of HIV and other STIs among Black and Latinx women compared to White women in the United States (U.S.) (Centers of Disease Control and Prevention, 2019). It is imperative that sexual health research consider multiply marginalized identities and the impact of intersectional oppression on health and well-being. The lack of an operationalized definition for sexual well-being is a barrier to further studying, measuring, and creating interventions to actualize this important aspect of sexual health.

PRESENT STUDY

The purpose of this study is to address a significant gap in the sexual well-being literature by highlighting the perspectives of sexually and racially marginalized women (queer women of color; QWOC). I use the term queer as an umbrella term to describe fluid sexualities and genders (Morandini et al., 2017), acknowledging that the term "queer" has been reclaimed as empowering by some but not all of the community. The term is still used derogatorily by outgroup members. Queer is a term that can be used to defy categorization and encompass a diversity of dynamic sexualities that are systematically marginalized because of their resistance to heteronormativity, monosexuality, and binary gender constructs (Callis, 2014; Kolker et al., 2020; Worthen, 2023). Additionally, queer is an identity label of choice for this author.

Prior to beginning analysis, the research team positionality was considered. The research team consisted of five individuals, a doctoral candidate who identifies as a Black mixed-race queer cisgender woman, and four undergraduate research assistants who identified as a White, queer cisgender woman, an Asian mixed-race heterosexual cisgender woman, a White, queer

nonbinary person, and a Southeast Asian heterosexual cisgender woman. At the start of the research project, the research team discussed their biases and beliefs about the project based on their own lived experiences.

Inductive content analysis was utilized to better understand the phenomenology of sexual well-being among QWOC. The use of an open-ended question asks participants to reflect on their lived experiences, and their narratives serve as the basis for constructing a definition of sexual well-being. Aligned with grounded theory methodology, data was collected, and the answers emerge from the data rather than approaching the data with a predefined hypothesis. This method is prioritized when there is little known about a topic.

The aim of this qualitative study was to focus on how QWOC might define sexual well-being in their own words. Actualizing health equity for QWOC requires a holistic understanding of the multi-dimensional mechanisms linking sexual experiences and well-being. Given the paucity of research in this area on this population, first steps are to develop a framework around the concept when knowledge is limited. Qualitative research can illuminate constructs that have been overlooked or reveal how a phenomena functions differently in a particular group. Development of a framework should be informed by the lived experiences of the population of focus to further define and conceptualize sexual well-being so that we might be able to know how and what it means and what facilitates or hinders it.

METHOD

Design. The goal of this study was to develop a framework of sexual well-being among QWOC. Toward this goal, I used qualitative, open-ended responses included in a larger online study exploring health and well-being among a sample of self-identified QWOC. This quantitative portion of the study included several measures of physical and mental health, as well

as attitudes, beliefs and experiences of sex and sexuality. Two open ended questions were included to explore how QWOC would define and experience sexual well-being. Ethical approval for this study involving human participation was obtained from the Institutional Review Board.

The current study analyzed the responses to one of the two questions: "What does sexual well-being mean to you?" Internet based surveys have proven to be helpful in accessing harder to reach populations, particularly sexual and gender minoritized communities (McInroy, 2016; Mustanski, 2001). While conducting research via online platforms is quick, low cost, and increases access to highly specific study populations, there are increased risks to data integrity with internet based research (Belliveau & Yakovenko, 2022; Griffin et al., 2022). To ensure data integrity, Prolific, an online recruitment platform for research studies, was used as the first step of ensuring the online data collected was from verified human participants. Prolific requires participants to complete a four-step verification process including email, phone, ID verification, and completion of a trial study. Research demonstrates that the Prolific platform provides high quality data compared to other online research platforms (Peer et al., 2021).

Participants could only access the survey from the Prolific platform. The survey was hosted on Qualtrics where participants were required to verify their unique Prolific identification number and pass a Completely Automated Public Turing Test to tell Computers and Humans Apart (CAPTCHA) feature, a common bot prevention method (Pickering & Blaszczynski, 2021; Teitcher et al., 2015; Watson et al., 2018). Qualtrics' internal screening further disqualified duplicate IP addresses and flagged fraudulent survey completion times (e.g., those that finished the survey too quickly to have read the questions). A total of three respondents were removed because they identified racially as White only. Additionally, attention checks, redundant

questions, and survey completion time were screened by the first author to ensure quality data above and beyond the aforementioned automatic parameters (Newman et al., 2021; Teitcher et al., 2015). Qualitative responses were required, and participants could opt out by following the instructions to type a specific word, i.e., "if you prefer to not answer, please type tooth". Participant's qualitative data was screened for nonsensical responses (Kennedy et al., 2020; Teitcher et al., 2015).

Participants. Participants were limited to Prolific platform users and the study was presented only to those that matched the requisite eligibility criteria: at least 18 years old, self-identified as LGBTQ, self-identified as a woman, self-identified as non-white racial identity, lived in the United States, and understood written English. The study was listed as a survey examining sexual and mental health of queer women of color. Participants were screened via their Prolific user profile data and had to re- affirm that they self-identified as part of the LGBTQ community and were fluent in English. If participants confirmed their eligibility and agreed to participate after reading the informed consent, they were prompted to complete the survey. Survey responses were collected in March 2023. Participants were compensated $10 upon completion of the survey.

