Young women’s stories of having a sexually transmitted infection: A feminist perspective

© Leah East RN BN (Hons)

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Outcomes of this thesis

Publications


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# Table of Contents

**List of Tables** .................................................................................................................... x
**Abbreviations** .................................................................................................................... xi
**ABSTRACT** ........................................................................................................................ xiii
**OVERVIEW OF THE THESIS** ............................................................................................ xv

**CHAPTER ONE: INTRODUCTION** ......................................................................................... 1
  - Genital herpes: herpes simplex virus type 1 (HSV1) and herpes simplex virus type 2 (HSV2) ......................................................................................................................... 2
  - Human papillomavirus (HPV) ............................................................................................. 3
  - Chlamydia (Chlamydia trachomatis) ................................................................................... 4
  - Gonorrhoea (Neisseria gonorrhoeae) .................................................................................. 5
  - HIV/AIDS ........................................................................................................................... 6
  - Trichomoniasis (Trichomonas vaginalis), donovanosis (Calymmatobacterium granulomatis), and syphilis (Treponema pallidum) ........................................................................ 7
  - Why are young people and women most at risk of STIs? .................................................. 8
  - Aim of the thesis ............................................................................................................... 9
  - Positioning of self ............................................................................................................. 10

**CHAPTER TWO: LITERATURE REVIEW** ............................................................................ 12
  - Chapter abstract .............................................................................................................. 12
  - Introduction ................................................................................................................... 13
  - Women, social norms, and STIs ....................................................................................... 13
  - Contraception and behaviour ......................................................................................... 17
    - Contraceptive choices and safer sex ............................................................................. 17
    - Condom negotiation and resistance ............................................................................ 22
    - Dual protection .......................................................................................................... 24
    - Relationship dynamics, multiple sexual partners, and contraception ....................... 26
  - Perception, Risk, and STIs ............................................................................................. 29
    - Perceived STI risk and knowledge ............................................................................. 31
    - Relationships and perception ..................................................................................... 33
    - Sexual health discussions and STI disclosure within partnerships ......................... 36
  - Stigma and STIs ............................................................................................................. 39
  - Conclusion .................................................................................................................... 42
    - Summary .................................................................................................................... 42
  - Significance to nursing ................................................................................................. 44

**CHAPTER THREE: METHODOLOGY** .................................................................................... 45
  - Chapter abstract .............................................................................................................. 45
  - Introduction ................................................................................................................... 46
  - Nursing and qualitative research .................................................................................... 46
  - Feminist research in nursing .......................................................................................... 47
  - Characteristics of feminist research ............................................................................. 49
  - Feminist perspectives underpinning this study ............................................................. 50
Oppression and women’s sexuality........................................................................50
The personal and political nature of STIs.................................................................53
Feminist consciousness and consciousness-raising ...............................................55
Stories .......................................................................................................................56
Differentiating stories and narrative .....................................................................56
Personal Stories .......................................................................................................57
The nature of personal stories ................................................................................60
Computer-mediated communication (CMC) .........................................................62
Methods ....................................................................................................................67
   Inclusion criteria ....................................................................................................67
   Exclusion criteria ..................................................................................................68
   Recruitment ..........................................................................................................69
   Data collection: Qualitative conversational encounters ....................................70
Ethical issues ............................................................................................................71
Thematic analysis .....................................................................................................73
Rigour .........................................................................................................................76
   Reflexity ................................................................................................................77
   Credibility ..............................................................................................................78
   Rapport ..................................................................................................................79
   Relevance ..............................................................................................................81
   Honesty and mutuality .........................................................................................82
   Naming ..................................................................................................................82
Summary ....................................................................................................................83
CHAPTER FOUR: FINDINGS CHAPTER....................................................................84
   Introduction ..........................................................................................................91
   Theme one: Disrupted sense of self: ................................................................92
      Sub-theme: Self-perceived invulnerability: This can’t happen to me ..........93
      Sub-theme: Self-blame and shame: I feel so ridiculously foolish ..........97
      Sub-theme: Self-preservation: Living in denial .............................................101
   Conclusion ..........................................................................................................107
   Theme two: Stigma and stereotypes ................................................................109
      Sub-theme: Tainted women: Dirty and diseased ..........................................110
      Sub-theme: Deviant women: Fear of rejection ..............................................116
      Sub-theme: Women unworthy of love: I worry about being alone ..........120
   Conclusion ..........................................................................................................123
   Theme three: Burdensome emotions, responsibilities, and consequences .......125
      Sub-theme: Damaged and devastated: Yuck and ruined ..........................126
      Sub-theme: Disclosure and transmission: I would be horrified if I infected someone ... 130
      Sub-theme: Motherhood and reproductive health: I just worry ...............134
   Conclusion ..........................................................................................................138
   Summary ..............................................................................................................139
CHAPTER FIVE: FINDINGS CHAPTER.....................................................................141
Appendix M: Amended information sheet................................................................. 270
Appendix N: Amended consent form..................................................................... 273
# List of Tables

Table 1: Themes ................................................................. 90  
Table 2: Theme one ........................................................... 92  
Table 3: Theme two ........................................................... 109  
Table 4: Theme three ....................................................... 125  
Table 5: Themes .............................................................. 141  
Table 6: Theme four ......................................................... 142  
Table 7: Theme five .......................................................... 156  
Table 8: STI table ............................................................ 248
Abbreviations

… Any text omitted between, words, sentences and/or paragraphs

AIDS: acquired immune deficiency syndrome
ART: assisted reproductive technology
CDA: Communicable Diseases Australia
CDC: Centers for Disease Control
CMC: computer mediated communication
Email: electronic mail
Herpes: genital herpes
HIV: human immunodeficiency virus
HPV: human papillomavirus
HSV: herpes simplex virus
HSV1: herpes simplex virus type 1
HSV2: herpes simplex virus type 2
IVDU: intravenous drug use
MSM: men who have sex with men
NCHSTP: National Center for HIV, STD, and TB Prevention
NIMH: National Institute of Mental Health
NPIN: National Information Prevention Network
NNDSS: National Notifiable Diseases Surveillance System
OCP: oral contraceptive pill
Pap: Papanicolaou
PID: pelvic inflammatory disease
STD/s: sexually transmitted disease/s
STI/s: sexually transmitted infection/s
TB: tuberculosis
UNAIDS: Joint United Nations Programme on HIV/AIDS
UNFPA: United Nations Population Fund
UNICEF: United Nations Children’s Fund
UWS: University of Western Sydney
USA: United States of America
VD/s: venereal disease/s
WHO: World Health Organisation
ABSTRACT

This study aimed to explore young women’s stories of having a sexually transmitted infection (STI) from a feminist perspective. Sexually transmitted infections (STIs) are prevalent throughout the world and can have serious physical and emotional sequelae. Although some aspects of having STIs, such as stigma, have previously been identified in the literature, there is a paucity of nursing literature that focuses on the experiential aspects of these infections. Further, an exploration of young women’s experiences of having such an infection from a feminist perspective has not been undertaken. This signifies that nurses may have limited knowledge pertaining to the gender aspects and the effects STIs can have on young women’s lives.

This research used a qualitative feminist methodology. Data were collected via online conversational interactions with ten women. The participants were from various backgrounds and aged between 21 and 39 years at the time of data collection. Once data collection was complete, the women’s stories were thematically analysed using a feminist narrative technique.

Five dominant themes each consisting of three sub-themes were revealed in the women’s stories. The first theme; Disrupted sense of self, illuminates how these women did not believe themselves to be at risk of STIs due to perceptions they held about women who contract these infections. Because these perceptions were incompatible with their own perceived views, the women experienced a disruption in their self-perceived
thoughts and beliefs following their diagnoses. The second theme; *Stigma and stereotypes* reflects how the women internalised the existing stereotypes of women with STIs and subsequently felt stigmatised. The third theme; *Burdensome emotions, responsibilities, and consequences* reveals the extent of the emotional burden these women felt by having an STI. The theme highlights the women’s fear and guilt associated with STI transmission, and the trepidation they felt surrounding their future reproductive health. The fourth theme; *Violated and vulnerable*, illuminates how the women were all at risk of these infections due to various factors including gender dynamics and some of the women’s hindered ability to practise safer sex. The final theme; *Strength and support in the face of adversity*, elucidates the women’s healthcare experiences and the support networks these women drew on to overcome the burden of having an STI.

The findings of this study have revealed the emotional burden and the detrimental impact that having an STI can have on young women’s lives. This study has provided greater insight into the difficulties women experience in negotiating condom use and practising safer sex. Further, although the majority of these women described experiencing negative healthcare encounters, findings from this research have revealed the benefits these women gained from participating in online support networks. Findings from this study have several implications for nursing practice and offers direction for future research.
OVERVIEW OF THE THESIS

This thesis is divided into seven chapters. The first chapter is the Introduction, which provides information on specific STIs, and the factors that influence young people and women’s vulnerability to these infections. The chapter presents the aims of this study and positions myself as a nurse and researcher, within the context of this thesis.

Chapter two; the Literature review, draws on the existing literature associated with STIs. The review explores issues associated with safer sex, STI risk perception, and relationship dynamics, and discusses how these factors can predispose women and young people to these infections. Drawing on the literature, the review illuminates the stigma that is attached to STIs, and the barrier this can create in healthcare seeking and treatment of these infections. The review concludes with a summary of the literature and the justification and significance of this research to the nursing profession.

The third chapter, the Methodology, explains the feminist principles underpinning this study and provides details on the storytelling approach and the communication medium, which was used to collect the women’s stories. The chapter provides information on ethical issues, the methods used, how the rigour of this study was enhanced, and explains the thematic analysis approach that was used for the purpose of this research.
The fourth and fifth chapters present the Findings of this study. The first Findings chapter introduces the ten women who participated in this study and consists of three themes. The themes in this chapter reflect the detrimental effects the STIs had on the women’s lives. The second Findings chapter consists of two themes and elucidates the women’s vulnerabilities to STIs, their healthcare experiences, and the support networks on which they drew to deal with and overcome the adversity of having an STI.

The sixth chapter is the Discussion, which reflects on the findings of this study in relation to the professional literature. The discussion highlights and elaborates on issues related to the shame and stigma of STIs, the women’s vulnerability to these infections and the disempowerment STIs can cause. Additionally, the chapter includes a discussion on the women’s experiences of healthcare treatment and support. The final chapter is the Conclusion, which summarises the findings of this study, offers direction for future research, and provides the implications of the findings of this research on healthcare practice and education.
CHAPTER ONE: INTRODUCTION

Sexually transmitted infections (STIs), previously known as sexually transmitted diseases (STDs), and venereal diseases (VDs), are infections transmitted through sexual activity (Adderley-Kelly & Stephens, 2005; Aral, 2001; Eng, 1997). These infections are caused by viral, bacterium and/or protozoan pathogens (Rutledge, 2005), and are a major public health issue, responsible for high morbidity and mortality throughout the world (Chesson, Blandford, Gift, Tao, & Irwin, 2004; Glasier, Gulmezoglu, Schmid, Moreno, & Van Look, 2006; World Health Organisation [WHO], 2002, 2007). The WHO (2001), estimated that in persons aged between 15 to 49 years the rate of chlamydia, gonorrhoea, syphilis and trichomoniasis had increased to over 340 million new cases per annum. However, rates for STIs are grossly underestimated. This is due to inadequacy of national and international surveillance systems, incomplete data, lack of access to healthcare services, and the large proportion of STIs which are not reported and remain undiagnosed due to the asymptomatic nature of some of these infections (Weinstock, Berman, & Cates, 2004; WHO, 2002, 2007). Further, STIs largely go undiagnosed because of the lack of knowledge among individuals, and the reluctance for people to associate themselves with these infections due to the negative perceptions and the social consequences of having STI/s (WHO, 2001, 2002).
There are over twenty-five pathogens responsible for STIs (Adderley-Kelly & Stephens, 2005; Eng, 1997), however, this chapter only provides data on the most common STIs in Australia, those that have existing prevalence data, and on the infections which are reported to the national disease prevalence program (notifiable STIs). Additionally, the data provided only includes infections that are transmitted exclusively through sexual activity, with the exception of the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS). For a more comprehensive overview of these, as well as other STIs please refer to table 8 appendix A (p. 248).

**Genital herpes: herpes simplex virus type 1 (HSV1) and herpes simplex virus type 2 (HSV2)**

Genital herpes is a chronic viral infection (Paz-Bailey, Ramaswamy, Hawkes, & Geretti, 2007), and one of the most prevalent STIs worldwide (Fife, et al., 2004; Rana, et al., 2006). The primary causative agent is herpes simplex virus type 2 (HSV2) (Cusini & Ghislanzoni, 2001), however, herpes simplex virus type 1 (HSV1), the virus largely responsible for causing oral cold sores, is increasingly being identified as also causing genital herpes (Haddow, et al., 2006; Kortekangas-Savolainen & Vuorinen, 2007; Roberts, Pfister, & Spear, 2003). Symptoms of genital herpes include non-specific symptoms such as itching, abrasions, and headaches, and more definitive characteristics, such as recurring ulcerated lesions on and surrounding the genitalia (Auslander, Biro, & Rosenthal, 2005; Roe, 2004). It is the clinical manifestations of this STI that causes concern for public health, as genital herpes significantly increases the risk of HIV transmission between sexual partners (Freeman, et al., 2006).
In Australia, it is estimated that 76% of adults over 25 years are infected with HSV1 and 12% (approximately 1 in 8) are infected with HSV2 (Cunningham, et al., 2006). Significantly more women are infected with both types of HSV, having a prevalence rate of 16% for HSV2, double that of men. Women aged between 35 and 44 years bear the greatest burden (Cunningham, et al., 2006). However, a majority of individuals who have genital herpes remain asymptomatic (Berger, 2008; Melville, et al., 2003), making the prevalence of HSV2 largely underestimated (Cusini & Ghislanzoni, 2001). Further, although the risk of contracting genital herpes increases with age (Dickson, et al., 2007; Smith & Robinson, 2002), infection with HSV1 is increasingly responsible for genital herpes among persons aged under 21 years (Roberts, et al., 2003).

**Human papillomavirus (HPV)**

Human papillomavirus (HPV) is the most common viral STI worldwide (Bosch, Qiao, & Castellsagué, 2006). Almost all sexually active individuals are at risk of contracting this infection (Moscicki, 2005). For example the Cancer Council of New South Wales (2007), states that “four out of five women will have HPV at some time in their lives” (p. 3). HPV can infect any part of the genital region, is responsible for causing genital warts, and is a prominent cause of cervical cancer (Goon & Sonnex, 2008; Moscicki, 2005). Although there are approximately 40 types of HPV that can infect the genitalia (Dunne, Nielson, Stone, Markowitz, & Giuliano, 2006), types 6 and 11 are largely responsible for genital warts, and are considered low-risk types causing low grade changes of cervical cells. However, types 16 and 18 are considered high-risk types, and are typically associated with genital cancer, particularly cervical cancer (Dunne, et al., 2006; Dunne, et al., 2007). Cervical cancer is the leading cause of cancer among women
in developing countries (WHO & United Nations Population Fund [UNFPA], 2006), and is the second most widespread cancer throughout the world (Brotherton & McIntyre, 2004), with 99% of cervical cancer diagnoses being associated with HPV (WHO & UNFPA, 2006).

Individuals can be infected with multiple types of HPV, and many will not develop clinical signs and symptoms of the infection (Baseman & Koutsky, 2005; Herbert & Coffin, 2008). Women may only become aware of having HPV through Papanicolaou (Pap) test results (if performed) that indicate cervical abnormalities and the presence of HPV (Farreira, 1998). Therefore, many individuals are unaware of carrying this virus, and many young women may unknowingly be at risk of developing cervical cancer.

**Chlamydia (Chlamydia trachomatis)**

Chlamydia is a prevalent STI, and is the most commonly notified bacterial STI in Australia (Commonwealth of Australia, 2005b). This STI is often an asymptomatic infection. Existing research estimates 77% of chlamydia cases do not manifest symptoms, resulting in individuals remaining undiagnosed, and therefore untreated, for the infection (Farley, Cohen, & Elkins, 2003). The consequences of remaining untreated can lead to detrimental health outcomes particularly for women. Some of these outcomes include pelvic inflammatory disease (PID), ectopic pregnancy and infertility (Braverman, 2003; Tao, Tian, & Peterman, 2007). Additionally, recurrent infection with chlamydia is not uncommon among female adolescents (Niccolai, Hochberg, Ethier, Lewis, & Ickovics, 2007).
The prevalence of chlamydia in Australia has been increasing annually for over a
decade, with 55,945 cases reported in 2008, an increase of more than 500% from 1998
(10,840 reported cases) (Australian Government, Department of Health and Aging,
Communicable Diseases Australia [CDA]: National Notifiable Diseases Surveillance
System [NNDSS], 2009c). During the last decade, chlamydia has disproportionately
affected women aged between 20-24 years, followed by 15-19 year olds and 25-29 year
olds respectively (Australian Government, Department of Health and Aging, CDA:
NNDSS, 2009a). Of the 55,945 reported cases of chlamydia in 2008, more than half
were reported in women (approximately 60% [33,403 cases]) with over 80% (28,488) of
these cases reported in women aged between 15-29 years of age (Australian
Government, Department of Health and Aging, CDA: NNDSS, 2009b). These data are
consistent with research that has found an increase in the incidence of chlamydia in
Sydney (Donovan, 2002), and research based on a Melbourne sample, which indicated
women aged 18-24 years have a higher prevalence rate for chlamydia compared to 25-35
year old women (Hocking, et al., 2006).

**Gonorrhoea (Neisseria gonorrhoeae)**

Gonorrhoea is a bacterial STI and like chlamydia is often asymptomatic. This infection
can also result in reproductive health complications including PID, ectopic pregnancy,
and infertility, with adverse outcomes more common in women than men
(Commonwealth of Australia, 2005b). In 2008, there were 7,404 reported cases of
gonorrhoea with individuals aged between 20-24 years having the highest incidence of

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1 Chlamydial infection reports from 1998 to 2008 were used from the Australian Government Department of Health and Aging, Communicable Diseases Australia: National Notifiable Diseases Surveillance System for this statement, with these reports being available from the same URL address (as per reference list)
1,728 cases (Australian Government, Department of Health and Aging, CDA: NNDSS, 2009f). In contrast to chlamydia, gonorrhoea has consistently affected more males than females over the last ten years. Over the last decade, individuals aged between 20-24 years have had the highest incidence of this infection, followed by 15-19 year olds and 25-29 year olds (with the exception of 1998 and 1999, in which 25-29 year olds had the second highest incidence of gonorrhoea) (Australian Government, Department of Health and Aging, CDA: NNDSS, 2009e)\(^2\).

**HIV/AIDS**

Although HIV is not exclusively an STI, and women with HIV/AIDS were excluded from the current study, STIs can increase the risk and facilitate the transmission of this virus (Risbud, 2005; WHO, 2007). It was for this reason, in addition to the use of literature focused on women with HIV/AIDS throughout this thesis, that information associated with the prevalence of this infection has been included.