On average, participants were 29 years old (*SD* = 8.87; range = 18 – 78). For a more detailed overview of participant demographics, see Table 7.

Table 7

Participant Demographics (n = 346)

	Frequency	Percentage (%)[1]
Age		
18-29	222	64.2
30-49	111	32
50-80	13	3.8
Gender		
Woman	301	87
Nonbinary	41	11.9
Other	4	1.2
Sexual Identity		
Bisexual	188	54.3
Lesbian or Gay	48	13.9
Pansexual	48	13.9
Queer	32	9.2
Asexual or Aromantic	15	4.3
Heterosexual	3	0.9
Other	9	2.6
Race		
Multiracial	119	34.4
Black	100	28.9
Latino	62	17.9
Asian	60	17.3
Indigenous/Native	5	1.4
Income (personal)		
< $24,999	174	50.3
$25,000-$69,999	113	32.6
>$70,000	51	14.8
Education		
Bachelor's degree	123	35.5
Some college	108	31.2
High School or GED	44	12.7
Associate's or technical degree	34	9.8
Graduate level	35	10.1
Insurance Type		
Employer Sponsored	112	32.4
Medicaid	102	29.5
Private Pay	49	14.2
Uninsured	46	13.3
Medicare	23	6.6

[1]Note. Column totals may not equal 100% due to missing data.

Procedure

This qualitative study focuses on participant responses to one open-ended question embedded within the larger online survey. We used qualitative inductive content analysis (Elo & Kyngäs, 2008; Erlingsson & Brysiewicz, 2017) to analyze the typed responses to the question, "What does sexual well-being mean to you." All coding and analysis were conducted with Taguette open-source qualitative data analysis software (Rampin & Rampin, 2021).

First, the research team determined the unit of analysis to be complete written responses from each individual participant. All research team members then engaged in recurrent readings to become familiar with the data. Team members engaged in weekly team meetings to discuss reactions and emerging ideas from their reading of the overall data. The data was then randomly divided into four sections with each section assigned to at least two reviewers. The team then went back into the raw data and condensed the unit of analysis (i.e., sentences) into one to three word "tags". The research team then met to discuss all 380 unique tags resulting from the first round. These tags were then grouped into categories to inform the next round of coding. Again, data was divided up such that all data was coded by at least two different team members. After the second round of coding, the research team met to discuss their process, reactions, and notes and to compare coding results. Coding discrepancies were discussed in a group until a consensus was met. Next, an iterative coding process and frequent team discussions around what similarities and differences were emerging from the data. Themes were developed to define the broad ideas emerging from the grouping of more specific sub-themes or codes.

RESULTS

Three overarching content themes emerged from the 346 participant responses to the optional open-ended question, "What does sexual well-being mean to you?": 1) physical health and

safety, 2) comfort, and 3) positivity. Participant responses were generally brief, ranging from several words to a few sentences. Descriptions of each theme, subtheme, and their frequency are presented in Table 8 and reviewed with exemplary responses below.

Table 8
Content Codes and Frequencies

Theme	Description	Frequency (n = 346)
1. Physical health and safety	behaviors and actions related to safer sex, overall health, and sexual health	81%
1a. Accessing healthcare	going to the doctor, getting check-ups, getting tested	12%
1b. Using safer sex methods	using contraception, condoms, birth control	13%
1c. Practicing consent	getting or talking about consent, engaging in consensual sex	6%
2. Comfort	comfort with aspects of sex/sexuality including affirmation, freedom, being well; also feelings of safety (distinct from actions)	46%
2a. comfort with self	comfort with one's self, sexuality, body, skin	28%
2b. comfort with others	comfort with partner(s), healthcare providers, other people, during sex, feelings of safety, consent	7%
3. Positivity	any positive aspects of sex or sexuality such as satisfaction, pleasure, orgasm, fulfillment, having needs met	37%

Note: Frequency refers to the number of responses coded in each theme. Sub-themes represent more specific codes within the broader theme and therefore do not add up to represent the entire overall theme.

Theme 1: Physical Health and Safety

Many respondents (81%) reported that sexual well-being involved some aspect of physical health and or safety, exemplified by behaviors or actions related to physiological health and safer sex behaviors. Responses were coded as physical health and safety if they included content related to safer sex methods, illness, physiological sexual functioning, pregnancy, or consent. Within this theme, specific subcategories further emerged that described using safer sex methods, accessing healthcare, and practicing consent.

Sexual well-being was most frequently defined as relating to overall physical health. Many participants equated sexual well-being with being "physically healthy," sometimes specified to include "healthy genitalia." Among participants who mentioned physical health, many described health as the absence or lack of sexually transmitted diseases or illness. Participants shared responses such as *"this means eating healthy and making sure I have no STDs"*, and *"sexual wellbeing also means that my genitalia are healthy, it also pertains to my absence of any sexually transmitted illnesses."*

Physical health involved participants specifying actions or behaviors toward realizing health such as one participant who defined sexual well-being as *"taking care of one's physical health, such as getting regular check-ups, practicing safe sex, and addressing any health concerns related to sexual functioning."* Responses included terms like taking care, eating healthy, and addressing health related concerns associated with sexually transmitted illnesses. Their responses suggested these actions were part of being able to engage in sexual activity safely and healthily. One participant shared, "*to me, sexual wellbeing is referring to the health of a person's body in regards to any sexually transmitted diseases or any ailments"*

Among this sample of QWOC, reproductive health was relevant to their overall physical health, such as how their physical health was related to fertility. One participant defined sexual well-being as *"making sure your body is healthy enough to procreate and have children."* Other participants included "*pregnancy and postpartum care*" or "*healthy pregnancy*" in their definitions of sexual well-being.

Subtheme: Using Safer Sex Methods

Within physical health and safety, responses commonly mentioned using safer sex methods. Participants defined using safer sex methods as actions and behaviors in service of promoting health and well-being. Some participants mentioned specific pregnancy prevention methods such as "contraceptives", "condoms", or "birth control." Whereas other participants highlighted safer sex methods as disease prevention related to "using protection" or being "healthy and clean." One participant described sexual well-being as, *"firstly sexual health involving disease prevention and maintenance is priority for me to engage with another human being and vice-versa."* Participants highlighted safer sex methods as happening across and throughout sexual experiences. One participant defined sexual well-being as "*taking care of yourself before, during, and after sex to ensure your health and the health of your partner by lowering the risk of any illnesses or infections that may come with having an active sex life... using protection such as birth control, condoms, and other products and practices."* Reproductive health was a subset of physical health involving the ability and choice to prevent "*unwanted pregnancy*" as an aspect of staying physically healthy.

Subtheme: Accessing Healthcare

Access to and utilization of healthcare was another subtheme within the category of physical health and safety. Responses were coded as accessing healthcare when they included

descriptions of behaviors such as going to a doctor, getting a check-up, or getting tested for sexually transmitted illnesses. A variety of healthcare services and resources were mentioned such as one participant who shared, *"having access to medical care for anything related to sexual health, including gynecological health, pap smears, STI testing, access to abortion, and birth control."* In addition to the availability of healthcare resources, participants also noted cost and quality of healthcare as it relates to access. One participant included "*access/affordability of contraceptives, or medication to treat any* [sexual health] *problems"* in their definition of sexual well-being. Several participants included regular utilization and "access to STD testing." Another participant shared, *"it means access to competent and respectful healthcare professionals, and access to supportive community."* Highlighting the additional layer of competent and respectful healthcare providers for the specific and diverse sexual health needs of QWOC.

Subtheme: Practicing Consent

Lastly, consent as a behavior and practice, emerged as a subtheme related to physical health and safety. Practicing consent was described in service of sexual safety and overall sexual well-being. Participants defined this as, *"not letting yourself be pressured into sex you don't want, and respecting other's boundaries during sex."* One participant defined sexual well-being as *"the right to choose sexual partners based on mutual consent between those partners."* For this sample of QWOC, consent was often defined as choice and agency such as one participant's response, *"freedom of choice (to have/not have sex, in whatever manner one wishes)."* The practice of consent involves participant agency to protect themselves and maintain their physical health and safety.

Theme 2: Comfort

Almost half of the responses (46%) included comfort with aspects of sex or sexuality in their definition of sexual well-being. Comfort included mentions of affirmation, freedom, being well, and feelings of safety and were separated into subthemes of comfort with self and comfort with others. Here, comfort is specifically related to feelings and perceptions as opposed to behaviors that enacted safety. When participants discussed actions or behaviors related to safety and comfort, they were coded in the category of physical health and safety. When they discussed feelings and perceptions that led to a subjective feeling of comfort, they were coded as comfort. For example, some participants defined sexual well-being as "*generally being comfortable in sexual situations*" and "*... having a good relationship mentally (e.g.: clear boundaries, awareness of preferences, and confidence/comfort) with sex, sexual expression, and my sexual partner."*

Subtheme: Comfort with Self

Within comfort, the most common response cited aspects related to comfort with oneself. Sexual well-being among this sample of QWOC also involved, *"how comfortable I am with my sexuality (or, how 'well' I feel with my sexuality)."* Participants also described how sexual well-being was related to comfort with one's physical body and desires, and thus a sense of agency and freedom. One participant shared, "*to me, it means being connected with myself, accepting myself as I currently am, and being comfortable expressing my sexuality with myself and others (if I choose to do so). It means feeling like I own my own body, and that I take care of it*". This response highlights the importance of participant agency and choice.

The subtheme of comfort with self included the ability to connect to and accept one's sexual response without shame as exemplified in one participant who wrote, "*being comfortable*

with my body and being able to feel my own sexual energy without shame. Being able to experience and enjoy arousal and being comfortable with what I find to be erotic." Others reflected a comfort with self that was described as an overall acceptance and freedom. "B*eing comfortable in one's own body and skin and feeling complete sexual freedom. Freedom of self, freedom of choice, freedom of all boundaries*." Comfort with self was also related to feeling happy or content with your sexuality such as the participant who shared, "*Sexual wellbeing to me means that you are comfortable with things related to your sexuality. Things like being happy with your sexual identity, needs, desires, relationships, body, and more*."