Approximately 33.2 million people around the world are living with HIV. Of these individuals, 22.5 million are residing in Sub-Saharan Africa, approximately 15.4 million are women, and 2.5 million are children under the age of 15 years. Further, in 2007, there were 2.1 million deaths caused by AIDS (Joint United Nations Programme on HIV/AIDS [UNAIDS] & WHO, 2007). The incidence of HIV/AIDS in Australia is low compared to countries such as Africa and the United States of America (USA), however the number of reported HIV cases has been steadily increasing in Australia since 1999

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\(^2\) Gonococcal infection reports from 1998 to 2008 were used from the Australian Government Department of Health and Aging, Communicable Diseases Australia: National Notifiable Diseases Surveillance System for this statement, with these reports being available from the same URL address (as per reference list)
In 2007 there were 27,331 known diagnosed cases of HIV and 10,303 known cases of AIDS in Australia. In the same year, there were 1,051 reported new diagnoses of HIV (over 85% of cases among males), an increase from 718 in 1999 (National Centre in HIV Epidemiology and Clinical Research, 2008). The dominant mode of HIV transmission in Australia is through men who have sex with men (MSM) (National Centre in HIV Epidemiology and Clinical Research, 2007, 2008). However, heterosexual transmission of this virus is a leading cause of infection (Witte, El-Bassel, Gilbert, Wu, & Chang, 2007) and is increasing throughout the world, with women commonly contracting HIV from male partners (UNAIDS & WHO, 2007). In addition, approximately 6,000 young people are infected with HIV daily (UNAIDS, 2003), making women and young people highly vulnerable to this virus.

**Trichomoniasis (Trichomonas vaginalis), donovanosis (Calymmatobacterium granulomatis), and syphilis (Treponema pallidum)**

Trichomoniasis, an infection caused by *Trichomonas vaginalis* protozoan (Braverman, 2003), is not a reportable STI in Australia and little data exists on the incidence and prevalence of this infection. However, according to research from the USA, trichomoniasis is one of the most common STIs among young people (Weinstock, et al., 2004), and the WHO (2001) estimated that there were 174 million new cases of trichomoniasis worldwide in the year 1999. Further, Australian research has suggested this infection may be common among young indigenous women (Panaretto, et al., 2006). Donovanosis is an STI caused by a bacterium (G. Lee & Bishop, 2006), and is rare in Australia, with only 2 identified cases reported in 2008 (Australian Government, Department of Health and Aging, CDA: NNDSS, 2009d). Finally, syphilis is also caused
by a bacterium organism (G. Lee & Bishop, 2006), and is not as common as other STIs in Australia, with 1,853 cases being reported during 2008 (Australian Government, Department of health and Aging, CDA: NNDSS, 2009g).

Despite the increasing incidence of STIs, the Centers for Disease Control (CDC) National Prevention Information Network (NPIN) (2006) states there is a lack of awareness of the risks and impact of these infections on both physical and psychological health. Further, STIs have more severe consequences for women than men (WHO, 2001), and although STIs can potentially affect any sexually active individual, these infections disproportionately affect women (National Institute of Mental Health [NIMH] Collaborative HIV/STD Prevention Trial Group, 2007; WHO, 2002) and young people (Dehne & Riedner, 2005).

**Why are young people and women most at risk of STIs?**

The high incidence of STIs among young people and women is attributed to, and influenced by social, behavioural, cognitive, and biological factors (Berman & Hein, 1999; Dehne & Riedner, 2005). Due to ongoing social change and trends such as delayed onset of marriage, young people are increasingly engaging in premarital sexual encounters at an earlier age (Berman & Hein, 1999; S. Moore, Rosenthal, & Mitchell, 1996; Redston-Iselin, 2001). Young people, in comparison to other age groups, are more likely to engage in risk behaviours as part of their normative development and exploration of their world (WHO, 2004), including engaging in unprotected sexual activity and having numerous sexual partners (S. Moore, et al., 1996; National Center for HIV, STD, and Tuberculosis [TB] Prevention, 2001).
Young people often perceive themselves as relatively invulnerable to STIs (Hillier, Harrison, & Warr, 1998; S. Moore, et al., 1996; Morojele, Brook, & Kachieng'a, 2006; Redston-Iselin, 2001), and may not fully consider the ramifications of their risk behaviours (Berman & Hein, 1999; Braverman, 2003). As a result of cognitive immaturity and lack of experience, young people may not have adequate knowledge and/or skills to implement safer sexual practices, such as barrier contraceptive use (Berman & Hein, 1999; WHO, 2004). Further, due to biological factors including cervical immaturity, (Berman & Hein, 1999), increased permeability of vaginal mucosal membranes (Doyal, 1994), mucosal abrasions of the vagina caused during sexual intercourse, and the female genitalia having a larger area with which secretions can come in to contact, women are at a heightened risk of STIs than males (Lindberg, 1999). Women are also at greater risk of STIs due to existing social and gender norms, which will be explored further in this thesis.

**Aim of the thesis**

From the aforementioned data, it is clear that women under 30 years of age are particularly vulnerable to STIs. Women have the highest rate of chlamydia, genital herpes, and HPV, with these infections having the ability to result in adverse health outcomes for both women and their children. Although the literature associated with STIs has found these infections carry stigma, which can create personal adversity, there is a paucity of literature that focuses on young women’s experiences of having an STI from both a nursing and feminist perspective. Further, despite an increase in sexual health services, many services do not take into account the differences between gender, sexuality and backgrounds of individuals, which hinders the effectiveness of these
services (P. J. Kelly, Bobo, Avery, & McLachlan, 2004; P. J. Kelly, Lesser, & Smoots, 2005). Some of the specific gendered issues associated with STIs remain largely unexplored. Thus, healthcare professionals may have gaps in their knowledge regarding the needs and concerns of specific groups, including young women. This thesis aimed to explore women’s experiences of having an STI when they were aged between 18 and 30 years from a feminist perspective.

Positioning of self

I came to this research with both a professional and personal interest. In my professional career, I have always had a strong interest in women’s health, reproductive health, and sexual health. From a research perspective, I felt there were many aspects and experiences of women’s lives that were yet to be fully explored, including the experiences of women who have an STI.

As a registered nurse working within a women’s health domain, I had provided care for women of all ages who had experienced reproductive anomalies, including those resulting from STIs. Whilst providing care for these particular women, I was struck by the detrimental effects these infections had on a woman’s reproductive system and capabilities, and the emotional burden this caused. Also, as a woman yet to experience pregnancy, I found the thought of contracting an infection that could jeopardise my fertility devastating.

As a young woman and a feminist, I understand the power of social norms and expectations as well as the power a woman’s reputation can have. I recall from my
school years the labels assigned to young women who had been discovered as being sexually active. Although oppressing, the demoralisation of women through their sexuality seemingly has not significantly changed throughout history. Within society, over time and in the present day, it seems that the possibility of a woman being sanctioned for her sexuality is a reality and a common occurrence, yet I believe this is a rarity for men.

STIs can affect all communities and societies. It is for this reason in addition to the previously stated comments; I have chosen to explore young women’s experiences of having an STI from a feminist perspective.
CHAPTER TWO: LITERATURE REVIEW

Chapter abstract

This chapter draws on the professional literature associated with young people, women and STIs. The literature review begins with a discussion of the societal norms and the associated factors that hinder women’s ability to practise safer sex, which subsequently puts women at risk of STIs. The review discusses contraceptive choices and the relationship characteristics that influence these decisions. Literature focused on STI knowledge, risk perception, and the factors that influence these perceptions are explored. Communication associated with sexual health and disclosure of sexual and STI history within sexual partnerships is examined, along with literature that identifies the stigmatisation and shame that often accompanies STIs. Concluding the chapter is a synopsis of the literature highlighting the gaps revealed through the review, and the significance of this study to the nursing profession. Please note that some of the content in this literature review has been previously published (see East, Jackson, O'Brien, & Peters, 2007).
Introduction

STIs cause immense physical and emotional burdens to individuals (Chesson, et al., 2004; WHO, 2001; NSW Department of Health, 2006), and although many STIs are preventable, people participate in sexual behaviour that places themselves and others at risk of these infections (Commonwealth of Australia, 2005c). Even though safer sexual practices can reduce the risk of STI transmission, many factors such as social norms can influence and impede the practice of safer sex, making particular groups vulnerable to these infections.

Women, social norms, and STIs

Societal norms have defined women’s sexuality according to stereotypical gender roles and behaviours, which have positioned women as sexually passive, repressed, and receptive to the powerful male gender (C. A. Campbell, 1995; Hird & Jackson, 2001; Holland, Ramazanoglu, Sharpe, & Thomson, 2004; S. M. Jackson & Cram, 2003; Sousa, 1998; Taylor, 1995). These norms and gender roles do not only exist in certain cultures and societies, but rather cross international and cultural borders (Marston & King, 2006), and can hinder women’s ability to practise safer sex and protect their sexual wellbeing.

The tension between societal expectations of appropriate (chaste) female behaviour and women’s initiation of condom use, places women in the position to choose between societal approval and expectations, or risk being labelled as promiscuous (by advocating safer sex practices) (Holland, et al., 2004; Kirkman, Rosenthal, & Smith, 1998; Wyatt & Riederle, 1994).
Women who express their sexuality are often viewed as promiscuous, undesirable and labelled in derogatory terms (Castro-Vázquez & Kishi, 2007; Gómez & Marin, 1996; Hillier, et al., 1998; J. Kitzinger, 1994; S. Reddy & Dunne, 2007; Taylor, 1995; Wyatt & Riederle, 1994). In contrast, masculinity and virility is endorsed and praised through men expressing their sexuality in terms of sexual dominance and engaging in sexual activity (Hird & Jackson, 2001; Simpson, 2007; Wight & Henderson, 2004). These views, commonly referred to as the ‘sexual double standard’ (S. M. Jackson & Cram, 2003; O'Leary, 2000; Shefer, et al., 2008), have been repeatedly enforced within patriarchal society, as a result of continued power imbalances and inequality experienced by women.

The sexual double standard is evident in the study by Gifford, Bakopanos, Dawson, and Yesilyurt (1998) that found women would risk their sexual health to preserve their social wellbeing within society and their relationship with their male partners. Among the culturally diverse sample, the women acknowledged that condoms were effective in preventing STDs, however social and cultural norms hindered condom use. The women disclosed that requesting condom use within a partnership threatened male dominance and implied mistrust and infidelity, with the latter being viewed as acceptable for men, but attracting societal disapproval for women (Gifford, et al., 1998). Therefore, for these women to protect themselves from STDs, a risk often associated with their male partners’ behaviour, they would have to risk relationship loss and societal disapproval (Gifford, et al., 1998). Similarly, among a South African sample of young women, it

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Although the WHO endorses the term STI over the previously used STD terminology, both terms are used interchangeably throughout the text depending on the cited authors’ use.
was found that the women would negate safer sexual practices in order to uphold social norms pertaining to women’s sexuality (S. Reddy & Dunne, 2007). Negating safer sexual practices could imply innocence and prevent the women being branded with derogatory terms that could occur through asserting condom use, thus revealing sexual health knowledge (S. Reddy & Dunne, 2007).

Qualitative research focused on males’ perceptions of beginning romantic and sexual relations with women, found that traditional gender roles, (the sexual double standard), were endorsed by the participants (Seal & Ehrhardt, 2003). The study found that the men perceived themselves as sexually dominant through being sexual initiators, with women expected to be responsive to their advances. The men in this study portrayed women as ‘conquests’, and enforced their masculinity through engaging in sexual activity (Seal & Ehrhardt, 2003). However, if sexual relations occurred within a perceived short time-frame, the men labelled these women with derogatory terms, and viewed these women as unsuitable for long-term commitments. On the other hand, the women who abstained from the sexual advances of the men for a perceived acceptable time-period were viewed as more desirable partners (Seal & Ehrhardt, 2003). Similar research focused on women’s perceptions of ideal sexual encounters (Ortiz-Torres, Williams, & Ehrhardt, 2003) resonates with Seal and Ehrhardt’s (2003) findings. Ortiz-Torres et al. (2003) found that most women wanted men to be relational and sexual initiators, thus endorsing traditional gender roles in which men express sexual dominance and women are the passive recipients of men’s sexual advances (Ortiz-Torres, et al., 2003).
Among an adolescent sample it was found that the male participants perceived their sexuality as uncontrollable, with sexual encounters enforcing their masculinity and virility (Hird & Jackson, 2001). However, women’s sexuality was confounded by the sexual double standard, with women’s sexual expression attracting social disapproval. This study also found that the men used romantic notions to gain sexual conquests, and that sexual coercion was common and influenced by gendered power imbalances, with women often forced to decide between the loss of a relationship, or submission to the sexual advances of their partners (Hird & Jackson, 2001). Similarly, male adolescent participants in Hayter and Harrison’s (2008) study admitted that they would coerce females into sexual activity. Further, how the adoption of traditional gender role behaviour had the ability to hinder safer sexual practices was evident in Buysse and Van Oost’s (1997) study, which revealed the more dominant a male partner is perceived to be, the less likely women are able to initiate safer sexual practices.

These power imbalances within relationships can have severe outcomes for some women and intensify their vulnerability to STDs (Champion, Shain, & Piper, 2004). A study of adolescent women with a history of an STD and abuse (physical or sexual), revealed that these women could not protect themselves from STDs due to fear of abuse (Champion, et al., 2004). Other research has asserted that adolescent girls exposed to physical and sexual dating violence are more likely to be diagnosed with an STD than adolescents who are not exposed to such abuse (Decker, Silverman, & Raj, 2005). This resonates with Coker’s (2007) systematic review that also revealed that intimate partner violence is associated with STI/s among women. All these studies suggest that stereotypical gender and societal norms hinder women’s ability to practice and advocate
safer sexual practices, therefore predisposing, and amplifying, women’s risks of contracting STIs.

**Contraception and behaviour**

*Contraceptive choices and safer sex*

The terms safer sex and contraception are often used ambiguously and interchangeably, although they have different meanings. Contraception refers to the controlling of fertility by using methods to avoid pregnancy, and although there is no such thing as totally ‘safe’ sex, ‘safer’ sex refers to precautionary actions taken to prevent the transmission of STIs (D. M. Anderson, Keith, Novak, & Elliot, 2002). Though the meaning, purpose and preventative techniques used differ between contraception and safer sex practices, safer sex is often equated to contraception and contraceptive use (Kirkman, Smith, & Rosenthal, 1998). This ambiguity increases vulnerability to STDs because of the perception that the use of any contraceptive is a safer sex practice, including techniques that are non-barrier contraceptives and hence do not afford any protection against STDs (Hillier, et al., 1998; Kirkman, Smith, et al., 1998).

The confusion may be (in part) because there is some overlap between contraception and safer sex, with condoms having some protective factors for both STIs and pregnancy. However, the most effective contraceptive, the oral contraceptive pill (OCP) has no efficacy in preventing STIs. Despite the epidemic proportions of STIs, and extensive publicity campaigns, condom use is reported to be generally inconsistent, particularly among young people (Abel & Brunton, 2005; Dehne & Riedner, 2005; Minkin & Wright, 2005; S. Moore, et al., 1996).
Among a college sample who had engaged in sexual intercourse, just over 70% stated that they had engaged in unprotected sex at some stage (Johnston Polacek, Hicks, & Oswalt, 2007). Similarly, in an Australian national representative sample of sexually active respondents, less than half had used a condom in the preceding 12 month period (R. O. de Visser, A. M. A. Smith, C. E. Rissel, J. Richters, & A. E. Grulich, 2003b).

Among a sexually active adolescent sample residing in New Zealand, over half reported inconsistent condom use (Abel & Brunton, 2005). Moreover, although among a British sample it was found that condom use had increased between the periods of 1990 to 2000, particularly among young people, and men aged 16-24 years, approximately two thirds of the sample who had at least two sexual partners reported inconsistent condom use within the preceding four weeks (Cassell, Mercer, Imrie, Copas, & Johnson, 2006).

A Korean study of young sexually active university students \( (n=243) \) found that only 10% of males and 8% of females reported consistent use of condoms. Not surprisingly, the lack of condom use, in addition to multiple partners, was associated with STD prevalence among the sample (S. Lee, et al., 2005). Likewise, over half of an HIV positive Taiwanese sample engaged in unprotected sexual intercourse and had a history of an additional STD (Chen, et al., 2006).

Even if individuals endeavour to use condoms, effective use is not always ensured due to inaccurate application and use. In a sample of young adults \( (N=1124) \) recruited from an STD clinic, it was found that almost a quarter reported errors with condom use that could lead to breakage and thus, greater exposure to STD transmission and pregnancy (Grimley, Annang, Houser, & Chen, 2005). Similarly, Australian research found that just under one quarter of a male sample had experienced condom breakage within a 12
month period (R. O. de Visser, A. M. A. Smith, C. E. Rissel, J. Richters, & A. E. Grulich, 2003a) and almost a third of an American male sample reported condom breakage within a three month period (R. A. Crosby, et al., 2007).

Condom use during sexual activity might not actually signify the practising of safer sex techniques. That is, it has been reported that condom application and removal during penetrative sexual activity may be a relatively common occurrence among young heterosexuals (R. Crosby, Sanders, Yarber, & Graham, 2003; R.O. de Visser & Smith, 2000; Hatherall, Ingham, Stone, & McEchran, 2007; Warner, et al., 2008). This behaviour is common among both casual and formed partnerships, although it may occur more frequently in the latter (R. de Visser, 2004). Furthermore, this behaviour is practised primarily for pregnancy prevention rather than STI prevention, despite the awareness of the consequences of STIs (R. de Visser, 2004). This may suggest that young people perceive their risk of contracting an STI to be low (R. de Visser, 2004).

Contraceptive choices are complex decisions involving interpersonal, social and cultural constructs (Cates & Stone, 1992a; Helweg-Larson & Collins, 1994), are influenced by contraception accessibility, knowledge (Fairley, 2005), and required purpose (Cates & Steiner, 2002), and also rely on dyadic communication (Wulff & Lalos, 2004). Young people perceive the risk of STIs to be low and the consequences of pregnancy to be real (Thorburn Bird, Harvey, Beckman, & Johnson, 2001). Therefore, it is not surprising that contraceptive and safer sex methods are more often used for pregnancy prevention rather than STI control, and that gender differences influence contraceptive choice. Grady, Klepinger, and Nelson-Wally (1999) found that although pregnancy prevention was
ranked the most important characteristic of contraception among both males and females in their sample, men ranked prevention of STDs higher than women. Both men and women ranked the condom highest as a way of preventing STDs and the OCP was ranked the most effectual for birth control (Grady, et al., 1999). A Russian study reported that the importance of condom use for women was pregnancy prevention, but for men, condom use was associated with STD prevention (Bobrova, Sergeev, Grechukhina, & Kapiga, 2005).