Subtheme: Comfort with Others

The other subtheme of comfort was coded as comfort with others when the response included details around other people such as partners, community, or providers. The ability to feel comfortable with and trust a sexual partner as one participant shared, "*If I had sex, then I would trust the person I had sex with and would feel comfortable asking them questions about their sexual health and history*." Comfort with others was also described as an absence of fear or absence of harm such as another participant included, "*being able to safely express my sexual desires without fearing harm to myself or from others*." This response highlights an aspect of sexual well-being as comfortable and safe with others, "*being comfortable with whom you have sex with.*"

Theme 3: Positivity

A third theme emerged from some responses (37%) that referenced positive aspects of sex or sexuality as a part of their definition of sexual well-being. Responses were coded as positivity if they referenced sex-positive aspects such as satisfaction, pleasure, orgasm, fulfillment, or needs being met. Participants acknowledged unique and individual differences

around what qualifies as positive or satisfying sexuality. One participant responded, "*the first words that come to mind when I think of sexual wellbeing are pleasure, joy, and trust. I think having a satisfying amount of sex (however much that is for the individual or whether it's partnered or alone) is key to sexual wellbeing*." When asked to define sexual well-being, one participant wrote, "*having sexual experiences that are pleasurable, satisfying and empowering*."

Participants mentioned ability when referencing sexual pleasure or satisfaction as seen in this response, "*for me it means being able to feel sexually aroused and being able to be satisfied and reach an orgasm*." Beyond sexual satisfaction, some participants highlighted the need within positivity to involve positive appraisal of sexual partners, "*it means making sure I am satisfied not just with sexual acts, but the people I choose to be intimate with."* Aligned with feelings of pleasure and satisfaction, several participants mentioned self-pleasure such as, *"regular masturbation is also important to wellbeing*." Participant's responses highlighted that well-being was related to positive feelings toward one's sexuality such as, "*sexual wellbeing means having positive feelings toward your sexuality. Generally, to me, it would just mean feeling happy, confident, and satisfied with your sexuality*."

These findings support a participant-based definition of sexual well-being as a multifaceted phenomenon, encompassing physical health, safety, comfort, and a positive regard toward sex and sexuality.

DISCUSSION

Little is known about sexual well-being among QWOC and there is no agreed upon definition or measurement of sexual well-being more broadly. This study adds to the existing literature as the first to qualitatively explore the sexual well-being of QWOC. The qualitative data presented here highlights the voices of QWOC and their lived experience of sexual well-

being. Further, by illuminating a participant-defined meaning of sexual well-being, this study can inform the definition and measurement of sexual well-being going forward.

Utilizing a large-scale cross-sectional online survey, 346 self-identified QWOC responded to the open-ended question, "what does sexual well-being mean to you?" Using inductive content analysis methods, three general themes emerged from the data: physical health and safety, comfort, and positivity. While participant definitions were varied, consistent themes across cognitive, affective, and behavioral aspects provide further support that sexual well-being is a multidimensional construct.

The findings from this qualitative study of QWOC suggest a definition of sexual well-being as a multi-dimensional measure of one's subjective sense of physical health, safety, comfort, and positivity regarding sexual experiences and sexuality. This definition adds to past definitions that focused solely on satisfaction or sexual functioning (Byers & Rehman, 2014). The existence of multiple, complex dimensions of sexual well-being has been suggested with sexual health research calling for empirical data to elucidate which dimensions are important and to whom. Moreover, this is the first definition to be developed within a multiply marginalized population.

Physical health emerged as a defining feature of sexual well-being. While the WHO definition of sexual well-being recommends moving beyond simply the lack of disease, many responses included just that. Many responses included some description of a "lack of disease" aligning with the dominant focus on STIs and illness focused approaches to sexual health. This finding adds ambiguity to recent efforts toward differentiating sexual well-being from sexual health as distinct constructs (Lewis et al., 2024; Mitchell et al., 2023). Responses from this study indicate that physical health is indeed an important and even intertwined facet of sexual well-

being. It may be challenging to disentangle the prevention and treatment of STIs and physiological health of sexual organs from one's overall experience of sexual well-being. Similarly to how it is difficult to separate overall health and well-being (Kesavayuth et al., 2022). On the other hand, responses highlighting the importance of the sexual health aspects of sexual well-being may be a reflection of the mainstream messaging about sex and sexuality that continue to focus on disease, or the lack thereof. These findings show that how participants describe sexual well-being is based on their experiences broadly speaking, which includes the information that they have received about sex and sexuality.

Comfort with sex and sexuality was another important aspect of sexual well-being. This finding aligns with the definition of sexual well-being conceptualized by UK-based researchers Mitchell and colleagues (2023). They use the term "comfort with sexuality" which is defined as "One's experience of ease in contemplation, communication, and enactments of sexuality and sex" (Lewis et al., 2024). Despite the data for the current study being collected prior to the Mitchell et al. publication, the theme of comfort that emerged from our analysis aligns with the Mitchell concept. This study added to their concept by further distinguishing comfort with self (e.g., acceptance and ease with one's sexuality including but not limited to physical body and sexual desires) from comfort with others which involved feelings of ease and safety to express those desires with other people.