Among a Japanese sample of men aged 24-26 years, it was found that condom use was primarily used for pregnancy prevention rather than STI prevention (Castro-Vázquez & Kishi, 2007). Likewise, Flood’s (2003) Australian qualitative study examining condom use among male heterosexuals aged between 18-26 years, found that condom use was associated with the prevention of pregnancy rather than the prevention of STDs. Of a sample of 119 heterosexual college couples (N=238) approximately 67% reported negating condom use by choice, primarily attributed to the use of other contraceptives such as the OCP (Seal & Palmer-Seal, 1996). Therefore, it could be posited that if young men are willing to negate condom use through penetrative intercourse that carries the risk of pregnancy, refusal of condom use within other sexual practices that carry high STI risk (but low pregnancy risk) such as anal intercourse is highly probable. This places young women in a position that requires condom assertiveness to protect against STIs, a position that may pose difficulties for some women (East, et al., 2007; Ehrhardt, et al., 2002; Holland, et al., 2004).
Although the introduction of female contraception has empowered women to have greater control over the reproductive aspects of their bodies (C. Lee, 1998), the contraception most effective in preventing STIs, that is the male condom (Weller & Davis-Beaty, 2002), is controlled by men (Wulff & Lalos, 2004). Sexual behaviour within a relationship is determined by the characteristics of the involved individuals and the existing relationship dynamics (Luke, 2005). Further, it has been reported that young women feel more positive towards condoms, and are more committed to their use than men (S. M. Campbell, Peplau, & DeBro, 1992; De Bro, Campbell, & Peplau, 1994). However, women’s use of condoms is hindered by repressive relationship dynamics and gender attitudes (Tang, Wong, & Lee, 2001), meaning that women who are positioned and considered subordinate in their heterosexual relationships may lack the power to assert condom use. It may be for these reasons that research has suggested that accessibility (such as carrying condoms) does not necessarily predict condom use among adolescent women (DiClemente, et al., 2001).

It has been suggested that male dominance is associated with inconsistent condom use (S. Hoffman, O'Sullivan, Harrison, Dolezal, & Monroe-Wise, 2006). This poses great concern for all women in male dominant relationships, particularly women with older partners (Luke, 2005). These women may experience greater difficulty negotiating safer sex practices and contraceptive use due to the power inequality within the relationship, in comparison to same age dyads (Lam & Barnhart, 2006; Luke, 2005). Thus these women (among others), are at a greater risk of STIs (K. Ford, 2003; Lam & Barnhart, 2006; Luke, 2005). Additionally, due to the characteristics of the male condom allowing for male use (Macaluso, Demand, Artz, & Hook, 2000), men do not necessarily need to
negotiate condom use, whereas women do. Therefore women may have to negotiate and initiate condoms in order for them to be used (Buysse & Van Oost, 1997; J. A. Carter, McNair, Corbin, & Williams, 1999; Pequegnat & Stover, 1999).

Condom negotiation and resistance

Condom negotiation requires women to have high self-efficacy, perceived control within the sexual encounter, acceptance of sexuality, and adequate communication skills (Bryan, Aiken, & West, 1997; R. O. de Visser & Smith, 2001; Ehrhardt, et al., 2002). However, as previously mentioned, condom negotiation among women is hindered by cultural, gender, and entrenched societal norms that limit women’s assertiveness to use condoms through power imbalances and inequality (Cates & Stone, 1992a; Maxwell & Boyle, 1995; Rademakers, Mouthaan, & De Neef, 2005; Wingood & DiClemente, 1998). Because female assertion of condom use is in conflict with traditional norms, many women who endeavour to use condoms may be met with male resistance and relational conflict (Amaro, 1995; Gómez & Marin, 1996). Moreover, condom negotiation can be hindered by women perceiving a negative reaction from partners, including fear of emotional or physical abuse (Ehrhardt, et al., 2002; Morojele, et al., 2006).

The introduction of the female condom has given women an alternative contraceptive and safer sex option. However, though the female condom has the potential to facilitate consistent condom use, this option is still reliant on relationship dynamics and partner negotiation (Artz, et al., 2000; Macaluso, Demand, Artz, & Hook, 2000). Male condoms are used more often than the female condom and may be preferred (Ehrhardt, et al., 2002; Morojele, et al., 2006).
The female condom is relatively new, expensive, may be difficult to use, and is bulkier and obtrusive and has lower availability compared to the male condom (Artz, et al., 2000; Gollub, 2000; Haignere, et al., 2000; Macaluso, et al., 2007). It may be because of these reasons that male partner objection is the main factor for non-use of the female condom (Feldblum, et al., 2001).

The issue of perceived sexual pleasure is central to the use of contraceptives and safer sex options regardless of whether the purpose of use is to protect against STIs, prevent conception, or both. Although literature has acknowledged that women may resist condom use (Higgins & Hirsch, 2008), men (more than women) value a contraceptive that does not interfere with sexual pleasure (Grady, et al., 1999). Men may also feel that birth control methods interfere with pleasure (Pesa, Turner, & Mathews, 2001) and more specifically, may assert that condom use limits sexual gratification and intimacy (R. Crosby, Yarber, Sanders, & Graham, 2005; Flood, 2003; Holland, et al., 2004; Skidmore & Hayter, 2000). Thus, men may be more resistant to condom use (R. de Visser, 2004) and may refuse to use condoms (Bobrova, et al., 2005; Sangi-Haghpeykar, Poindexter, Young, Levesque, & Horth, 2003). Men may also assume birth control is the responsibility of women, which further contributes to male resistance towards the use of condoms (Berer, 2006; Flood, 2003; Skidmore & Hayter, 2000). Additionally, the condom is often associated with casual sexual encounters (Baylies, 2001; Rhodes & Cusick, 2000) and infidelity, and thus implies mistrust within a partnership (Kirkman, Rosenthal, et al., 1998; S. Moore, et al., 1996; Singer, et al., 2006; Sobo, 1995, 1998; Whittington, et al., 2001; Wingood & DiClemente, 1998). All these factors further
hinder women’s use of effective STI preventative methods (primarily the condom) and contribute to the reported inconsistent use of condoms by both women and men.

**Dual protection**

Ideally, the most effective method for fertility and STI control is the combined use of two protective methods, such as the OCP and the male condom; often referred to as dual contraception (Cates & Stone, 1992b; Wilson, Koenig, Walter, Fernandez, & Ethier, 2003). However, the term ‘dual contraception’ is ambiguous and implies methods to avoid conception rather than STI prevention. Therefore, for the purpose of this review, the term dual protection will be used to signify the use of two methods simultaneously (such as the OCP and condom), with the aim to prevent STI transmission and conception.

Use of dual protection is not widespread. This is considered to be due to various factors including individuals having insufficient finances, and individual hesitancy to use dual protection (Cates & Steiner, 2002) due to the preferred method of a single contraceptive (Cates & Stone, 1992b). Moreover, the promotion of dual protection is more difficult than promoting the use of only one protective method (Glasier, et al., 2006), and the use of two methods can possibly result in the inconsistent use of at least one (if not both) of the methods (Cates & Steiner, 2002). Due to the suggestion that condoms are more strongly associated with contraception rather than safer sex (Garside, Ayres, Owen, Pearson, & Roizen, 2001), this association can mean that young people may stop using condoms when contraceptives such as the OCP are used (Wulff & Lalos, 2004).
Darney, Callegari, Swift, Atkinson, and Robert (1999) found that their sample of adolescent females using a hormonal implant as contraception were aware that the device did not protect against STDs; yet condom use declined significantly over the three year period, despite partner changes. This resonates with other research which found the use of hormonal contraceptives can actually act as a barrier to condom use (Roye & Seals, 2001) and that when oral contraceptives are used condoms are often not (Woods, et al., 2006). Similarly, a longitudinal study of women using injectable contraception, revealed that less than one fifth of the sample used condoms consistently, despite the participants being aware that their choice of contraception did not protect against STDs (Sangi-Haghpeykar, Poindexter, & Bateman, 1997).

Wilson et al. (2003) found that just under 40% of a sample of women used dual protection. However, of these women, just under two thirds reported using the two contraceptives for pregnancy prevention rather than STD prevention (Wilson, et al., 2003). Likewise, in a national sample of American women ($N=7145$) using various contraceptive methods, less than 10% were using two or more forms of contraception (Piccinino & Mosher, 1998). Similarly, more recent research found that approximately 28% of Australian women aged 18-44 years ($N=2,221$) who were using the OCP were also using the condom simultaneously, with this also being the most common form of dual protection (Parr & Siedlecky, 2007). These studies signify that dual protection is not widespread and therefore, many women are placing themselves at risk of STI/s.
Relationship dynamics, multiple sexual partners, and contraception

Relationship dynamics encompass the beliefs, communication, emotions, needs and desires that occur between the involved individuals (Edlin & Golanty, 2004) and have a strong influence on contraceptive use (Cooper, Agocha, & Powers, 1999; Juarez & Castro Martin, 2006). Barrier protection declines as relationship length increases (Bralock & Koniak-Griffin, 2007), and is less frequently used in exclusive relationships, perceived monogamous partnerships and with regular sexual partners, in comparison to casual relations (Cooper, et al., 1999; R. de Visser, 2007; Juarez & Castro Martin, 2006; LaBrie, Earleywine, Schiffman, Pedersen, & Marriot, 2005; Macaluso, Demand, Artz, & Hook, 2000; Rhodes & Cusick, 2000).

Civic (2000) found that condom use in established relationships is inconsistent and declines with relationship progression, primarily attributed to the use of other contraceptive methods (Civic, 2000). Although monogamy may be viewed as a safer sex practice (James, Reddy, Taylor, & Jinabhai, 2004), risk behaviour still exists within perceived monogamous relationships as the safety depends on the behaviours of both partners (Finer, Darroch, & Singh, 1999; Lawrence, et al., 1998). This was demonstrated in Seal and Palmer-Seal’s (1996) research, which found that women were more likely to perceive no STI risk from their male partners, even though information from their partners was often contradictory and suggested that there was a degree of risk to the women. The authors concluded that personal perceptions are often inaccurate particularly in reference to sexual risk, sexual and STD history, and relationship status (Seal & Palmer-Seal, 1996).
Although individuals may perceive their partner as low risk, and believe they are fully aware of their partner’s sexual history, they can be mistaken and hold beliefs that are based on deceptive or incomplete information. Ellen, Vittinghoff, Bolan, Boyer, and Padian (1998) found that many individuals were unaware of their partners’ risk behaviours associated with STDs/HIV. Among a sample of 192 young heterosexual participants (96 partnerships), of which 11.5% had an STI, 32% of participants had additional sexual partners outside their current sexual relationship, and 74% of partners were unaware of this behaviour (Drumright, Gorbach, & Holmes, 2004). Similarly, Rosenberg, Gurvey, Adler, Dunlop, and Ellen (1999) found that almost one third of their sample who had a primary sexual partner actually had additional concurrent partners during this time, with this being associated with STD diagnosis. These findings concur with other research, which found that perceived partner concurrency is often discordant with partner behaviours among adolescents and young adults (Lenoir, Adler, Borzekowski, Tschann, & Ellen, 2006). These studies highlight how individuals can be at heightened risk of STIs, due to the presence of undisclosed risk factors and high-risk behaviours by their partners.

Multiple sexual partners and partner concurrency, is associated with an increase risk of STI exposure among individuals and sexual networks. Partner concurrency allows for the harbouring of such infections and contributes to the reproduction rate of STIs through various sexual partnerships expanding throughout different communities and social groups (Gorbach, Drumright, & Holmes, 2005; Jennings, Glass, Parham, Adler, & Ellen, 2004). Due to changing social factors as previously mentioned, the existence of multiple sexual partnerships is not uncommon, with men more likely to have a greater
number of sexual partners than women (Baylies, 2001; R. O. de Visser, A.M.A. Smith, C. E. Rissel, J. Richters, & A. E. Grulich, 2003; Rissel, Bauman, McLellan, & Lesjak, 2000). However, young women are increasingly at risk of STIs as early sexual initiation among females may lead to sexual risk behaviour including condom inconsistency and multiple sexual partners (Houlihan, et al., 2008; Kahn, Rosenthal, Succop, Ho, & Burk, 2002; O'Donnell, O'Donnell, & Stueve, 2001; Santelli, Brener, Lowry, Bhatt, & Zabin, 1998; Santelli, et al., 1997).

Increasingly, women are exposed to STIs, either through their own actions and/or their sexual partners’ behaviours, evidenced by the following studies. Among a sample of Hispanic women (some having concurrent sexual partners), it was found that condom use was inconsistent among both primary and other sexual partners (Sangi-Haghpeykar, et al., 2003). This occurred despite some women’s partners having high STD risk factors including multiple sexual partners, inconsistent condom use, and a history of intravenous drug use (IVDU) and/or an STD (Sangi-Haghpeykar, et al., 2003). Similarly, among a sample of men it was found that among the 15% who engaged in sexual relations outside of their primary partnership, less than one quarter used condoms (Pulerwitz, Izazola-Licea, & Gortmaker, 2001). Thus, these men exposed both themselves and their sexual partners to STD risk, with the primary partners largely being unaware of their male partner’s behaviour (Pulerwitz, et al., 2001).

Among a sample (N=360) of young women (18-30 years), of which 58% had a history of an STD, it was found that STDs were associated with the risk factors and sexual behaviour (concurrency and STD symptoms) of the women’s primary sexual partners,
rather than the women’s concurrent partnerships (Ehrhardt, et al., 2002). Further, it has been reported that women who have multiple partners lack control over sexual encounters through lacking condom assertiveness and communication skills, with men becoming less concerned with safer sexual practices with an increase in number of sexual partners (Monahan, Miller, & Rothspan, 1997). Multiple partnerships and concurrency, in addition to condom inconsistency and treatment non-compliance, increase the risk of STI transmission, and provide an environment for repeat infections (Fortenberry, et al., 1999; Rietmeijer, Bemmelen, Judson, & Douglas, 2002; Whittington, et al., 2001).

Perception, Risk, and STIs

Many people do not perceive themselves at risk of STIs and often do not perceive their behaviour as a risk factor for contracting these infections (Sobo, 1995). This perceived invulnerability then leads individuals to perceive that STIs happen to others rather than themselves (Abel & Brunton, 2005; S. Moore, et al., 1996), and may therefore, engage in sexual risk behaviours that predisposes them to these infections (WHO, 2004).

C. A. Ford, Jaccard, Millstein, Bardsley, and Miller (2004) examined the perceived risk of contracting chlamydia and gonorrhoea among sexually experienced (experienced in vaginal intercourse) individuals aged between 18-26 years ($N=11,821$). The results of this study showed that almost 85% of the sample perceived themselves at no risk of STIs, although 78% of the sample denied use of, or were inconsistent condom users. During the study period, 500 individuals (mostly females), tested positive for chlamydia
or gonorrhoea. Of these individuals, 75% reported no or inconsistent condom use, and 49% declared only one sexual partner within the previous 12 months (C. A. Ford, et al., 2004). These results demonstrate that young sexually experienced adults perceive themselves at a low risk for contracting an STD, despite the high prevalence of inconsistent condom use among this group (C. A. Ford, et al., 2004).

Similarly, in a sample of young women \( n=93 \) and their male sexual partners \( n=82 \), the majority (94.9%) perceived themselves to be at little or no risk of STDs, despite the women’s erroneous knowledge and reporting of their partners sexual history (Hutchinson, 1998). Likewise, of a sample of adolescent females \( N=209 \) almost 89% believed themselves to be at little or no risk of contracting an STI, despite some being previously diagnosed with an STI and some participants engaging in risk behaviours including unprotected sex and having multiple sexual partners (Ethier, Kershaw, Niccolai, Lewis, & Ickovics, 2003).

Among a sample of 300 female adolescents, just under 25% perceived themselves at no risk of STDs/HIV or pregnancy, although 63% were inconsistent condom users, and 38% had a history of an STD, with a further 16% acquiring an STD during the study period (Kershaw, et al., 2005). Although between 17-20% of this sample felt susceptible to either an STD, HIV, pregnancy, or all three, this relatively high perceived risk did not negate sexual risk behaviour including inconsistent condom use and having multiple sexual partners (Kershaw, et al., 2005). This finding resonates with past research, which concluded that previous diagnosis of an STD does not alter sexual risk behaviour.
including condom inconsistency, among female adolescents (Davies, et al., 2006; DiClemente, et al., 2002; Kershaw, et al., 2004).

**Perceived STI risk and knowledge**

The perceived low risk of contracting an STI among young people may be attributed to the lack of knowledge concerning STIs and associated sexual health issues. A qualitative study focused on determining the perceived and actual knowledge of STDs among young women found that the majority of women were confident in their knowledge in reference to STDs, primarily HIV/AIDS, although they demonstrated little knowledge in reference to symptoms of these infections (Rouner & Lindsey, 2006). This study recognised that although most of the women perceived their STD knowledge to be high, it was essentially limited to naming a few STDs with HIV/AIDS being the most commonly named. This finding suggests that these women were possibly unaware of the nature and possible health consequences of other STDs (Rouner & Lindsey, 2006).

Similar to the preceding example, a British study which examined the knowledge and attitudes of adolescents in reference to STDs, found that although HIV was most commonly recognised as an STD, other STDs such as chlamydia were not (Garside, et al., 2001). The participants had little knowledge about possible symptoms of STDs and often associated condoms with pregnancy prevention rather than protection against STDs (Garside, et al., 2001). Among a sample of women ($N=1,032$), only a small number of participants (30%) had heard of HPV and most participants had limited knowledge about the infection (Waller, et al., 2003). Another study also revealed that although women may have heard of HPV, many were unaware of the associated risk
factors and the long term consequences of the infection (Giles & Garland, 2006); a finding that was also evident among a USA sample (Friendman & Shepeard, 2007).

In contrast, Gorman and Bohan (2001) examined condom use in relation to perceived AIDS risk and HIV testing. Their findings demonstrated that women who had undergone an HIV test (having a perceived risk of infection) were more likely to use condoms than those who had not been tested. However, of the women who perceived that their partner may be at a high risk of infection, almost one third of the women did not use condoms. Further, of the women who perceived themselves as having a high risk of being HIV positive, only 60% used condoms in comparison to 67% of women who perceived themselves at a low risk (Gorman & Bohon, 2001). These authors suggested that women suspecting themselves to be HIV positive may not be as concerned about transmission because of their belief that they may have already contracted the virus from their current partner (Gorman & Bohon, 2001).

James et al. (2004) examined knowledge of STIs among young people (15-21 years). Their findings indicated that although a majority of the sample were aware that condom use and monogamy were effective in preventing transmission of STIs, condom use was inconsistent. Similarly, as previously discussed (and likely due to the high media coverage and public health programmes surrounding HIV/AIDS), young people are more knowledgeable about HIV/AIDS rather than the more prevalent conditions such as chlamydia (Trani, Gnisci, Nobile, & Angelillo, 2005). However, despite this knowledge, consistent condom may still be infrequent (Trani, et al., 2005).
In contrast to the aforementioned studies, a longitudinal study, which described the knowledge, attitudes and sexual behaviour of young women found that although knowledge of STDs may be high this did not positively influence protective sexual behaviour (Andersson-Ellstrom & Milsom, 2002). Likewise, Skidmore and Hayter (2000) found comprehensive and accurate knowledge of STIs among their young sample, however unprotected sexual encounters were frequent among the group despite some participants believing they had acquired an STI in the past. These studies demonstrate that although young people may have some knowledge about STIs, this knowledge does not necessarily equate to behavioural changes or influence young people’s risk perception of STIs.

**Relationships and perception**

Relationships and the associated intimate, loving and trusting emotions that usually accompany romantic partnerships, all have the power to influence and impact on the sexual practices that occur within relationships (L. J. Bauman, Karasz, & Hamilton, 2007; Holland, Ramazanoglu, Scott, & Thomson, 1994; Holland, et al., 2004; Pilkington, Kern, & Indest, 1994). These emotions usually result in positive regard for partners and can diminish perceptions of the possible sexual risk that partners may pose and hence, negate safer sex practices that can reduce the risk of STIs (Holland, et al., 2004; Kirkman, Rosenthal, et al., 1998; S. M. Moore & Rosenthal, 1998; Pilkington, et al., 1994; Sobo, 1995). These emotions and sequelae of behaviours can be detrimental to young people’s health, particularly among young women who may be more concerned with the commitment and intimacy of a relationship compared to their male partners (Hynie, Lydon, Cote, & Wiener, 1998; Kirkman, Rosenthal, et al., 1998). What is more
concerning is the suggestion that the average time-frame young women’s relationships progress from being treated as new, to being considered established (marking the beginning of unsafe sexual practices) is 21 days (Fortenberry, Tu, Harezlak, Katz, & Orr, 2002). This time period, as noted by the authors, may not be adequate time for an infection to emerge or even elapse (Fortenberry, Tu, et al., 2002).

The development and formation of romantic and sexual relations begins in the period spanning between adolescence and young adulthood (Regan, Durvasula, Howell, Ureno, & Rea, 2004). Although romantic love among young people can have various meanings (Kirkman, Rosenthal, et al., 1998), it is generally characterised as having attributes including trust, attraction, happiness and friendship (Seiffge-Krenke, 2003). Within the context of romantic love, sexual relations can be guided by gender scripts, which equate sexual activity as being a sign of trust, intimacy and commitment among young women and a source of physical pleasure, particularly for young men. Safer sex and condom use can be hindered due to the condom implying mistrust, and unsafe sex often being ascribed as a declaration of one’s love (Kirkman, Rosenthal, et al., 1998; Rhodes & Cusick, 2000). Within the romantic love discourse it is difficult to conceive that the one who holds the affection of another could possibly be a source of sexual infection (Goldmeier & Richardson, 2005).

A study exploring the attitudes of safer sex and love among single adult heterosexuals found that safer sex was confounded by love (D. Rosenthal, Gifford, & Moore, 1998). The study found that women associated sexual activity with love, romance, and the potential formation of a relationship. While male participants expressed some similar
views, they could also conceive sexual activity independent of love and romance. The
participants expressed the difficulty in discussing condom use with newly acquainted
partners, and women expressed sacrificing protective sex due to the fear of a negative
reaction that could cause loss of a potential partnership (D. Rosenthal, et al., 1998). In
addition, men admitted to using the promise of romance to gain their sexual desires from
females and forgoing unprotected sex for physical satisfaction. Male participants also
expressed a reluctance to use condoms, with some admitting to refusing condom use,
thus leaving women with the decision of forgoing safer sex or risk losing a potentially
satisfying romantic relationship (D. Rosenthal, et al., 1998). This resonates with more
recent research that also found young women associate sexual activity with love, and
perceive that the practice of safer sex can threaten a potential loving partnership (S.
Reddy & Dunne, 2007). Therefore, young women will forgo safer sex due to fear of
Likewise, among a sample of adolescents it was found that boys used false promises
such as implying an interest in a long-term commitment to negate condom use, and girls
engaged in unprotected sex in hope of a long-term partnership, and perceived
unprotected sex as a representation of a boy’s faithfulness and possible commitment (L.
J. Bauman, et al., 2007). These findings suggest that perceived trust, desire for intimacy,
holding a relationship in positive regard, belief in monogamy within relationships and
perceived low risk of STI override concerns about contracting infections.

The low perceived risks of sexual partners due to the positive emotions associated with
romance are often founded on assumptions of partner behaviour (Critelli & Suire, 1998),
and subjective thoughts rather than on an accurate assessment of risk (Roye & Seals,
Hoffman and Cohen’s (1999) research concluded that an individual’s sexual riskiness was based on personal looks and characteristics, and perceived trust rather than factual information. This, as the authors suggested, reinforces sexual risk behaviour through individuals assuming their subjective assessment of partner risk to be correct, particularly when they have engaged in unprotected sex and have not contracted an STI.

Participants in another sample claimed that unprotected sexual encounters were influenced by the physical appearance of potential sexual partners as well as being dependent on how much the individual knew and trusted their partner (Skidmore & Hayter, 2000). These participants asserted that they would only have unprotected sexual encounters with partners they knew and trusted (Skidmore & Hayter, 2000). However, many of the participants had engaged in unprotected sexual activity with casual partners who were merely acquaintances (Skidmore & Hayter, 2000). Stoner et al. (2003) also found that individuals underestimated their partners’ sexual risk, and consequently acquired an STD. As previously noted, these subjective assessments determining a sexual partners’ risk are often erroneous and can conflict with a sexual partner’s actual lived background. This means that young people can increase their risk of contracting STI/s due to their low perceived risk of these infections and their tendency to negate barrier protection.

**Sexual health discussions and STI disclosure within partnerships**

Disclosure of an accurate sexual history to a potential partner is a safer sex practice. Acquiring this knowledge can allow individuals to establish the potential risk of possible sexual partners and allows for more informed decision-making (Lucchetti, 1999).
However, the frequency of the occurrence of such discussions is largely unknown, and it could be assumed that they are relatively infrequent, considering that such intimate discussions may hinder the development of a new relationship and that young people may regard these as unnecessary (Stein & Samet, 1999).

A qualitative study of young women found that sexual health discussions were infrequent within relationships prior to sexual intercourse, and more likely to occur as intimacy and trust developed, usually post sexual activity (Cleary, Barhman, MacCormack, & Herold, 2002). These discussions were hindered by discomfort in discussing sexual history due to fear of judgement, loss of relationship and/or offending partners, and low perceived risk of STDs; and therefore the perception that these discussions were irrelevant (Cleary, et al., 2002). Additionally, the women perceived that if these discussions associated with sexual health were to occur, it would be through female initiation. However, such discussions did not influence use of barrier protection considering that the use of condoms declined over time within the participants’ relationships even without these types of conversations occurring (Cleary, et al., 2002).

Among a sample of 18-20 year olds, it was found that trust within a partnership was needed for discussions based on sexual risk behaviour, and it was this trust that lead to the belief that one’s partner was not an STD risk (Lock, Ferguson, & Wise, 1998). Similar to findings of other studies (for example Cleary, et al., 2002), it was found that women were more likely to initiate such discussions (Lock, et al., 1998). Another study conducted among African American female adolescents, investigating infrequent communication in reference to STDs, pregnancy, and condom use, found that the
individuals who infrequently communicated with their sexual partner/s were more likely to use condoms inconsistently (R. A. Crosby, et al., 2002).

Lucchetti (1999) conducted a study examining the knowledge of disclosing sexual history as a safer sex practice and the extent of truthfulness in disclosing sexual history among a college sample (N=364). The results found that although 99.7% perceived themselves as knowledgeable about safer sex practices, 42% were not aware that disclosing sexual history is considered a safer sex practice, with 37% deeming it to be unnecessary (Lucchetti, 1999). Further, of the sexually active participants (n=322), 32% omitted disclosing their sexual history to at least one partner, 17% omitted disclosing to all partners and 24% lied about their sexual history, with men being more deceptive than women (Lucchetti, 1999). Although this study did not examine why the participants chose not to disclose and why some participants misled partners, it could be assumed that full disclosure did in fact pose a threat to their relationships; a risk that some chose not to take (Lucchetti, 1999).

Not disclosing one’s sexual history and STI status is concerning, considering the potential risk this poses to contracting an STI, and because it has been suggested that sexual contact without disclosure of STD/HIV positive status is a common practice (Ciccarone, et al., 2003). Longitudinal research found that among individuals with symptomatic herpes, engagement in sexual activity without disclosing their infection to partners was prevalent (Morgan, Mahe, Okongo, Mayanja, & Whitworth, 2001). Among a sample receiving treatment for a recurring STD, non-disclosure to spouses was common, particularly among men (Pitts, Bowman, & McMaster, 1995).
In a study examining the extent of HIV positive serostatus disclosure and sexual risk behaviour among a South African sample \((N=69)\), 78% of the sample had not disclosed their diagnosis to their sexual partners (married or cohabiting), regardless of their partner’s serostatus (Olley, Seedat, & Stein, 2004). In addition non-disclosure was associated with being male, having multiple sexual partners and not using barrier protection (Olley, et al., 2004). Olley et al’s (2004) findings concur with previous research that suggested HIV positive adolescent females are more likely to negate condom use during sexual activity when they have not disclosed their HIV status to sexual partners (Sturdevant, et al., 2001).

**Stigma and STIs**

STIs are stigmatising conditions that not only create an emotional and physical burden for the individual, but can also strain and alter intimate relationships (Newton & McCabe, 2008b; Newton & McCabe, 2005; NSW Department of Health, 2006). The stigma surrounding STIs is intensified due to the mode of transmission and the societal perception that one who contracts an STI must exhibit deviant behaviours (Bunting, 1996). STIs influence sexual behaviour and contraceptive choices within a relationship, and may create strong emotional responses such as fear of rejection (Newton & McCabe, 2005), guilt associated with STI transmission, and concern that others are aware of an individual’s STI status (Oster & Cheek, 2008; S. L. Rosenthal, et al., 2006; Scrivener, Green, Hetherton, & Brook, 2008).

Kahn et al’s (2005) study explored the psychological and behavioural impact of an HPV diagnosis on a sample \((N=100)\) of young women (14-21 years). The findings established
that 51% were HPV positive and 23% had cervical abnormalities. The study found that a positive result and abnormality lead to distress and anxiety related to stigma and risk for cervical cancer. More recent findings by Kahn et al. (2007) revealed that young women felt guilty, ashamed and blamed themselves if they had an abnormal pap test or a HPV diagnosis. The young women expressed concerns about being stigmatised and feared rejection from others, due to the societal view that STIs are associated with ‘dirty’ promiscuous individuals (Kahn, et al., 2007). Similar outcomes were reported by McCaffery et al. (2004) and McCaffery, Waller, Nazroo, and Wardle (2006), who suggested that women with a positive HPV diagnosis experienced anxiety, shame and stigma, leading to negative views and feelings towards their own sexual relations.

Knowledge of the sexually transmissible nature of HPV can affect the stigma and shame felt on diagnosis (Waller, Marlow, & Wardle, 2007). According to Waller et al. (2007), young women who are aware that HPV is an STI experience greater stigma and shame compared to those who do not possess this knowledge. Other research conducted among a diverse ethnic sample of women also found that the stigma attached to HPV is associated with the sexually transmissible nature of the infection (McCaffery, et al., 2003). Additionally, the study found that the stigma associated with HPV could hinder HPV testing due to the perception that even testing for HPV conveyed infidelity and promiscuity (McCaffery, et al., 2003).

Several other studies have suggested that the social stigma associated with STIs acts as a barrier to STI testing and treatment. Barth, Cook, Downs, Switzer, and Fischhoff (2002) found that social stigma and the perception of others could potentially hinder the seeking
of healthcare services for STIs among their sample of college students. Fortenberry (1997) suggested that stigma may delay seeking treatment for STDs particularly among adolescent females, and was also found to be a hindering factor in gonorrhoea and HIV testing (Fortenberry, McFarlane, et al., 2002). The perceived stigma associated with STIs acted as a barrier and delayed healthcare treatment for STIs, among a Brazilian sample, particularly among the women participants (Malta, et al., 2007). Additionally, feelings of shame due to having an STI could have contributed to the delay in seeking STI treatment among a sample of Vietnamese women (Do, Ziersch, & Hart, 2007). These studies suggest that the stigma and negative perceptions attached to STIs are so strong that even if severe health adversity occurred from an STI, sexual health testing and treatment may not be sought.

Mills, Daker-White, Graham, and Campbell (2006) identified gendered aspects to chlamydia diagnosis. The women of their study who were diagnosed with chlamydia feared being stigmatised and judged by others; they also perceived themselves negatively and felt ashamed, which was due to their negative views of individuals who contract STI/s; a finding also evident in Duncan, Hart, Scoular, and Bigrigg (2001), and Nack’s (2002) research. This caused many women to conceal their diagnosis from others, yet the male participants did not fear stigmatisation, or perceive themselves negatively (Mills et al.2006). These findings concur with other research, which found women perceived themselves more negatively in comparison to men when they contracted an STI (Christianson, Johansson, Emmelin, & Westman, 2003; Darroch, Myers, & Cassell, 2003; G. Green, 1996; L. M. Lewis, Rosenthal, Succop, Stanberry, & Bernstein, 1999; Mulholland & Van Wersch, 2007). These feelings of negativity among
women who contract an STI reflects the typical societal norms that sanction women with these infections as shameful, yet this sanction is not applied to men due to societal approval of male virility. All these studies suggest that the stigma and shame that accompany an STI not only causes concealment of an STI, but can also have an immense impact on the psychosocial and emotional wellbeing of individuals, particularly women.

**Conclusion**

This literature review has revealed that although STIs are prevalent worldwide, many individuals, particularly young people, perceive themselves invulnerable to these infections. People often are more concerned with pregnancy prevention than the avoidance of STIs, which leads to the negating of barrier protection, and thus greater STI vulnerability. Individuals often mistake sexual partners’ risk, and perception of STI risk is based on trust and love rather than objective information, particularly among young women. Further, the literature presented has confirmed that women are particularly vulnerable to STIs; a consequence of gender norms that oppress the advocating of female sexual wellbeing and endorse power imbalances and male dominance within sexual relationships.

**Summary**

The literature reveals many gaps. Firstly, the literature relating to aspects of STIs is largely dominated by quantitative research. The qualitative data that does exist is mostly concerned with specific aspects associated with STIs such as knowledge, treatment, and stigma, rather than the totality of the experience pertaining to having an STI. Further, the
existing literature is dominated by professional domains such as psychology, sociology, and public health rather than nursing, with only a few exceptions (for example Keller, Sadovszky, Pankratz, & Hermsen, 2000; Madrid & Swanson, 1995; O'Byrne & Holmes, 2005; Swanson, 1999; Swanson, Dibble, & Chapman, 1999). Moreover, of the qualitative research available there is minimal literature relating to STIs from a feminist perspective; rather the existing feminist literature such as Jackson and Cram (2003) and Peart, Rosenthal, and Moore (1996) is focused on gender, heterosexuality and relationships.

Young women represent a vulnerable population for contracting STIs, and are at an increased risk of these infections due to the fore-mentioned highlighted factors throughout this review. Additionally, differences exist in regards to the experiences and impact on men and women who contract STIs (Dibble & Swanson, 2000; Mills, et al., 2006; Rasera, Vieira, & Japur, 2004). In light of these facts, and in considering the previous stated gaps within the literature, the purpose of this study was to explore the experiences of young Australian women who had contracted an STI from a feminist perspective. Due to STIs affecting women largely under 30 years of age (as identified in the introduction), for the purpose of this study, young women were regarded as those who contracted an STI between the ages of 18 and 30 years. The study aimed to gain valuable insights into the emotional, physical, and psychosocial impact an STI had on participants’ lives using a feminist methodology. This research contributes to the existing body of literature through exploration of the experience of having an STI and the potential of having a life-long infection. In exploring this, essential insights were
gained into the experiences of young women who had contracted an STI, which has the potential to facilitate and guide services and holistic care for these women.

**Significance to nursing**

This research is of significance to the discipline of nursing. Nurses have a fundamental role in the provision of treatment, education and care for women’s sexual health and STIs (Tyler, 2005). The study will contribute to the existing literature and assist nurses in the provision of professional therapeutic care to young women with STIs through providing enhanced understandings of the complex life aspects and psychosocial issues affecting young women with STI/s.
CHAPTER THREE: METHODOLOGY

Chapter abstract

This chapter presents the methodological framework and methods that were used to address the research aim of this study. The chapter gives an overview of qualitative research in nursing, provides examples of nursing studies that have previously used a feminist approach, and discusses the feminist perspectives underpinning this research. The methodology including the collection of personal stories via computer mediated communication (CMC), and the methods used including qualitative conversational encounters, recruitment strategies, ethical issues, and the inclusion and exclusion criteria for this study are elucidated. An explanation of the data analysis procedures used for this research is provided, and following this is a discussion focused on the measures used for achieving rigour. Please note that material from some parts of this chapter have been produced and accepted for publication (East, Jackson, O'Brien, & Peters, 2008b, in press).
Introduction

This study was conducted within a feminist framework using a storytelling methodology. Feminist and storytelling approaches to research both value subjectivity and place participants and their stories at the forefront of the research (Chase, 2005; Elliot, 2005; Joyappa & Self, 1996), making these approaches ideologically compatible. A feminist framework was selected to guide this study because of the focus on women and their experiences. Although the use of other qualitative methodologies are equally able to explore aspects of women’s lives, a feminist framework recognises and makes apparent the oppression and social constructs that influence women’s experiences (White, Russo, & Travis, 2001). Sexuality is socially constructed (Baker & Rosenthal, 1998; C. Kitzinger, 2000; M. Lewis, 1998), and therefore, effective exploration of women’s experiences with STIs, could not be effectively achieved without taking into account the gendered social and cultural forces that have been imposed on women’s sexuality.

Nursing and qualitative research

Nursing is a profession that is concerned with the therapeutic and holistic care of individuals (D. Jackson, Daly, & Chang, 2003). The profession values individuality and recognises that individuals and their experiences are unique. Nurse researchers, who use a qualitative approach to focus on the exploration of these experiences, contribute to nursing knowledge and can incorporate this knowledge into the clinical setting, which has the potential to enhance patient care (Overcash, 2004). Qualitative research focuses on the exploration of phenomena within the human world to gain greater understanding
and insight into human experience (Darlington & Scott, 2002; D. Jackson & Borbasi, 2008; D. Jackson, et al., 2003; Polit & Beck, 2008; D. Whitehead, 2007). This type of research embraces subjective knowledge, and places value and importance on individuals and their experiences (D. Jackson & Borbasi, 2008; Rubin & Rubin, 2005; D. Whitehead, 2007). Therefore, the utilisation of a qualitative framework for this study was chosen due to this research being focused on gaining insight and understanding into young Australian women’s experiences of having an STI, and to contribute to the limited nursing research that has focused on women’s experiences of these infections.