Findings also emphasize the importance of sex positivity as an indicator for sexual well-being. Positive aspects of sexuality reported in this sample included sexual satisfaction, pleasure, orgasm, and fulfillment. These elements contribute significantly to an individual's overall sense of sexual well-being. However, the positive and pleasurable aspects of sex are often understudied, despite being critical to a holistic understanding of sexual health (Gruskin &

Kismödi, 2020; Jones, 2019). Sex positivity, which encompasses accepting and embracing one's sexual desires and experiences, has been shown to enhance sexual satisfaction and emotional fulfillment. Increased experiences of sexual pleasure and positive self-evaluations of one's sexuality are strongly linked to better overall life satisfaction and well-being (Anderson, 2013). These positive experiences foster a healthy relationship with one's sexuality, promoting psychological and emotional health.

Responses also included positive aspects of sex and sexuality illuminating how members of a marginalized community assert their own sense of value and pride. A sex-positive perspective can reduce stigma and shame associated with sexual expression, leading to more open and honest communication about sexual needs and desires. This openness can improve intimate relationships and contribute to a supportive sexual environment, further enhancing sexual well-being. Therefore, incorporating sex positivity into sexual health research and interventions is essential for fostering a comprehensive and inclusive understanding of sexual well-being.

A participant-based definition of sexual well-being as a multifaceted phenomenon, encompassing physical health, safety, comfort, and a positive regard toward sex and sexuality, has several implications. This study adds community derived information to an overlooked concept within a marginalized population. The findings of this study pave the way for more sex positive and inclusive sexual health research. How QWOC described sexual well-being warrants further examination and deeper understanding. For example, how do QWOC attain, navigate, and negotiate across the domains they mentioned. The themes highlighted here have implications in clinical practice with QWOC as well. Feelings of comfort with sexuality can be developed and supported by affirming and competent healthcare and clinicians. More comprehensive and

inclusive research methods will have implications for creating future assessment tools and interventions could be better tailored to address the specific needs of individuals, focusing not just on physical health or safety but also on enhancing comfort and fostering positive attitudes towards sex and sexuality. The creation of affirming and sex positive interventions in turn have serious implications for public health as we increase understanding around sexual behaviors, we can respond more effectively to create solutions for health equity.

Limitations

As the first study to qualitatively assess how QWOC define sexual well-being it is not without its limitations. First, as a cross-sectional study the findings represent a single point in time limiting causality between the factors described by participants and the meaning of sexual well-being. Second, this online study was restricted to registered users of Prolific. While this facilitated more efficient collection of high-quality data, participants comfortable with digital surveys may not represent the broader population. Third, the transparent title of the survey as it was posted on the recruitment platform may have contributed to a self-selection bias and overrepresentation of demographics based on use of the words “queer women of color” and “sexual well-being”. Participants may have higher than average sexual well-being or more comfort with the topic of sex. Research suggests that people who identify as queer are more likely to be cisgender women or genderqueer/nonbinary, younger, and more educated (Goldberg et al., 2020; Mereish et al., 2017). Fourth, data were short written responses that we were unable to clarify or probe further. Although this is a common limitation when analyzing open ended survey responses, integration of qualitative interviews or focus groups will allow future research to explore such responses further. Fifth, data was not analyzed to look at within group differences. QWOC encompass a broad and diverse group of women with different racial

identities, sexual orientation, behavior, attraction, and gender identities. Assuming their answers reflect a homogenous experience of sexual well-being is limiting. Lastly, the mean age of participants in this study was under 30, limiting the generalizability of these findings across the lifespan.

Despite the limitations of this study there are several strengths. This is the first study to qualitatively explore sexual well-being among QWOC. This population is overlooked and undervalued in sexual health literature and when included the research on this population is focused almost exclusively on sexual violence and disease. The dominant discourse on risk and vulnerability of marginalized populations risks perpetuating stigma based on sexual behavior and identity. QWOC are more than their victimization and research on their lived experiences should reflect this reality. Further, this current study used qualitative inquiry, which is uniquely valuable when examining topics with little existing research and research with underexamined populations. Qualitative methods help resist top-down definitions of concepts and research biases becoming embedded within the scholarship and potentially missing important factors that were not previously known. Together, this study adds a community defined meaning of sexual well-being, highlights the need for sex positive research, and centers a population of QWOC that are rarely prioritized in existing research.

Conclusion

In conclusion, this study represents a pioneering effort to explore sexual well-being among QWOC, providing invaluable insights into their lived experiences. The findings highlight the multifaceted nature of sexual well-being, encompassing physical health, safety, comfort, and sex positivity, and underscore the importance of considering these dimensions in both research and clinical practice. This study makes significant contributions to existing research by offering a

participant-defined perspective on sexual well-being. This emphasizes the necessity for inclusive, holistic approaches in sexual health research and interventions, which can better address the diverse needs of marginalized populations. Future research should aim to employ longitudinal designs, broaden sampling strategies, and utilize in-depth qualitative methods to further validate and expand upon these findings.