**Feminist research in nursing**

Nursing research conducted from a feminist perspective can provide valuable insights into the nursing profession itself, in addition to the personal experiences of patients/clients (Dunphy & Longo, 2007). Further, several nurse scholars have conducted research from a feminist perspective to gain insight into various life experiences. For example Gabrielle, Jackson, and Mannix (2008) utilised a feminist approach to explore the concerns of practising nurses aged between 40-60 years and gained insight into these concerns and the needs of this group. In recognising the distress that can occur among nurses and midwives providing care for women who had experienced a pregnancy termination during their mid-trimester, Huntington (2002) adopted a feminist perspective to illuminate how the amalgamation of feminist principles with nursing practice can enhance the wellbeing of both nurses and patients in these circumstances. Similar to Huntington, Aléx and Hammarström’s (2004) research among a group of Swedish women also used a feminist perspective to explore experiences of abortion.
Peters, Jackson, and Rudge (2007a) explored the effects of the promotion and often over-inflated assisted reproductive technology (ART) success rates on couples who had accessed these services. By using a feminist lens, the conflict between what participants considered success of ART (a live healthy baby) compared to advertised statistics (which can include non-viable outcomes), became apparent (Peters, et al., 2007a). This study recognised how these statistics often overshadow the unsuccessful outcomes of this treatment, which as the authors suggested, has the potential to influence couples’ decisions to access and continue ART (Peters, et al., 2007a). Tower, McMurray, Rowe, and Wallis (2006) explored the healthcare experiences of women who had been exposed to domestic violence. The research, which was informed by feminist and post-modern theory, illuminated the complex healthcare needs of these women, and shed light on the need for healthcare services to adopt a more holistic approach when providing care for women who experience domestic violence.

Feminist approaches have been used to explore ‘mother blaming’ (mothers perceived to be responsible for the health and behaviours of their children) among women (D. Jackson & Mannix, 2004), and to explore the effects of living with, and specifically the pain associated with endometriosis (Huntington & Gilmour, 2005). Further to this, nurse researchers have applied feminist methods to explore the experiences of young women who had a history of self-harm (McAndrew & Warne, 2005), and to recognise and illuminate how women’s experiences of cardiovascular disease are distinct from men’s (McCormick & Bunting, 2002). By using a feminist approach, all these studies have
positioned women and their experiences at the forefront of their research, to illuminate the distinct healthcare needs of women facing particular challenges.

**Characteristics of feminist research**

Feminist theory can be viewed as a broad theoretical and ideological perspective (Chafetz, 2004; D. Jackson, 1997; Kushner & Morrow, 2003) and although there is no one distinct form of feminist theory (Gatens, 1991), feminist researchers apply feminist principles to existing theory and methodologies and utilise these to conduct research (Brooks & Hesse-Biber, 2007; Gatens, 1991). Feminist research focuses on the exploration and the examination of oppression, particularly, although not exclusively, women’s oppression (Bailey & Cuomo, 2008a; Brooks & Hesse-Biber, 2007; Chafetz, 2004), and arose from the recognition of the lack of literature and knowledge about women’s perspectives and experiences (Beasley, 1999; Brooks & Hesse-Biber, 2007; Cowman & Jackson, 2003). Rather, the knowledge and literature that existed tended to focus on male (the norm) perspectives, which was perceived to be representative of both men’s and women’s experiences (Beasley, 1999; Letherby, 2003). Thus, women’s experiences have been largely invisible in the construction of knowledge (D. Jackson, 2000).

Feminist researchers recognise that knowledge and experience are influenced by, and derived from societal constructs, such as gender, culture, and race (J. C. Campbell & Bunting, 1991; Cowman & Jackson, 2003; White, et al., 2001). Additionally, feminist research should be carried out in a way that does not contribute to the (further) oppression or exploitation of participants (Hall & Stevens, 1991; Letherby, 2003). In
acknowledging and examining oppressive experiences, feminist research aims to produce knowledge and facilitate change to improve inequality both at a societal and personal/individual level (Aranda, 2006; Brooks & Hesse-Biber, 2007; J. C. Campbell & Bunting, 1991; Cuomo & Bailey, 2008; Harding & Norberg, 2005; Hoffmann, 1991; Joyappa & Self, 1996; Letherby, 2003; White, et al., 2001).

**Feminist perspectives underpinning this study**

The central feminist perspectives underpinning this study are the oppression to which women’s sexuality has been subjected, the personal and political nature of STIs, and feminist consciousness-raising. Women’s sexual oppression is a result of the female gender being ascribed and positioned subordinately within patriarchal society (Bernhard, 2003). The ‘personal is political’ recognises that aspects of the public domain are felt and experienced within the personal domain (Stanley & Wise, 1993), and consciousness-raising adheres to the perspective that through a feminist lens life aspects can be viewed differently (Stanley & Wise, 1993). These three central feminist perspectives are now discussed in relation to this thesis.

**Oppression and women’s sexuality**

The foundation of women’s oppression does not arise from the biological constructs of women, but rather a society that has socially constructed women as inferior to men, and marginalised women as a result (Stanley & Wise, 1990). Women’s sexuality has traditionally been perceived as passive and functional to serve men’s sexual needs (Hird & Jackson, 2001; Holland, et al., 2004; Nelson, 2005), and has been portrayed as subservient to men through pornographic (Whisnant & Stark, 2004) and medical
discourses (Amaro, Raj, & Reed, 2001). Traditional research has positioned women’s sexuality as a medical biological construct, ignoring societal influences which can have an immense impact on sexuality (Amaro, et al., 2001). Although perceptions of female sexuality are becoming broader and more accepting, women’s sexuality remains governed by traditional gender norms, and women are subjected to oppressive and demeaning labels depending on perceptions of behaviour (Holland, et al., 2004; S. M. Jackson & Cram, 2003; Nelson, 2005).

Women’s sexuality has been constructed through the whore/slut and the chaste/madonna dichotomy with the former typically characterising sexually active women, and the latter representing the pure virgin, the married woman, or the idealised woman (Hird & Jackson, 2001; Lebowitz & Roth, 1994; Nelson, 2005; P. T. Reid & Bing, 2000). This dichotomy has led to women’s sexuality being defined according to behaviour, with women being perceived as either virtuous through virginity and perceived chaste behaviour or immoral and condemned through perceived inappropriate sexual behaviour and activity (Nelson, 2005; P. T. Reid & Bing, 2000). Additionally, men’s sexual activity is endorsed through patriarchal values whereas women are condemned for the same behaviours (Crooks & Baur, 2005a; S. M. Jackson & Cram, 2003). Despite these societal views, women are often still positioned as responsible for controlling men’s sexual desires and behaviours, although this is in conflict with the expectation of women to be sexually passive recipients (Nelson, 2005).

Generally, society has perceived STIs as ‘dirty’ diseases associated with deviant, immoral and dangerous sexual behaviour (Davidson & Hall, 2001; Lawless, Kippax, &
Crawford, 1996; M. Lewis, 1998; Spongberg, 1997). Women with STIs have been viewed as tainted, and as “vectors of disease” (Amaro, et al., 2001, p. 326) who pass their infections on to men (Amaro, et al., 2001; Spongberg, 1997). This perception of women with STIs partly arises from these infections having a long historical association with female prostitution (de Vries, 2001; M. Lewis, 1998; McKie, 1996; Spongberg, 1997) and generally any woman who engaged in sexual activity that occurred outside of socially approved and accepted norms (Davidson & Hall, 2001; M. Lewis, 1998). Due to society being governed by patriarchal values, women were sources of STI infection and men were victims; victims of seductive, deviant, immoral women (de Vries, 2001; Spongberg, 1997). As a result of these gendered stereotypes, women with STIs are stigmatised and oppressed. In contrast, men who contract STI/s are not commonly subjected to demeaning labels, and having an STI is perceived to be a normal, albeit unwelcome, outcome of a man’s virility (Bolan, Ehrhardt, & Wasserheit, 1999). Moreover, historically STIs were conceptualised simply as a medical dilemma for men, yet denoted immorality among women (M. Lewis, 1998).

Although women’s sexuality has become more liberated over the decades, women are still perceived to be the main source of STIs and continue to experience oppression with regard to sexuality (Amaro, et al., 2001). As highlighted by Amaro et al. (2001), mainstream non-feminist research has largely ignored women’s sexuality as being anything more than biological. This in turn discounts the social constructs that oppress women’s sexuality, and are detrimental to women’s sexual health and wellbeing (Amaro, et al., 2001). Moreover, women continue to experience oppression and stigmatisation associated with STIs through treatment services which can hinder the
therapeutic and adequate care of women with these infections (Amaro, et al., 2001; Bolan, et al., 1999; Lawless, et al., 1996).

**The personal and political nature of STIs**

Throughout history, women have traditionally been associated with the domestic home or personal sphere (Beasley, 1999; Landes, 1998). However, men have had the ability to move between both the private and public sphere which is associated with capitalism and political power (Gatens, 1991). Women’s confinement to the personal sphere has been recognised as a major foundation of women’s marginality, as it has restricted women’s involvement in the public arena, and positioned women as inferior to men on the social and political landscape (Beasley, 1999; Landes, 1998). The notion that ‘the personal is political’ is a central component of feminist theory (Stanley & Wise, 1993), and arose from the belief that women’s oppression derived from established patriarchal systems of power and norms, which affected both the personal and public lives of women (Weedon, 2003). From a feminist perspective, the personal and public spheres are intertwined, therefore an individual’s position in, for example, society and their personal experiences are influenced by social factors and constructs that exist in the public realm (Bent, 1993; Crooks & Baur, 2005b; Stanley & Wise, 1993). Hence, gaining insight into these constructs and how they influence individual lives can be achieved through the exploration of the personal realm (Stanley & Wise, 1993).

Women’s sexuality has been at the forefront of political contention for decades (Bailey & Cuomo, 2008b) due to the social construction of gender and sexuality (C. Kitzinger, 2000; Mac an Ghaill & Haywood, 2007). Society has sanctioned women’s sexuality to
be oppressed and governed by male desires, and has marginalised it through stereotypical norms; with these constructs impacting on the way women feel about their own sexuality as well as their sexual choices (Nelson, 2005). How the public sphere impacts and exists within the personal realm is evident throughout history in the context of power structures subjecting female prostitutes to medical examinations and interfering with their ability to work in the hope of STI control (de Vries, 2001; M. Lewis, 1998; Spongberg, 1997). Moreover, this impact is clear when considering the influence of religion on the sexual choices people make and how sexuality is perceived (Crooks & Baur, 2005b). Historically, some religious bodies have claimed that sexual acts are sinful acts, and individuals who participate in such activities must be punished through penance (Crooks & Baur, 2005b). Additionally, STIs have been perceived as punishment for sinful activity (Allen, 2000).

STIs are a personal, public health, and political issue (Richards & Bross, 1999) - carry considerable mortality and morbidity and have a high economic burden (J. E. Siegel, 1999; WHO2001). STIs pose a public health threat particularly with increasing rates of infections, some of which can cause fatality (Commonwealth of Australia, 2005a, 2005b). In response to the rising incidences of STIs within Australia, the Australian Government devised a national strategy in the hope of curbing these trends. The strategy outlines the government’s approach to controlling and minimising the extent of STIs, which includes health promotion, education, access to appropriate care and treatment, STI screening, partner notification, vaccination, and surveillance data of selected STIs (Commonwealth of Australia, 2005b). The national response to STIs, signifies how
these highly personal and intimate infections, are also a highly politicised issue; as stated by Richards and Bross (1999):

“STD prevention is the most legally and politically complex public health problem. STDs involve the most intimate human behaviours and are intertwined with deeply held religious and moral beliefs. In our modern “age of the condom,” issues of STD control are easily obscured by the rhetoric of personal protection” (p. 1441).

**Feminist consciousness and consciousness-raising**

Feminist consciousness-raising developed from the recognition of women’s subordination within both the private and public sphere (Weedon, 2003). The aim of feminist consciousness-raising, which was facilitated by women’s groups, was to promote equality through raising awareness and bringing issues of women’s oppression and subordination into the public arena (Hughes, 2002; Landes, 1998). These groups facilitated women in exploring their experiences through a feminist lens which promoted women’s feminist consciousness (Hughes, 2002; Stanley & Wise, 1993; Weedon, 2003). Feminist consciousness is a perspective that focuses on women’s experiences and ways of being and understanding, from a woman’s position within society (Stanley & Wise, 1993). Further, feminist consciousness is a process that involves understanding and seeing realities within the world, and acknowledging that although all realities are different and diverse, many people experience subordination and oppression from the same systems of power (Rogers, 1998; Stanley & Wise, 1993).
Throughout the process of writing this thesis, I participated in two key feminist consciousness-raising activities. Firstly, I joined a feminist group with colleagues. Within this group, feminist literature was explored and personal issues relating to our discussions were raised. Feminist groups enhance feminist consciousness through building rapport and establishing relationships with other women, and discussing issues and experiences relevant to women (Bernhard, 2003; C. Kitzinger, 2004). Secondly, I have kept a journal both for the feminist group, and also for my own personal reflections and experiences throughout my candidature. By keeping a journal, I have been able to reflect on my experiences both personally and professionally, which has facilitated the growth of my own feminist consciousness (Bernhard, 2003).

Conducting and disseminating the findings of this research has the potential to facilitate consciousness-raising among the participants and a wider audience of women and health professionals. By providing the opportunity for women to discuss their experiences with STIs, the women in this study were able to explore their experiences, and what these experiences meant to them. Through eliciting and interpreting the women’s stories, this study can assist consciousness-raising among women, researchers and healthcare professionals about a stigmatised and hidden, yet highly politicised aspect of many young women’s lives.

**Stories**

*Differentiating stories and narrative*

The terms ‘story’ and ‘narrative’ are ambiguous (Polkinghorne, 1988) and are frequently used interchangeably (Riley & Hawe, 2005). According to Polkinghorne (1988),
narrative constructs events into a storied form that contain “… beginnings, middles, and ends” (p. 183), and Frank (2000) asserts that people convey and tell stories rather than narratives. Within the context of healthcare, stories have been defined as informal and subjective accounts of personal experiences, whereas narratives have been conceptualised as being structured and more formal (Wiltshire, 1995). Within research, stories are the ‘phenomena’ under study, and the narrative is the researcher’s mode of inquiry (Connelly & Clandinin, 1990). Moreover Connelly and Clandinin (1990) propose that “… people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience” (p. 2).

**Personal Stories**

Like everyday conversations, stories are, and always have been, a vital form of communication through which people, communities and society at large, relay messages, entertainment, experiences and knowledge to others (Bowles, 1995). Our first ways of learning and gaining knowledge come through stories, and throughout life, people tell stories every day (Yoder-Wise & Kowalski, 2003). Stories bring meaning into our lives, convey values and emotions, aid in reaffirming and validating our lives and experiences, and have the ability to connect us with our inner selves, with others, and with society (Atkinson, 2002).

The value of personal stories is recognised within the qualitative research paradigm. Research that focuses on the exploration of individual experiences through the collection of qualitative conversations/interviews can be considered as accounts of participants’
personal stories (R. M. Thomas, 2003). Within the healthcare context, stories are used to educate, inform, share, and gain knowledge and insight into personal experiences and phenomena (Hunter & Hunter, 2006; Steiner, 2005; Warne & McAndrew, 2007).

Storytelling can be the basis for research through which greater understanding of human experience can be achieved (Banks-Wallace, 1999; Benner, Tanner, & Chesla, 1997; Bowles, 1995; Cronin, 2001; Pennebaker & Seagal, 1999). Individual stories can provide insights into the backgrounds and experiences of research participants, thus providing a greater depth of understanding about individuals within their specific contexts. Although the use of storytelling is coherent with a number of qualitative research designs, storytelling as a methodology has specific attributes that align with feminist research. Feminist research values subjectivity, aims to empower participants, and aims for a research plane in which the researcher and the participants are on a non-hierarchal level. Further, feminist research supports the voices of marginalised individuals and resists contributing to oppression among groups and individual participants (Hall & Stevens, 1991; Harding & Norberg, 2005; Joyappa & Self, 1996).

Due to the nature and focus of this research, it was deemed appropriate to use a storytelling methodology to gain insights into the women’s experiences. By listening to personal stories, insight into experiences and individual’s perceptions of these experiences can be gained (R. M. Thomas, 2003). Asking women to tell their personal stories of having an STI also minimised the hierarchal researcher and participant relationship (Elliot, 2005; R. M. Thomas, 2003). This occurred through the women being asked to tell their story freely, which lessens the researcher’s power and direction.
of the research encounter, and emphasises the collaborative nature of the encounter between the researcher and the participant (R. M. Thomas, 2003). By asking participants to elucidate their own stories in the way they choose, the power of the researcher that often accompanies research encounters is transferred to the participants, through the focus being on the participants stories, and what they choose to disclose, rather than the researcher’s questions (Chase, 2003). The research encounter that focuses on participant stories changes the research relationship from being characterised as an interviewer/interviewee relationship to a storyteller/active listener relationship that is characterised as the researcher as listener and the participant as storyteller (Chase, 2005). Moreover, by inviting the women to disclose their personal stories, they could disclose the story they wish to be heard in their own words (Atkinson, 2002).

Relaying personal stories also has the potential for the teller of the story to reflect on and better understand their personal experiences (Andrews, Day Sclater, Squire, & Tamboukou, 2004; B. Carter, 2008; Clandinin & Connelly, 2000; Elliot, 2005; Frank, 1995, 2000; McAllister, 2001; B. L. Murray, 2003; Vezeau, 1994). Stories of personal illness, have profound meaning and have the ability to shape lives (Ezzy, 2000; Frank, 1995; Kleinman, 1988). Personal illness stories are shaped and influenced by both personal and societal constructs (Frank, 1995; Kleinman, 1988). This is the case with stories related to personal experiences with STIs (Kleinman, 1988). STIs are perceived negatively within society, and as highlighted in the previous chapter, individuals who contract an STI are often sanctioned and labelled by derogatory terms. Illnesses and infections that carry stigma have a profound effect on the individual, and have the ability to shape the person’s experience of illness as well as their own personal life story.
(Kleinman, 1988). Sharing stories of personal illness can bring understanding and meaning into the illness experience within an individual’s particular life circumstances (Kleinman, 1988).

According to Frank (1995), stories of personal illness give voice to the body. Through the body finding a voice, and sharing stories of illness, reaffirmation of one’s personal identity can be achieved (Frank, 1995). Within the research and storytelling context, the researcher is the active and respectful listener to the storyteller (Chase, 2005; Elliot, 2005). Therefore, facilitating the telling of the women’s stories in this study could assist these women to reflect on their experiences, and give these women the opportunity to be heard and reveal an aspect of their lives that may be hidden, thus providing a potentially beneficial and therapeutic experience (Elliot, 2005; B. L. Murray, 2003; Vezeau, 1994). Using a storytelling approach also had the potential to promote empowerment among the women. This was achieved by providing the women with the opportunity to discuss an intimate experience that is largely taboo and stigmatised within society. Additionally, by sharing their stories the women could contribute to knowledge, and provide insight and understanding into the experiences of having an STI, to potentially benefit healthcare professional practice.

*The nature of personal stories*

Personal stories can reveal the diversity and similarities between different people’s experiences (R. M. Thomas, 2003). Each individual story carries its own meaning and perceptions, which will differ from others (Atkinson, 2002). When people share their personal stories, they position themselves within the story. They may emphasise or
diminish parts of their story and can position themselves in particular ways, at times to prevent being perceived negatively by others (Frank, 1995; C. Kitzinger, 2004). This may be the case when for example, relating stories of trauma and stigma. The storyteller may not fully share their story, perhaps through reluctance, shame or embarrassment, due to concerns about the acceptability of their story (Frank, 1995).

Stories may vary over time (Andrews, et al., 2004; Sandelowski, 1993). They are influenced by environments, social situations, changing perspectives, the audience, and the purpose of relaying the story (Chase, 2005; Sandelowski, 1993). Additionally, the human memory is not perfect (C. Kitzinger, 2004), and people remember a story the way they wish to remember it, and within the context of their own lives. Thus, stories are subjective accounts.

In order to construct a comprehensive story, people make choices about what to include, making certain events and aspects visible, whilst omitting others (Z. Bauman, 2004). As Z. Bauman (2004) posits, without the selection, illumination, and exclusion of certain aspects the account simply would not be a story. Hence, although the stories we tell are individual and subjective, stories of personal experience are original and hold meaning to both the storyteller and active respectful listener. It is necessary to remember that stories, being subjective accounts, will differ, and that their purpose is to provide insight and understanding into aspects of human experience, rather than to produce generalisable results (Koch, 1998). Further to this, personal stories can be expressed both verbally and textually (B. Carter, 2008), and the following section discusses the
communication medium that was used by the participants of this study to relay their personal stories.

**Computer-mediated communication (CMC)**

Computer mediated communication (CMC) refers to typed conversational style interaction that occurs between individuals and is mediated through a computer (Mann & Stewart, 2002). The two types of CMC are asynchronous, which sends data via electronic mail (email) for example, and is not subject to time, and synchronous, which allows for concurrent or ‘real time’, interaction between individuals using different computers at different locations. Software and programs that offer instant messaging and discussion groups are examples of synchronous CMC (Berg, 2007; Mann & Stewart, 2002).

The current study gave the participants the option of telling their stories within a face-to-face conversation, or through CMC, via email or using an internet-based communication package called MSN Messenger. MSN Messenger is a synchronous online service that offers instant online messaging within a private domain, with only invited contacts having the ability to join the conversation.

Within the research context, CMC has multiple advantages for both researchers and participants. Benefits for participants include greater flexibility about when the research encounter is to occur (M. K. Reddy, et al., 2006), and not having to travel to the interview location (Cantrell & Lupinacci, 2007; Mann & Stewart, 2002). This eliminates the need for the researcher to organise suitable interview sites, as participants can
participate in the research via a computer within their own homes (Markham, 2004), which, has the potential to enhance comfort for participants (Cantrell & Lupinacci, 2007; Fleitas, 1998). CMC also promotes participant autonomy, as participants can simply log off from the interview at anytime, and can respond to questions via email at a time suitable and convenient to them. Communication via this medium also allows the researcher to review the text during the interview, to develop follow-up prompts if needed (Markham, 2004), and eliminates the time and cost of transcription associated with face-to-face encounters (Beck, 2005; Davis, Bolding, Hart, Sheer, & Elford, 2004; Lakeman, 1997).

One of the most valuable aspects of using CMC for research purposes is the ability to recruit individuals and communities that are difficult to access. This includes hidden populations such as people confined to their own homes, shift workers (Mann & Stewart, 2000), participants who are geographically distant, and communities that are situated in isolated and remote locations (Berg, 2007; Cantrell & Lupinacci, 2007; Davis, et al., 2004; B. Thomas, Stamler, Lafreniere, & Dumala, 2000). Additionally, access to people who are in ‘closed sites’, where a researcher is unable to meet participants such as individuals in the military, or in certain religious domains can be achieved (Mann & Stewart, 2000). Although the current research did not seek access to ‘closed sites’, the use of CMC provided the opportunity for women from interstate to participate in this study.

Several other qualitative studies have also successfully employed CMC to reach geographically distant participants. These studies had the benefit of the participants
experiencing a reduced level of isolation and having the opportunity to reflect on their experiences (Adler & Zarchin, 2002; Beck, 2005; Fleitas, 1998; Kralik, Koch, & Brady, 2000). Fleitas (1998) used chat rooms and email to explore the experiences of children with serious illness. The study yielded rich insights into the participants’ experiences and had the advantage of reaching children confined to their homes because of illness.

Research that utilised an online email focus group to explore women’s experiences of bed rest due to preterm labour, found the participants gained comfort and support from the group, which minimised their feelings of isolation (Adler & Zarchin, 2002).

Beck (2005) interviewed women via email to explore their birthing stories. Beck’s research produced in-depth findings with the women expressing many benefits including feeling the online study aided in the reduction of their felt isolation and gave them a chance to reflect on their experience through writing (Beck 2005). Like Beck (2005), Kralik et al. (2000) used emails as a form of correspondence (in addition to postal letters) to explore women’s experiences of living with chronic illness. Findings from this study were both rich and insightful with this mode of communication reported as being beneficial to participants as they did not feel pressured to answer questions immediately. Rather, the participants could take the time to consider their responses before writing them into email, which enhanced the women’s reflection and insight into their own responses (Kralik, et al., 2000).

Qualitative nursing research is often focused on healthcare experiences that are personal and sensitive in nature. CMC conversations are particularly useful for research that explores sensitive issues (Couch & Liamputtong, 2008; C. D. Murray & Sixsmith, 2002;
Peiris, Gregor, & Alm, 2000), such as STIs. This is because they facilitate the sense of privacy, and can provide the anonymity that may be needed to enhance discussion of issues that are difficult to discuss in the presence of others (Bachman, 2003; Peiris, et al., 2000). Research projects that focus on sensitive issues may be subject to participant self-censorship as a result of shame and embarrassment (Ellish, Weisman, Celentano, & Zenilman, 1996; M. K. Reddy, et al., 2006). This reticence concerning the disclosure of intimate and personal information, can potentially influence research findings (Ellish, et al., 1996; M. K. Reddy, et al., 2006). Participants may fear stigmatisation, shame, judgement, and being perceived as deviant particularly in face-to-face interviews. CMC has the potential to reduce these fears and perceptions through enhancing anonymity and privacy and increasing comfort, which may yield greater disclosure and more information from participants (Cantrell & Lupinacci, 2007; Peiris, et al., 2000; M. K. Reddy, et al., 2006).

However, like all research methods, CMC is not without its disadvantages and criticisms. This method of communication may not be available for use among some communities due to lack of knowledge and access to computers and associated software (Davis, et al., 2004). Moreover, researchers need to be able to effectively use the computer based software (Mann & Stewart, 2000). Additional disadvantages include the inability to observe non-verbal behaviour (Davis, et al., 2004), although this can be overcome with technological devices such as web cams. CMC interviews can take much longer than face-to-face interviews as the researcher needs to give adequate time for reflection and typed responses (Markham, 2004). However, the reflective processes that
often accompany writing and the formulation of textual responses can ameliorate this particular disadvantage.

From a feminist perspective, Im and Chee (2001) assert that using CMC and the internet for research purposes may create selection bias. Im and Chee postulate that using CMC as a sole option for data collection may exclude individuals who may prefer communicating in person from participating in research. Moreover, Im and Chee suggest that use of CMC does not take into account the environment in which individuals are situated, meaning that individuals may respond differently depending on the environment from which they are participating in the study. For example, participating in CMC in the work environment may yield different responses to that of other environments (Im & Chee, 2001). Additionally, it has been put forward that most research conducted using computer technology comes from a quantitative perspective that lacks contextual information and insight (Cotton, 2003; Im & Chee, 2001). Im and Chee propose that to overcome or minimise these barriers researchers need to examine their motivations for internet use, consider selection bias when developing recruitment strategies, minimise the hierarchical structure of the relationship between the researcher and the participant, aim to include contextual data, and empowerment of participants should be a focus of the research outcomes.

This study overcame these barriers by firstly being focused on women and their personal experiences of having an STI, thus providing contextual insight into the participants’ own experiences. Further, although advertisements were placed online as part of the recruitment strategy for this study, no particular social, cultural, or ethnic group were
targeted, and all participants were given the choice of participating in an online or an in-person conversational encounter. This aligns with a feminist perspective in that the power relationship between the participant and the researcher is minimised with the participants being given a choice of interaction mode. In addition, the CMC interactions were conducted at a time suitable for the women, which offered greater flexibility and the opportunity for the women to participate from the comfort of their own homes, outside working hours and at a time convenient for them.

As previously mentioned, this study aimed to empower the women through listening to and facilitating the telling of their stories, which is able to be achieved through using CMC. For example, Kennedy’s (2000) feminist research found that the CMC interaction was empowering for participants, and the women in Beck’s (2005) research expressed being personally acknowledged, and valued their participation in the online study. Further to this, the women in Beck’s study relayed that the writing process which they engaged in during the CMC interactions, facilitated their understanding of their own stories, with this process being a source of personal empowerment for the women (Beck, 2005).

**Methods**

**Inclusion criteria**

Ten women participated in this study. To participate, the women needed to be able to communicate fluently in English. Initially this study aimed to recruit women aged between 18 and 25 years. However, after reflecting on the current literature and recognising the magnitude of young women affected by STIs, particularly those up to
the age of 30 years, it was acknowledged that a key group of young women who are affected by STIs were excluded from the restricted age criteria. (For example of the reported cases of chlamydia among women in 2008, over 80% were among women 15-29 years (Australian Government, Department of Health and Aging, CDA: NNDSS, 2009b); Therefore, an ethics amendment was granted to include women (of any age) who had experienced having an STI between the ages of 18 and 30 years. The participants were required to have a past or present diagnosis of an STI, which was contracted exclusively through sexual intercourse between the ages of 18 and 30 years. For the purpose of this study, sexual intercourse was defined as heterosexual vaginal or anal intercourse due the focus on the gendered aspects associated with STIs. The women who participated were required to engage in a confidential conversational encounter, which lasted between one and two hours either face-to-face or via CMC.

**Exclusion criteria**

This study focused on exploring women’s experiences of having an STI that was contracted exclusively through sexual transmission. The study excluded women who contracted a viral condition such as HIV/AIDS, and hepatitis. This is because these viruses can be contracted through non-sexual avenues such as IVDU and medical procedures. For the purpose of this study, oral sexual contact was also excluded from the definition of sexual intercourse. Although STIs can be transmitted via this route, oral sexual activity has a lower STI risk compared to vaginal and anal intercourse (Edwards & Carne, 1998). In addition, past literature has suggested that oral sexual contact is not necessarily viewed as an act of sexual intercourse (Chambers, 2007; Sanders &
Reinisch, 1999) and is not perceived by young people to be as intimate as penetrative vaginal or anal intercourse (Chambers, 2007).

**Recruitment**

Due to the highly stigmatised nature of STIs, difficulties in recruitment were anticipated and multiple recruitment strategies were developed. These strategies included a poster advertisement (appendix B), a media release⁴ (appendix C), and advertisements placed on internet support websites and forums (appendix D). Recruitment posters were placed around all university campuses of University of Western Sydney (UWS) and several sexual health clinics (once permission was granted; see appendix E for letter sent to sexual health clinics seeking permission for poster advertisement). The media release was placed in local newspapers, and advertisements were placed on several websites (after permission was granted from the site owners), inviting potential participants to make contact for further information regarding their participation in the study.

Once potential participants had made contact, they were forwarded an information pack through email, inclusive of an introductory letter (appendix F), an information sheet (appendix G), a copy of possible areas for discussion (appendix H), a consent form (appendix I), and an internet interview instruction sheet (appendix J). The information sheet gave potential participants clear and unambiguous information pertaining to the aims of the research, details of the inclusion criteria, and what was required of participants. Additionally, the information sheet also addressed the voluntary nature of participation with specific reference to participants having the right to withdraw from

⁴ This was released prior to the amended age change of possible participants
the study at anytime without obligation, how confidentiality would be maintained, and how the results of this study would be disseminated. The potential participants were invited to make contact for further queries about participation in this research. Provision of the information pack, answering participants’ queries and questions, explaining and ensuring the participants understood the nature of the study, and their involvement prior to the conversational encounter, allowed for informed consent to be obtained. Further, in the event that the participant wished to remain anonymous via the MSN messenger service or email, participation in the online conversational encounter was considered implied informed consent.

**Data collection: Qualitative conversational encounters**

Qualitative conversational encounters that utilise open-ended and broad questions, invite participants to express their experiences, perceptions and emotions in their own words (Reinharz, 1992). Data collection methods of this nature are likened to conversations (J. Green & Thorogood, 2004; Holland & Ramazanoglu, 1994; D. Jackson & Borbasi, 2008; Rubin & Rubin, 2005), and storytelling approaches (D. Jackson & Borbasi, 2008). Posing a broad opening question such as “can you tell me your story of having a sexually transmitted infection” (supported by probing questions and follow-up prompts when required), allowed the women in this study to tell their stories using their own words. Further, all the women chose to participate in the conversational encounters via CMC rather than the face-to-face option. This choice was attributable to the highly sensitive nature of the topic, and the desire of the women to retain as much control as possible over the research encounter. The encounters each lasted between 40 and 120 minutes and generated between 6 and 16 pages of text.
Ethical issues

This study was approved by the UWS Human Research Ethics Committee (appendix K). All women who met the inclusion criteria were welcome to participate in the study. Confidentiality was maintained at all times. The women in the study either provided or were provided with pseudonyms, and events, places, and other names disclosed in the women’s stories were altered without changing the meaning, so no identifiable data could be linked with individual women. All data obtained from the women is and has been held in the strictest confidence. Only myself and my supervisors (after removal of identifiable data) have had access to the data. All computer files are protected with passwords and no personal identifiable information is attached to any of the obtained data. All data is kept in a secure cabinet on the UWS Parramatta campus and will be kept for the mandatory five-year period in accordance with the UWS Research Code of Practice policy (University of Western Sydney, 2009). All data will be destroyed after this period.

There are specific issues to be addressed when conducting research on sensitive topics (Sieber, 1993). Due to the sensitive nature of this research, all participants were provided with a list of professional services that provide free confidential counselling on matters relevant to STIs, reproductive and sexual health (see appendix L). Supplying participants with these services was considered essential, as the reflection on and recounting of sensitive stories and memories in relation to STIs may allow strong emotions to surface, which could have potentially caused emotional distress to participants. Whilst this may be burdensome, the emotional distress that may be aroused when recounting stories of
personal experience is balanced by the value that is attributed to the participant of having their stories heard (Elliot, 2005).

Although participants had the option of participating in the research either face-to-face, or via the internet using MSN Messenger, two participants wished to participate in the study via email, therefore an ethics amendment was sought and granted to allow participation in the study via this medium (please see appendix M and N for amended information sheet and consent form respectively). Although CMC has the ability to enhance participant anonymity, this anonymity as well as participant confidentiality can be threatened. The internet is a public domain, and therefore is subject to potential hackers (Binik, Mah, & Kiesler, 1999). Additionally, participants’ computers can be accessed by others (Kralik, Price, Warren, & Koch, 2006), and data generated cannot be protected when in transit and can be traced (Cotton, 2003; Fox, Murray, & Warm, 2003). However, it has been suggested that the ethical issues surrounding CMC and the potential threat to anonymity and confidentiality are the same potential threats that arise with more traditional established research data collection methods (Fox, et al., 2003; Kralik, Warren, Price, Koch, & Pignone, 2004; L. C. Whitehead, 2007).

A feminist approach to ethics requires that women in general and participants of research, are not further oppressed and marginalised through the research process and outcomes (Hall & Stevens, 1991; D. Jackson, 1997; Tong, 1993). Feminist approaches to ethics are concerned with the power structures and the prevention of oppression among individuals (D. Jackson, 1997; Peters, Jackson, & Rudge, 2007b; Tong, 1993). Additionally, these approaches place high value and acknowledgement on women and
their interests, which has often been lacking in the traditional patriarchal approaches to ethics (D. Jackson, 2000; Tong, 1993). This research has taken a feminist approach to ethics through being concerned with and focused on women and their STI experiences, by reducing the power imbalances often associated within the researcher and participant relationship, and facilitating the telling of the women’s stories in a way that enhanced participant autonomy and anonymity. Further, in keeping with Webb (1993), the findings of this study will be made available to participants. However, because of the personal and sensitive nature of this research, the women who wished to acquire a copy of the findings in the form of publications needed to indicate this on the consent form. Before forwarding this to the women, they will be notified by email to confirm that they still wish to receive the study’s findings.

**Thematic analysis**

On completion of each research encounter, the women’s personal stories were subjected to thematic analysis. Thematic analysis was based on techniques suggested by K. Anderson and Jack (1991), and involved examining transcripts to identify themes and commonalities which were categorised accordingly (J. Green & Thorogood, 2004; D. Jackson & Borbasi, 2008; Morse & Field, 1996). K. Anderson and Jack’s techniques were originally developed for analysis of oral interviews, however in this study they were applied to participants’ written narrative. These techniques focus on how to effectively listen to participants, and although researchers working with textual data cannot listen to text as such, researchers can effectively engage with the written text through continuous reading and verbalising of text.
The first process of data analysis proposed by K. Anderson and Jack (1991) involves the researcher immersing themselves in the participants’ stories. This was achieved by first writing my own thoughts, feelings and ideas immediately after each conversational encounter. Doing so allowed reflection and clarification of my own thoughts and perspectives in relation to the women’s stories. Each typed conversation was then read as soon as possible following the encounter to immerse myself in the data. This served to further clarify my own thoughts and assisted in greater understanding of each of the woman’s experiences and perceptions. I then continued to read and re-read the transcriptions to identify themes and used coloured pens to assist in the categorisation of the common threads within the women’s transcripts (Morse & Field, 1996), which was guided by the following techniques.

According to K. Anderson and Jack (1991), to gain rich narrative from participants the researcher needs to be able to effectively engage with participants’ stories and words. K. Anderson and Jack assert that researchers may not effectively listen to participants due to the researcher’s own beliefs and knowledge creating assumptions on participant’s words and experiences. K. Anderson and Jack propose, for researchers to avoid these types of assumptions and effectively hear participants, the researcher must listen to the participant’s ‘moral language’, ‘meta-statements’ and the ‘logic of the narrative’ (pp. 19-22).