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CONCLUSION

Sexual well-being, a critical part of human life, is deeply connected to physical and mental health. Despite global initiatives calling for the inclusion of multidimensional approaches to sexual health research, the dominant discourse continues to be disease and deficit focused. While multiply marginalized groups are hyper visible in the sexual health research on risk and disease, they are rarely considered in the arena of sexual well-being. Importantly, despite sexual minority women being exposed to increased sexual violence and subsequent negative mental and physical health consequences, this makes them more, not less, worthy of attention regarding their sexual well-being. This project stands in resistance to narratives that pathologize marginalized sexualities as one of the first projects to focus on the sexual well-being of queer women of color (QWOC). Below I discuss the findings across the three papers and their broad implications for research, practice, and policy.

Summary of Results

This dissertation is comprised of three separate but related studies. Each is presented separately as stand-alone articles to be submitted for publication. This format was chosen to allow for timely and efficient dissemination of these findings, which is particularly important given the existing literature has largely ignored QWOC and their needs. The studies utilized data from a large online survey of 397 self-identified QWOC living in the United States. Participants completed self-report measures assessing multidimensional aspects of sexual well-being (i.e., sexual self-esteem, sexual pride, sex life satisfaction, and sexual shame) as well as self-reported measures of health, demographic characteristics, and residential zip code. I utilized rigorous methods to ensure both the quality and the validity of the data sourced from the online survey, resulting in a large, robust dataset focused on QWOC from across the United States.

Study I examined the relationship between self-rated health and sexual well-being. Compared to national norms, this sample of QWOC reported lower self-rated health and moderately high levels of sexual self-esteem. Multiple linear regressions showed self-rated emotional well-being and general health predicted all dimensions of sexual well-being except for sexual shame, which was only predicted by emotional well-being. Sexual pride was additionally influenced by income and identifying as a survivor of sexual abuse. Black women reported higher levels of sexual pride and self-esteem compared to other racial groups. Within group differences across dimensions of sexual well-being highlight the need for intersectional and person-centered research that respects the heterogeneity of QWOC.

The findings from Study I are in contrast with general findings that higher satisfaction with sex life is associated with higher self-rated health (Flynn et al., 2016). One dimensional measures of sexual well-being such as, only measuring sexual satisfaction, do not capture the complete and complex relationship between experiences of sex and sexuality and overall health. The relationship between sexual well-being and self-rated health might differ among queer populations compared to their heterosexual counterparts. Differences in how sexual well-being interacts with health may be related to different sexual behaviors, relationship structures, and experiences. Aspects of queer sexuality, such as more frequent oral sex reported by lesbian and bisexual identified women (Bailey, 2003), might provide protective and buffering effects improving positive sexual well-being despite lower overall mental and physical health. These findings emphasize the need to investigate sex as a health behavior such as exercise and alcohol consumption (Diamond & Huebner, 2012). The mechanisms that connect and explain the relationship between sexual well-being and health are unknown. Additionally, racial differences found in the present study highlight the need to further examine the strengths and protective

factors associated with being a queer Black woman. Understanding protective factors could facilitate the creation of effective interventions desperately needed to attain sexual health equity.

Study II focused on structural determinants of health and sexual well-being. I utilized a person-centered approach to identify profiles of sexual well-being across QWOC and then examined profile membership in relation to structural determinants of health. Latent profile analyses revealed three profiles of sexual well-being: low, moderate, and high. The largest profile included participants grouped around average scores across measures of sex life satisfaction, pride, self-esteem, and shame which was a majority of the sample. Unsurprisingly, higher levels of positive sexual well-being measures were associated with lower levels of sexual shame. Over 75% of the sample was grouped into the moderate and high sexual well-being profiles. These study results are intriguing because within a group of QWOC, most of the sample converged on average or above average scores of a multidimensional measure of sexual well-being.

Structural determinants of health such as income and living in the southern region of the U.S. further predicted membership in the high sexual well-being profile. Indications of high sexual well-being among QWOC in a region with oppressive policies and violent rhetoric toward gender and sexual minorities warrants further investigation. These findings suggest that community-based strengths may persist above and beyond broad level restrictions. Further, generalizations about a large region of a country may oversimplify the nuanced lived experiences of individuals and communities. White supremacy, and all the related downstream effects of colonial violence that manufactured heterosexism, patriarchy, and cissexism, is not only a problem of the South. These issues are pervasive throughout the entire country as well as much of the modern world that has a history of settler colonialism. Overall, Study II showed that

QWOC are not a monolithic group, and they can and do experience sexual well-being at high levels, even in places and environments unexpected based on deficits-based research.