A participant’s ‘moral language’ involves the researcher recognising words that reflect the relationship between the participant’s own values and societal values and norms. It reflects how societal values, norms and expectations influences an individual’s
perception of themselves (K. Anderson & Jack, 1991) (see also D. Jackson & Mannix, 2003; D. Jackson & Mannix, 2004; Peters, et al., 2007a). Examination of participants’ ‘moral language’ is particularly salient within the scope of this research, as this research is focused on women’s experiences with STIs, a subject that is entwined with one of the most intimate and personal aspects of life - sexuality. As discussed earlier in this thesis, society holds firmly established assumptions and norms regarding women’s sexuality and these can have an immense impact on how individual women perceive themselves and construct their own sexuality. Through examining the women’s ‘moral language’ within their stories, this research highlights the societal effects on the women’s self-perception within the context of STIs.

‘Meta-statements’ are statements and thoughts that reveal participants’ reflective processes (K. Anderson & Jack, 1991). These reflections reveal how the participant’s own thoughts and perceptions contradict societal constructs and how societal constructs influence the way individuals think, feel, and perceive the self. This technique reveals how the women in this study perceived their experiences through their own eyes, in addition to how the women perceive society viewed them. Exploring participants ‘meta-statements’ highlights how these two perceptions can contradict or be consistent with each other (see also Peters, et al., 2007a). Furthermore ‘meta-statements’ emphasise how societal constructs influence and impact on personal lives and therefore, emphasises the personal is political.

Finally according to K. Anderson and Jack (1991), ‘logic of the narrative’ refers to being attentive to the consistencies and any contradictions within an individual’s statements
and story and how these are related in order to gain understanding into the individual’s experience (see also D. Jackson & Mannix, 2004; Peters, et al., 2007a). Being attentive to the consistencies and contradictions within transcripts aids the researcher in discovering the participant’s own beliefs and how they shape and influence the participant’s life.

Through immersing myself in the data and documenting my personal thoughts and ideas, my own preconceived conceptions and knowledge were recognised. Using K. Anderson and Jack’s (1991) techniques to analysis the data facilitated the emphasis on the women’s individual experiences and perceptions allowing for the women’s own perspectives to be revealed. This was also enhanced through the findings presented in the next chapters being represented in the participants’ own words, with my own analysis and interpretations throughout. This reflects a feminist perspective in that the research findings are a collection of both my own subjectivity, in addition to the participants of this study.

**Rigour**

According to Hall and Stevens (1991) rigour in feminist research is dependent on research adequacy. Adequacy refers to the congruency of the research study and encompasses the research reflecting meaning and relevance (Hall & Stevens, 1991). The adequacy of this study utilises the principles of reflexivity, credibility, rapport, relevance, honesty and mutuality, and naming (Hall & Stevens, 1991).
Reflexivity

Feminist research acknowledges the researcher as being a central component of the research process, and recognises that the researcher brings their own biases, values, behaviours and assumptions to their work (Harding, 1987; Kralik, 2005; Olesen, 2005; Stanley & Wise, 1990). Reflexivity involves self reflection on the researcher’s behalf to uncover their own subjective influences and ideas about their research (Darlington & Scott, 2002; Eichler, 1997) and makes the researcher apparent rather than a silenced objective party (Harding, 1987; Sigsworth, 1995). Through reflexivity and acknowledging the researcher’s position, the rigour of feminist research is enhanced (Carolan, 2003; Hall & Stevens, 1991; Webb, 1993).

My own positioning within the context of this research as well as my values, assumptions and choice of research subject matter have been stated in the introduction chapter. Further, the feminist group I have participated in has provided me with a forum to reflect and discuss the various stages of this research project, which has enhanced my reflexivity. Gough (2003) has suggested, that keeping a journal and engaging in self reflection, can reveal rich insight and greater understanding of research participants’ experiences, and can facilitate the realisation of how the researcher’s thoughts, feelings and assumptions inform their research. As mentioned earlier in this chapter, throughout my candidature, I have kept a journal, which has provided an avenue to record and reflect on my emotions, feelings, and experiences throughout the data collection process. Through writing my thoughts and emotions into a journal, I have been able to reflect on these and develop greater insight into my own thoughts throughout the research process.
**Credibility**

Credibility within feminist research is enhanced through member validation. Once the researcher has compiled and analysed the stories of participants, these interpretations are viewed by participants to see if these are congruent with the participants experiences, stories and perceptions (Hall & Stevens, 1991; Webb, 1993). This approach was deemed not feasible for this study due to the sensitive nature of the research, and the possible breach of confidentiality. This breach could occur through individuals other than the participant coming across transcripts within the participant’s home, or enquiring about a postal package or email within which they received. Further, as postulated by Sandelowski (1993), personal stories and the thoughts, feelings and emotions created by these stories vary over time. The variations within stories can occur between the time of the research encounter to the time of member validation. Moreover, the effects of listening to and reading excerpts of one’s personal story in their own words are uncertain (Sandelowski, 1993). Considering these issues and the sensitive nature of this research, this form of credibility was deemed inappropriate.

Instead, this research utilised believability to enhance the credibility of this study. Hall and Stevens (1991) describe this approach as other feminist researchers, scholars, and/or activists deeming the research as credible. Believability is achieved when the research is deemed logical, congruent, representative, and valid (Hall & Stevens, 1991). During my candidature, a supervisory panel constantly examined this research to offer guidance and facilitate outcomes. In addition, I have presented various aspects of this research at numerous conferences to elicit feedback, and have sent manuscripts produced from this
thesis to gain anonymous peer review feedback and obtain further feminist critique. Therefore, other feminist scholars were able to regularly assess this research and offer guidance through offering opinions, feedback, criticisms, and the agreement of congruent findings, which enhanced the credibility of this study.

**Rapport**

To gain enriched narrative about participants’ experiences and produce adequate findings, it is essential for the researcher and participants to have rapport (Hall & Stevens, 1991; Hesse-Biber & Leavy, 2006). According to Hesse-Biber and Leavy (2006), rapport within the research encounter encompasses participants feeling their stories are of value, as well as feeling safe and comfortable.

Although computers can be viewed as impersonal (Newman, et al., 2002) and devoid of emotions (Peiris, et al., 2000), the internet is a communication medium, which is largely used for interpersonal communication through avenues such as emails, chat rooms and social networking sites (Cummings, Butler, & Kraut, 2002). The internet is a source for individuals to access and gain support from others (Im & Chee, 2004; Whitty, 2002) and provides the opportunity for people to form friendships and emotional attachments (Mileham, 2007). Through CMC, emotional connections and personal relationships are formed (for example see Couch & Liamputtong, 2008; Parks & Floyd, 1996; Whitty & Gavin, 2001) with findings by Peris et al. (2002) suggesting that these online relationships can be perceived to be just as ‘real’ and as important as face-to-face relationships (Peris, et al., 2002).
Within the research context, CMC is made personal by conveying empathy and sensitivity through use of language, and awareness of communication appropriate within an online environment (Peiris, et al., 2000). The use of emoticons such as smiley and sad faces, and well-known and widely used chat acronyms such as LOL (laugh out loud), can demonstrate feelings, moods and emotions (Kralik, et al., 2006). The researcher can establish rapport and trusting relationships through listening, responding appropriately, and being aware of interaction differences in textual dialogue and breaks in the text. Although breaks in text may indicate periods of reflection, this may also indicate misunderstanding of questions and/or reluctance to discuss certain issues, which may require precision of clarification and reassurance through text (Mann & Stewart, 2002).

Furthermore, Walther (1992) asserts that although the researcher may not be able to observe non-verbal cues, in-depth and personal encounters are conveyed in CMC through individual’s motivations and willingness to interact and communicate online. Several studies have reported the rapport and relationships that have developed through CMC use (for example Adler & Zarchin, 2002; Im & Chee, 2003; Kralik, et al., 2000).

Kralik et al. (2000) found that close and positive relationships developed between researcher and participants through the use of email correspondence over a twelve month period. Adler and Zarchin (2002) found that friendships were formed between the women participants in their internet based study. Similarly, Im and Chee (2003), who explored gender differences in pain among cancer patients through an email discussion group, found that close relationships between participants as well as between researchers and participants were formed. In this current study, rapport was enhanced through contacting participants’ post-recruitment and prior to the conversational encounter, to
answer any questions they may have had. By doing so, open communication was enhanced and several emails were exchanged with each participant focused on both the study and general conversation. Emoticons such as a laughing and smiley face were also used within the women’s transcripts, in addition to acronyms to convey emotions. Further, due to rapport needing to be established to discuss sensitive issues, qualitative health researchers may experience difficulties in maintaining clear boundaries in terms of the participant and researcher relationship when engaging in and conducting sensitive research (Dickson-Swift, James, Kippen, & Liamputtong, 2006). To maintain clear professional boundaries associated with the researcher/participant relationship in this study, when potential participants made contact regarding participation, my role as a researcher and as a PhD student (rather than a counsellor for example) was clearly stated to avoid potential boundaries being blurred (Dickson-Swift, et al., 2006). Participants were also reminded of this again at the commencement of the conversational encounters.

Relevance

According to Hall and Stevens (1991) relevance is necessary to enhance adequacy, and refers to the research addressing issues that are of concern and benefit to participants. This research is relevant and significant to the women in this study as the STIs have had an immense impact on their physical and psychological wellbeing, as well as impacting on the sexual and intimate relations these women held with others. This study aimed to gather insights into women’s experiences and perceptions associated with having an STI in order to facilitate improved therapeutic care for these individuals. Gaining insight into these women’s experiences also can provide healthcare workers with greater understanding, which can guide the support provided to young women who have
contracted an STI. Further, due to STIs being a political and public health issue, this study is relevant to professionals working in public health and providing education associated with STIs and safer sex.

**Honesty and mutuality**

Honesty and mutuality is another way of ensuring rigour in feminist research (Hall & Stevens, 1991). In the current study, honesty was upheld through the comprehensive information provided to the women regarding details of the study, which ensured the women’s participation was both voluntary and informed. Within this study, mutuality was enhanced through the non-hierarchal approach within the conversational encounter. This, according to Hall and Stevens (1991) facilitates the preservation and validity of the participants’ stories, through allowing participants to express their thoughts and stories freely. In addition, whilst providing the opportunity to share their personal stories may have been therapeutic for these women, their generosity in sharing their stories has allowed me to produce this thesis (which is of obvious benefit to me).

**Naming**

According to Hall and Stevens (1991) naming refers to going and seeing beyond existing schema in one’s knowledge and thoughts and “is addressing women’s lives in their own terms and generating concepts through words directly expressive of women’s experiences” (p. 26). In keeping with this, throughout this thesis, findings are presented using the women’s own words, with my interpretation and analysis incorporated throughout. This allows the women’s stories to be read as they were written, and allows readers to follow how interpretations of the personal stories were derived.
Summary

In summary, this study was guided by a qualitative feminist approach. The women’s stories were collected through qualitative research encounters via CMC and were subjected to thematic analysis based on K. Anderson and Jack’s (1991) techniques. In the following two chapters, the women who participated in this study are introduced and the findings from this research are presented.
CHAPTER FOUR: FINDINGS CHAPTER

Key descriptions

… Any data omitted between sentences and paragraphs

…. A pause as indicated by the women participants in their transcripts

[ ] data included to improve clarity and/or to signify abbreviations

Abbreviations used in participant transcripts

Ad: advertisement

AD’s: anti-depressants

Appt: appointment

B4: before

C: chlamydia

Caesar: caesarean section

’cause: because

Coz: because

CPAP: continuous positive airway pressure

DNA: deoxyribonucleic acid

Dr: doctor

Drs: doctors

Gf: girlfriend
**Chapter abstract**

The following pages present the women’s stories of having STI/s. Five dominant themes emerged from the women’s stories, each consisting of three sub-themes (see table 1 p. 90). The findings of this study are presented over two chapters. This chapter, consists of three themes, and reveals the impact of the STIs on the women’s lives and highlights how the women felt and perceived themselves within the context of being women who had contracted STI/s. Please note that content from this chapter has been submitted for peer review and publication (see East, Jackson, O'Brien, & Peters, 2008a).
The participants

This chapter begins with an introduction to the 10 women who shared their stories for the purpose of this research. Their age, information about their STI/s, how they perceived they contracted the STI/s and their relationship status at the time of data collection is included.

**Rita** was 24 years of age and had a professional career. In 2003, Rita contracted HPV, which manifested itself through both genital warts and a cervical infection. Although she was not completely sure, Rita believed that she contracted HPV from an abusive boyfriend with whom she had lived. Since her diagnosis, Rita had been involved in two long-term heterosexual partnerships. At the time of the study, Rita was not involved in an intimate relationship.

**Lilly** was a 25 year old student who was diagnosed with HSV2 in 2006. Lilly had a strong feeling that she contracted this virus from a man with whom she had a casual sexual encounter. Lilly was involved in a relationship with another male partner at the time of data collection.

**Sam** was 24 years of age and had a professional career. She contracted chlamydia from a boyfriend when she was 19 years of age, and contracted genital herpes from another partner at the age of 22. Sam had been intimate with two men since contracting genital herpes, and was not involved in an intimate relationship at the time of this study.
Charlotte was 31 years of age and contracted genital herpes at the age of 26 years. She was unsure from whom she contracted the virus, although Charlotte suspected it was from a previous long-term partner. When she was diagnosed, Charlotte was involved in an intimate relationship, although she was not involved in a relationship at the time of this study.

Melinda was 35 years of age and contracted genital herpes at age 30. Melinda contracted this infection when she was 29 years of age from an older long-term partner. Melinda was not involved in a relationship at the time of the study, and had not been intimate with a man since her diagnosis.

Ruby was 29 years of age and a mother of two children. When Ruby was approximately 22-23 years of age she was diagnosed with chlamydia, genital warts, herpes, pubic lice, and another STI that she could not recall. Ruby had contracted these STIs from her older, abusive husband who is the father of her children. Since her diagnoses, Ruby had been involved in a relationship with a woman and had ‘some’ brief intimate sexual relationships with men. At the time of data collection Ruby was not involved in a relationship.

Cathy was 21 years of age and was diagnosed with HSV2 at the age of 20. Although Cathy was not completely certain, she felt that she contracted this STI through rape when she was 19. Since diagnosis, Cathy stated that she had been intimate with one partner who also had HSV2, and had been in a relationship, which dissolved just prior to her participation in this research.
Bree was 22 years of age and was diagnosed with chlamydia at the age of 17 years and HSV2 when she was 21. Bree contracted the herpes virus from a man with whom she had a casual sexual encounter. Bree had been intimate with a man following her herpes diagnosis and was still involved with him at the time of her participation in this research.

Fleur was 39 years of age and had a professional career. She contracted HSV2 at 26 years of age. At the time of this study, Fleur was not involved in a relationship.

Cindy was 28 years of age and was diagnosed with HSV1 at approximately 18 years of age. Cindy contracted this virus through being sexually assaulted by five men. Cindy had been intimate with a ‘few’ men since her diagnosis, and at the time of data collection was a student and was also married with two children.
### Table 1: Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>Disrupted sense of self</td>
<td>Self-perceived invulnerability: <em>This can’t happen to me</em></td>
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<td></td>
<td>Self-blame and shame: <em>I feel so ridiculously foolish</em></td>
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<td></td>
<td>Preservation of self: <em>Living in denial</em></td>
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<tr>
<td>Stigma and stereotypes</td>
<td>Tainted women: <em>Dirty and diseased</em></td>
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<td></td>
<td>Deviant women: <em>Fear of rejection</em></td>
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<td></td>
<td>Women unworthy of love: <em>I worry about being alone</em></td>
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<tr>
<td>Burdensome emotions, responsibilities, and</td>
<td>Damaged and devastated: <em>Yuck and ruined</em></td>
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<tr>
<td>consequences</td>
<td>Transmission and disclosure: <em>I would be horrified if I infected someone</em></td>
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<td></td>
<td>Motherhood and reproductive health: <em>I just worry</em></td>
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<tr>
<td>Violated and vulnerable</td>
<td>Violation and betrayal: <em>How could someone think I’m so worthless</em></td>
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<td></td>
<td>Condom initiation: <em>Unable to speak up</em></td>
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<td></td>
<td>Wary of men: <em>I feel I am too vulnerable</em></td>
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<tr>
<td>Strength and support in the face of adversity</td>
<td>Healthcare professionals: <em>It made it worse</em></td>
</tr>
<tr>
<td></td>
<td>Sources of support: <em>Strength to carry on</em></td>
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<td></td>
<td>Drawing on strength and resilience: <em>I feel like a stronger person</em></td>
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Introduction

All the women’s stories were replete with contradictions. These contradictions were revealed through the women’s expression of the burden and emotional pain that having an STI had caused them, yet the women simultaneously denied the extent of their burden in the context of their intimate relationships. Some women elucidated the positive aspects and effects they had gained from contracting an STI, which conflicted with their expressed emotional pain. The women expressed their desire not to transmit STIs to intimate partners, yet some of the women continued to engage in unprotected sex, in a context of non-disclosure. Some women stated they felt a responsibility to disclose having an STI to partners, however despite this, many had not disclosed, and this is able to be attributed to the women’s fear of stigma and rejection. Stigma was an overarching theme throughout all the women’s stories. Their felt stigma was overwhelming, and was an underlining component in how they perceived themselves, the way they felt others would view them, it influenced their safer sexual practices and their decisions to disclose having an STI to others, and in some cases had an impact on their healthcare experiences. However, although stigma underpinned many aspects of the women’s stories, theme two, ‘Stigma and stereotypes’ focuses on the women’s stories of explicitly being and feeling stigmatised. Stigma is also addressed elsewhere in the findings, where it influenced any of the other themes.
**Theme one: Disrupted sense of self**

The theme ‘Disrupted sense of self’ is comprised of three sub-themes as depicted in table 2. The first sub-theme: Self-perceived invulnerability: *This can’t happen to me*, reflects that prior to STI/s diagnoses, all participants had felt they were not likely to contract this type of infection due to their negative perceptions of women with STIs. The second sub-theme: Self-blame and shame: *I feel so ridiculously foolish*, illuminates how the women had previously perceived themselves as responsible young women, however since their STI diagnosis they felt the behaviours that led to contracting STI/s reflected foolishness and naivety, which jarred with their sense of self. This sub-theme also uncovers how the women engaged in self-blame and mostly absolved their male partners of responsibility due to this self-blame. The final sub-theme in this section: Preservation of self: *Living in denial*, elucidates how the women made their experience more bearable. The women attempted to reduce the burden of having STI/s through wishful thinking and denial. These mechanisms were used to preserve their sense of self, and for some women, to avoid disclosing their STI/s to others. Each sub-theme will now be discussed individually.

**Table 2: Theme one**

<table>
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<tr>
<th>Theme</th>
<th>Sub-themes</th>
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<tr>
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<tr>
<td></td>
<td>Preservation of self: <em>Living in denial</em></td>
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</table>
Sub-theme: Self-perceived invulnerability: *This can’t happen to me*

Prior to STI diagnosis, the women did not believe they were at risk of STI/s. This belief was attributed to age, naiveté, and the perception that their behaviours such as practicing unsafe sex in perceived monogamous relationships did not carry risk. Comments such as the following were frequent throughout the women’s stories. *B4 [before] I got HSV [herpes simplex virus] I don’t think I would have thought very much about it. But now I look back and realise how naive I was* [Cathy]. Though some of the women were aware of the risks of engaging in unsafe sex, they did not believe they themselves were women who contracted STIs. That is they did not perceive themselves as promiscuous women with loose morals and thus, STIs were not in accordance with their perceived sense of self. Their self-perceptions and perceived invulnerability to STIs meant that these women did not associate their behaviour with risk behaviour.