Given the lack of an agreed upon definition of sexual well-being, Study III analyzed qualitative data to gain insight on conceptualizations of sexual well-being among QWOC. Open-ended responses to the question, "what does sexual well-being mean to you?" were analyzed using inductive content analysis. Three main themes emerged to conceptualize sexual well-being as a multifaceted phenomenon, encompassing physical health, safety, comfort, and a positive regard toward sex and sexuality. Responses revealed a multidimensional concept of sexual well-being contextualizing the quantitative results from the first two studies. Qualitative responses revealed the importance of sexual health as a part of sexual well-being for QWOC. This predominately young sample may be mirroring the most recent information about sex and sexuality that is commonly delivered to them. The main focus of sexual health messaging to young adults is prevention of disease and pregnancy.

The most common theme, physical health and safety, reflect this dominant discourse on sexual health. Safer sex methods and the absence of disease are important to QWOC, but so are feelings of comfort with themselves, others, and positive aspects of sexuality like pleasure, and masturbation. The theme of comfort reflected values around feeling affirmed and free to express their sexuality. These important affective and cognitive appraisals of sexual experiences offer a nuanced view, expanding our positive sexuality lens from solely focusing on orgasm or satisfaction. Findings inform a definition of sexual well-being by adding first ever, in-depth qualitative data from racialized and sexually marginalized women on how they define sexual well-being for themselves.

INTEGRATION OF FINDINGS

This dissertation presented three studies that examined sexual well-being among QWOC in three distinct ways. Taken together, they offer an important addition to the extant literature on sexual well-being and QWOC, a population that is often overlooked in research. This dissertation offers empirical evidence of the complex interplay between health, sexual well-being, and overlapping systems of power and oppression. These findings also identify an urgent need for more research examining the strengths within marginalized populations and structural factors influencing sexual well-being.

Findings across these studies align well with the WHO's working definition of sexual well-being. The WHO offered that sexual well-being could include measurement broadly of "self-perceived sexual health", involving factors such as comfort and satisfaction with sexuality and identity as well as perceived abilities to maintain or improve one's sexual health. This definition is useful and more inclusive of an individual's unique experience compared to measures of sexual health based on "objective" measures. This definition is also supported by findings from the current project that highlight the importance of comfort and empowerment. Responses from Study III further echo the WHO's definition, and advocate for a need for accessible, competent, and affirming healthcare that is connected to abilities to maintain or improve one's health. Overall, these studies, when taken as a whole, affirm the WHO's working definition of sexual well-being and re-establish the importance of subjective, or "self-perceived" measures of sexual well-being.

Furthermore, subjective measures of sexual well-being allow for the discovery of factors related to sexual health and functioning that may otherwise be missed from an objective or symptom-based viewpoint. For example, perceptions of one's sexual health and experiences of

sexual well-being may differ across individuals diagnosed with a sexually transmitted infection or engaging in casual sexual encounters. “Objective” risk-based research codes these diagnoses and behaviors only as negative without examining the nuanced version of an individual’s experience including their strengths. This dissertation project showed that sexual well-being involves capturing the subjective balance between positive and negative elements of sexuality such as sexual pride and experiences of childhood sexual abuse (World Health Organization, 2010). Additionally, findings in the present study that point to high levels of sexual well-being in racial enclaves (e.g. the South) offer some of the “culture- and context specific” indicators of sexual well-being that the WHO mentions needing to complete their definition.

There were some unexpected findings that may seem surprising in the context of the existing literature. For example, this research suggests that an Asian, queer woman who is a survivor of childhood sexual abuse living in a southern state in the U.S. can experience high levels of subjective sexual well-being. The majority of the extant literature is hyper focused on how that hypothetical woman would have increased risk for negative sexual, mental, and physical health outcomes, but does not explore potential strengths related to her sexuality and sexual experiences. For example, how might satisfying or fulfilling sexual experiences contribute positively to her overall health and well-being, perhaps even mitigating potential risks associated with multiple marginalization? This is not to say that state-level restrictions around reproductive healthcare (Guttmacher Institute, 2024) and heteronormative religious attitudes (Jelen, 2017) are not harmful to QWOC living in the South. Nor do these findings diminish the well documented deleterious impacts of sexual violence (Kearns & DiRienzo, 2023; Letourneau et al., 2018; McCauley et al., 2015). These findings demonstrate a more complete and nuanced view of the risks and barriers to sexual well-being. We must expand our focus from a deficits-based risk

assessment of sex. These perspectives are one important part of a complex story, and researchers should be cautious to not reify generalizations that ignore strengths and positive factors within marginalized communities.

Across studies, sex positivity emerged as an impactful theme. Participants named sex positivity as a meaningful dimension of sexual well-being. Quantitatively, sex positivity was assessed via sexual self-esteem and pride measures. These findings highlight the importance of considering the protective and sex-positive aspects of queer sexuality and the vital role of emotional well-being in sustaining self-esteem, pride, and satisfaction despite marginalization. Positive sexuality has a beneficial impact to overall well-being and should be leveraged in trauma informed interventions (Anderson, 2013; Baggett et al., 2017). These studies inform their utility with multiply marginalized individuals.

The three studies collectively highlight that sexual well-being among QWOC is influenced by a combination of emotional, physical, and structural factors. Emotional well-being and general health are foundational to sexual well-being, yet socio-economic status and personal history (e.g., sexual abuse) also play significant roles. Racial differences and the impact of structural determinants like income and regional living conditions point to the necessity of an intersectional and person-centered research approach. Finally, the multifaceted concept of sexual well-being, incorporating themes of physical health, safety, comfort, and positivity, emphasizes the complex and diverse experiences of QWOC. Addressing these factors holistically could lead to better health outcomes and improved sexual well-being for this population.

Overall Conclusions

At a broad level, these findings suggest QWOC experience sexual well-being in multidimensional and diverse ways that counter the dominant discourse of their disease, risk, and

vulnerability. Overall, researchers need to examine their risk-focused biases and start asking what could be good about queer sexualities? QWOC are more than their victimization and deserve pleasure, joy, and sexual well-being. If we could further understand the mechanism between some sex behaviors and buffering effects to emotional well-being we could leverage that to improve health outcomes. Despite a focus on the deficits and risk factors associated with their sexual behaviors.

Implications

These findings have several implications to research, practice, and policy. The heterogeneity within this sample of QWOC imply that more intersectional and person-centered research is needed. Integrating intersectional research methods into quantitative work is challenging but necessary to move the field forward (Bauer, 2014; Bauer et al., 2021). Sexual health researchers must go beyond simply incorporating multiple identities (although, even this is rare) and include systems of power and oppression. Research that continues to ignore the social structures and systems that contribute to health and well-being risk becoming irrelevant over time (Buchanan & Wiklund, 2020).

Positive aspects of sexuality, such as pleasure, are critical aspects of improving sexual health outcomes (J. V. Ford et al., 2019; Jones, 2019; Mitchell et al., 2021). These studies present empirical support for the ways in which positive aspects of sexuality impact QWOC. Incorporating sexual pleasure into sex therapy interventions, sex education, and public health initiatives could significantly improve sexual health inequities (Fine & McClelland, 2006; J. V. Ford et al., 2019; Hanbury & Eastham, 2016; Heredia & Rider, 2020). Funding sources need to recognize the utility of sex-positive and pleasure-based research to inform clinical and public health interventions. Understanding these dynamics can help in framing sexual health

interventions that recognize both the risks and the positive aspects of sexual behavior. Overall, the findings highlight the need for a balanced perspective that incorporates the diverse motivations and outcomes associated with sexual pride and behavior

FUTURE RESEARCH

As one of the first studies to focus on the sexual well-being among QWOC, there are unlimited potential future research opportunities. I will describe a few of the ideas I have based on what I learned. First, longitudinal research is needed to illuminate causal patterns and better understand sexual well-being across the lifespan. Deficit-based research is overly focused on the negative outcomes of youth and adolescent sexuality. Sex research excludes older populations and aging research rarely examines sex or sexuality (Gott & Hinchliff, 2003). Given sexual self-esteem increased with age in this sample, potential positive effects might continue for aging QWOC. Second, sex positive and strengths-based approaches are imperative to combat racism, sexism, heterosexism, and cis-sexism. Queer and racialized sexualities are more than their trauma. Marginalized communities contain multitudes of strengths, if only we would value their voices and listen to them. Finally, to uplift the voices of marginalized communities, qualitative and mixed methods are urgently needed. Future research needs to involved community based participatory research methodologies that uplift and give back to the communities that we intend to serve.

Further research is desperately needed to inform evidence based clinical guidelines and interventions. These overall study findings highlight the important role that clinicians have in supporting sexual well-being, particularly for racially and sexually marginalized patients. The significant association of emotional well-being across domains of sexual well-being support the need for affirming mental healthcare providers who are comfortable addressing not just sexual

concerns but positive aspects of sex and sexuality as well. The standard curriculum and training in clinical psychology does not adequately address sexuality-related topics (Abbott et al., 2021). Trainees and clinicians can and should explore their own sexuality, beliefs, and values so that they can listen to patients with non-judgmental curiosity. Often, patients are uncertain of appropriate topics for therapy and clinicians can provide psychoeducation, normalization, and model comfort from the first intake appointment by asking about sex in inclusive and positive ways.

In conclusion, this dissertation provides a comprehensive examination of sexual well-being among queer women of color (QWOC), addressing a critical gap in the existing literature. Through three distinct studies, it underscores the multidimensional and diverse nature of sexual well-being, challenging the dominant deficit-focused narratives. The findings reveal the significant roles of emotional well-being, general health, socio-economic status, and personal history in shaping sexual well-being. Moreover, the research highlights the importance of sex positivity and the protective aspects of queer sexuality, offering new perspectives for trauma-informed interventions. These studies advocate for a shift from risk-based approaches to those that also recognize the strengths and positive aspects within marginalized communities. By integrating intersectional research methods, this work calls for a more nuanced and person-centered understanding of sexual well-being to include the complex experiences of overlapping and multiply marginalized identities. Future research should continue to explore these dynamics longitudinally and incorporate community-based participatory methods to further illuminate the mechanisms that enhance sexual well-being and overall health outcomes for this population. Ultimately, this dissertation paves the way for more inclusive and comprehensive approaches to sexual health research, practice, and policy, ensuring that QWOC are seen not just through the

lens of vulnerability, but through the full spectrum of human experience including pleasure, joy, and well-being.

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