Even though some of the women had engaged in unsafe sexual practices in the past, their continued perceived invulnerability outweighed the risks associated with this behaviour. Although Bree had chlamydia prior to being diagnosed with herpes, she continued to have a sense of invulnerability: *... it is always in the back of your mind, but it’s one of those situations where you think “it doesn’t happen to me” but it did.* Likewise, although Lilly’s friends had discouraged her risk behaviour she continued to practise unsafe sex. In the circumstances in which she contracted genital herpes, barrier protection was not available. Lilly put contracting an STI down to simply being bad luck:
My friends always have told me that I should use protection, as this wasn’t the first time I had unprotected sex. But for some reason I never thought I would be that unlucky.

Some of the women in this study felt protected from STIs through being in loving and perceived committed relationships. This is evident in Sam’s comment; after the initial shock of "this can’t happen to me" coz [because] I had a loving boyfriend… Due to the positive emotions and loving feelings that characterised Sam’s relationship, she believed that she would not be at risk of contracting an STI from him. Similarly, Ruby could not conceive that within the safety net of a marriage she could contract several STIs. Ruby felt deceived and taken advantage of by her husband who was significantly older. When reflecting on her perception of her own risk Ruby commented:

*I thought I was in a monogamous relationship and was totally devastated and shocked when I found out the truth. I think I was very naive and foolish.*

Prior to being diagnosed with herpes, Melinda felt that she had only engaged in secure monogamous relationships with men she knew well, and whom she believed did not have STIs. Conversely, since her diagnosis and on reflection, she asserted that she was at a heightened risk of STIs by being in an exclusive relationship with a man who had an existing STI. Melinda’s narrative revealed that she considered casual sexual encounters with persons of unknown STI status, less risky than monogamous relationships when one partner has a known STI:

*I have herpes. I felt really shocked when I first found out. I was so surprised! ... No [did not think she was at risk of STIs]! I’ve slept with a total of 3 people, and I knew them all for a long time before we became 'romantic' - and they were all long-term*
relationships. I guess though - in hindsight - if you are in a relationship with someone with an STI - then you are more exposed to it than someone who only sleeps with people casually.

Rita’s perceptions of people who contract STIs did not resonate with her own perceived character; in her mind, she was not a woman who contracted STIs:

*It was a boyfriend who I was seeing and living with for 3 months. I didn't think I was at risk. I felt immortal; I thought it didn't happen to people like me, until I was diagnosed with warts.*

Cindy attributed her perceived invulnerability to her lack of knowledge and young age of 18 years at which she contracted genital herpes. Her story also indicated a belief that she was not the ‘sort of woman’ that would contract an STI. She contracted herpes as a result of sexual assault. Although at the time of this study Cindy still lacked knowledge about transmission of STIs, she felt that older people (in their late twenties) would not be likely to contract these infections. Cindy felt that more mature individuals should possess enough knowledge to protect themselves from the risks associated with unprotected sexual intercourse. She felt that people that do contract STIs through casual sexual encounters needed to take responsibility for their own actions. When talking about ‘older’ people Cindy commented:

*No never [thought she was at risk of STIs]. It is the invincibility at that age [18 years] I think- I would be surprised at a person contracting an STI at my age [28 years] or older through non-exclusive relationships, because by this age you should be educated enough to know better. I don’t think I knew the name of any STIs then except for HIV, but that*
was not something I would get - Russian roulette really. Still the only STIs I really know anything about are herpes and HIV; at least now I know the names of others.

Like Cindy, Rita explained that it was her age and life stage that influenced her feelings of invincibility. Since being diagnosed with an STI, Rita realised her vulnerability when engaging in risk behaviours:

*I guess like every other teenager you don't think bad things will happen to you. It's like teenagers speeding when driving, they'll never have an accident. It's not until things like this happen to you that you realise, yes it can happen to me and statistically it probably will. Sometimes I think that's the only way that some of us learn. By it happening to us.*

Similarly, Charlotte attributed her sense of invulnerability to her young age and naiveté. Although, she was aware of STIs and felt that she took adequate precautions to prevent contracting an infection, on reflection she realised her own vulnerability. Charlotte asserted:

*I feel that I was a mixture of cocky & naive. It was a period of my life when I was at my most sexually active. I had long-term partners & also some one night stands. A lot of partying, drinking & being easily trusting of people, was just who I was at the time. ... Also, I felt I checked out my partner’s genitalia quite well, not knowing, at the time, how well STDs can disguise themselves. As I first said, I was naive.*

When asked to reflect on whether she felt at risk of contracting an STI, Fleur revealed how vulnerable anyone can actually be to STIs. She realised that through engaging in sexual activity, she was at risk of STIs, and although safer sex can minimise risk it cannot entirely prevent it. Fleur stated:
Yes I was aware and educated about them all [STIs], but you do the best you can, even protection will not prevent HSV2. I knew straight away on detection of [the] blister what it was.

Although the women perceived themselves invulnerable to STIs, since diagnoses the women came to realise their own vulnerability, and subsequently blamed themselves for contracting STI/s.

**Sub-theme: Self-blame and shame: I feel so ridiculously foolish**

Even though some of the women contracted STI/s through forced or coerced sex and deception, all of the women took responsibility for the infection/s and subsequently blamed themselves. Some women not only blamed themselves for their own actions but the actions of their male partners as well. They felt that they could have prevented contracting an STI if only they were more careful. On reflection, the women viewed themselves as naive – contrary to the mature women they had previously perceived themselves as. By contracting STI/s the women felt they had let themselves down. They felt spoiled and shamed. The women feared being perceived as irresponsible to those around them, and felt others would be let down by their actions in contracting an STI. The following comment by Rita reveals her apparent shame and disrupted sense of self;

*I felt dirty because people would know I had had unprotected sex and taken a risk. For such a sensible person this wasn't acceptable to me.* Ruby’s narrative revealed the extent of her shame and distress. The impact of her diagnoses on her sense of self is clear in her disclosure of disgust and self-hatred:

*I felt ashamed. Looking back I know I did not do wrong but I felt dirty and used, and I felt like I was just disgusting. ... I was filled with shame and it turned into self-hatred in
a way. I still can't believe I was treated so badly. ... I got out of there [medical centre] as soon as I could and never went back. I remember my baby was in the stroller gurgling at me while the doctor was telling me [the diagnoses]. I felt frozen and just took off.

By contracting STIs, the women felt they were revealed as careless and foolish. Lilly’s remorse was amplified by the fact that she contracted an STI from a casual sexual encounter rather than through an ongoing loving partnership. Traditional views of femininity do not endorse casual sexual relations for women and Lilly felt shamed and regretful for her actions:

No not a boyfriend at the time, which made the feelings of disappointment so much higher for myself. ... The disappointment I felt was due to my careless actions of engaging in unprotected sex with a male who I was not in a relationship with at the time, and having contracted herpes via this means. ... In hindsight, I feel so ridiculously foolish and regretful.

Cathy did not want to be revealed as careless. Her feelings of being spoiled and ashamed meant that she had trouble in disclosing her situation to close friends and family. Cathy asserted that friendships are based on trust and honesty, and by not disclosing having an STI to her friends, she felt that she had been deceptive. This led her to question her honesty and actions that further contributed to her disrupted sense of self. Her actions and beliefs were in conflict with each other:

I felt like a disappointment and as a result I have not told any of my family and I don’t intend to. ... I just think with friends you should be honest and open and by not telling them I feel I am keeping stuff from them. But I guess that is just a mental thing. I know my parents wouldn’t be disappointed but in my head I think they would be ...
Rita felt her actions had let others down. She felt that her own actions jarred with her sense of self and feared this would be revealed to others. This in turn would further injure and damage her already disrupted sense of self:

Yeah definitely people would have judged me, not only had I let myself down I felt I'd let my mum down too, because she has always taught us to have protected sex and do the right thing. I felt my friends and family would have seen me as being irresponsible when I prize myself on my maturity and sensibility.

Like Rita, Charlotte was concerned that she had let her parents down. Charlotte was ashamed of having an STI and felt that her parents’ religious beliefs would compound this shame. Her story revealed that in her family, an ideal daughter would be one that remained a virgin until marriage. This view intensified Charlotte’s shame, as she was not only a woman who had contracted an STI, but had done so out of wedlock:

I think people can feel all sorts of shame in regard to their body’s, never mind their sexual parts! Being overweight or stretch marks or birthmarks can make people feel ashamed so an STD is the cream of the crop. And it is a disease of your sexual organ area, so you instantly feel less desirable to others. My parents are very supportive but they are also religious and semi-conservative, so my shame was first felt when I thought of telling mum because she would have expected more sense from me, and didn’t really approve of my level of sexual activity. She loves me to bits, but like any parent obviously would have preferred me being a virgin going into the marriage bed!

In a sense, Bree felt as though she had let both herself and her partner down. The disruption to Bree’s sexual self-perception hindered her freedom and ability to build intimacy with others. Bree felt that the infection limited her ability to fulfil her sexual needs within her relationship for fear of passing the infection on to her partner:
I was a highly sexual person, very free in that respect, and I still have those feelings, but can’t fulfil them like I used to. ... Being with the guy I am with at the moment, there are so many things I want to do, but feel I can’t do them because I don’t want to pass this on to him.

The women’s stories reflected their perception that women are responsible for men’s sexual behaviour. Cindy concluded, that although she did not have control over the sexual assault situation, she blamed herself for it. She negated the behaviour of the men that were involved and criticised herself for her actions at the time. Cindy stated *I was a silly drunk 18 yo [year old] who got in the car with a group of guys and thought I was old enough to take care of myself.* Similarly, Bree felt angry and blamed herself for engaging in unprotected sex and contracting herpes. She felt that her actions were careless and irresponsible, and although Bree also expressed anger towards the male partner, she ultimately took responsibility. Bree partially excused the man’s behaviour through presuming he was unaware of his serostatus:

*I felt pissed off at myself, because I should have been more careful, and [not] allowed myself to be in that situation where I was at risk. Pissed off at the guy, because he should have let me know about his situation and didn’t give me the choice. But in hindsight, he might not have known he had it [herpes].*

Melinda contracted genital herpes from a long-term partner. Although Melinda’s partner was aware that he had genital herpes, he kept this from her. When Melinda contracted the infection, she discovered her partner’s serostatus and subsequently the relationship deteriorated. Melinda believed that if she had put more thought into her choice of
partner, she could have avoided contracting an STI. She blamed herself for not doing this and trusting him:

*I can only blame myself. Because it was my choice - I just wish I had made an informed choice rather than being lied to. ... I blame myself for selling myself short. I should have been more careful and more choosy. Because he wouldn’t have been good enough with herpes, so then he shouldn’t have been good enough without herpes. I sold myself short. ... I shouldn’t have trusted him.*

Ruby’s endurance of her husband’s abuse led her to question her own actions. At the time of this study, Ruby was an independent single mother and was perplexed at how she could have been in such a situation. Ruby perceived that it was her actions and behaviours that led to the abuse; her husband’s actions were negated through Ruby’s self-blame:

*I do think about it sometimes and wonder why and how I could have let myself be treated like that, and what messages was I sending to let him think it was OK to treat me like that. I gave him all the love I had but in the end it meant nothing.*

**Sub-theme: Self-preservation: Living in denial**

Despite the expressed anguish and burden the infections caused, these women minimised the impact of the infection/s in other contexts. This was revealed through ambivalence and contradictions within the women’s stories. Although the women perceived themselves as sensible and responsible, some women did not disclose their infection status, and on occasions continued to engage in unsafe sexual practices after their diagnoses. Due to the women’s beliefs that … *a lot of guys would think that any woman who has had about 5 STDs is a slut* [Ruby], the women denied and minimised
the extent of the infections to preserve their integrity and image to others. The women used wishful thinking and denial to diminish the burden of having an STI to repair their disrupted sense of self and return to their previous state of wellbeing. This is clear in Bree’s comments:

*It is a virus, cold sores, a skin infection, I play it down in my mind, but I can’t be as spontaneous or casual as I used to be. ... It is hard to admit to things sometimes, I get a bit emotional about it, denial. ... Sometimes, I think that maybe if I get a blood test, it would come back negative and I would be fine! I have had one outbreak since I was diagnosed.*

Likewise, although Ruby’s herpes infection was diagnosed via clinical pathology, she stated she had never been symptomatic and contemplated whether the diagnosis was a mistake:

*With the herpes it was diagnosed with a blood test but I don’t ever remember having it so I suppose I have been in a bit of denial about that. ... I never told these men I slept with about it or any of them. With herpes I have read that it is painful so I think I would know if I had it.*

Melinda took medication in hope the infection would disappear from her life. By taking medication to suppress the physical symptoms of herpes, she could deny having the infection, as she would not be reminded by having an outbreak. However, over time Melinda began to accept her diagnosis:

*I took ... suppressive treatment for about six months. I didn’t really need to - but it just made me feel better psychologically. ... But after I accepted this huge nightmare/change*
[having herpes]- then I didn’t need to take suppressive treatment anymore. However, I know others continue to get outbreaks, so their situation may be a lot different from mine.

Cathy had dealt with having genital herpes by comparing her symptoms and infection to other people, which facilitated her acceptance of having an STI:

I have had 4 or 5 [outbreaks]. So I see myself as fairly lucky ‘cause [because] I read stories of people getting it numerous times a month. ... I just look at it as though I have it, there is nothing I can do so I might as well get on with life. I can’t make it a burden on myself or else it will consume me. I look at it; that if in life it is something that I have to have, it isn’t going to kill me, and it could be much worse.

When discussing why people deny their infections, Charlotte felt that it is the shame people feel that leads to denial. People would rather live in denial than run the risk of being someone who is tainted and outside of societal norms. Charlotte stated:

People can live in denial quite easily. ... It is easier to believe you don’t have an STD than to take responsibility for it, mainly because of the stigma that goes with it. I suppose that anything that may be seen as wrong or shameful by society’s standards has the capacity to be hidden and not talked about, hence the normal, human, knee-jerk reaction of denial.

Some of the women had chosen not to disclose having an STI to their sexual partners. Ruby’s justification for non-disclosure was that she was not engaging in heterosexual intercourse; ... I got a female partner. She was great and I didn’t feel I had to tell her anything about the diseases as there was no penetrative sex. Although both Ruby and Sam acknowledged they could pass on STI/s they felt they were at just as much risk of
contracting STIs from future male partners. Sam had not disclosed her infection to any of her sexual partners since being diagnosed with genital herpes, because she felt she had taken adequate precautions to minimise transmission:

Well truthfully I haven’t told any guys like guys I’ve just been "seeing" only 2 guys since. ... The two guys I have been with in the past 2 years since finding out, I haven’t told them but have used condoms and taken Valtrex\(^\text{5}\) as a suppressive. ... I’m at as much risk of catching something from them as they are from me.

Prior to disclosure, Rita needed to ensure her partners were going to continue the relationship. Although Rita had disclosed her infection status to her long-term partners, she discounted the necessity of disclosure to casual sexual partners. Within this context she felt her personal details were hers alone and did not need to be shared; she perceived her infection was unlikely to be burdensome for the male partner or interfere with this type of encounter:

Yeah I have disclosed my STI to the 2 long-term relationships I have had since the infection. ... I just needed to know that they wanted to stick around ... If it was a one nighter or anything it's not worth mentioning.

Charlotte did not want to be viewed as a woman with an STI. Self-preservation and the need to conserve her integrity was the catalyst for her non-disclosure to previous sexual partners:

\(^{5}\) Valtrex (valacyclovir) is a drug used to reduce the symptoms, occurrence, duration and viral shedding of the infection herpes simplex virus type 2 (Lehne, 2001).
I did not contact previous partners that may have been at risk to warn them because I didn’t want them or the whole town to find out I had it, and I had no idea how long I may have had it anyway.

Sam’s denial also led her to rationalise her non-disclosure to potential sexual partners. As she was taking medication that suppresses outbreaks, symptoms and viral shedding of HSV2 (Lehne, 2001) she did not perceive she was an infection risk. Although this medication does not cure nor completely prevent transmission, like Charlotte, Sam did not want to be labelled as a woman with an STI. She stated; *living in denial pretending I don’t have it seeing as I take Valtrex© I can pretend I don’t have it so that way I don’t have to tell guys.* Sam’s story revealed the belief that STIs are capable of damaging a woman’s reputation, and it is for this reason that she held the belief women (more so than men) are more concerned with avoiding STIs. Sam also implied that men are ambivalent about their sexual health as well as their sexual partners’ health, and may in fact be deceitful. However, Sam knew from her own experience that denying and not disclosing is easier than risking rejection from a potential partner. Sam asserted:

*One of my good friend’s boyfriend’s said that he has heaps of friends with STDs who don’t tell, and just spread stuff, so guys just live in denial and ignore they have anything and don’t get tested etc. Whereas any single girl I know gets tested every 6 months. ... You can’t have trust with someone doing that. Intentionally spreading something is inexcusable, but I also know how hard it is to tell. Denial is very easy.*

Some of the women’s denial manifested itself through expressing that having an STI had little impact on, and was not a cause for concern within their intimate relationships, despite the emotional pain they revealed having an STI had caused them (as revealed in
theme three). Although Lilly’s narrative revealed that her partner’s reaction to her diagnosis could have been potentially problematic, she stated that the infection was no big deal, and had only caused a minor disruption within their relationship:

*It sounds like he is not happy about it, but I’m glad he can express this and not just wash over it. I feel like he has really thought about it and has chosen to take on board this minor hindrance.*

Cindy outlined how her husband reacted when she disclosed having an STI to him. Like Lilly, she denied and described the infection as only having a minor impact on their sexual relationship, despite her husband’s negative reaction. Cindy commented:

*My husband was horrified to say the least I think he considered leaving me but really sexually it has not had an impact on our lives and he does not appear to have contracted it.*

Rita discussed her and her partners’ sexual health screening practices. Rita felt it unnecessary for her first long-term partner (after her diagnosis) to undergo a sexual health screen due to her belief she had adequate knowledge about his sexual history. Even though Rita had previously stated that she had ‘learnt her lesson’ from engaging in unsafe sex, a joint decision was made to forgo condom use, hence, her infection was perceived as not being significant enough to interfere with the closeness of the intimate relationship:

*I know this is really vague the first one [partner] no [she did not ask her partner to have a sexual health screen], but there were significant circumstances and the second yes. The first long term relationship, ... the guy had just come out of a 5 year relationship with*
his high school sweetheart, both had never been with anyone else because I knew them both personally. So with the knowledge I had at about 8 months we decided to stop using condoms. ... I still had the HPV virus on my cervix but no reoccurrence of warts at this time...

Charlotte was involved in a relationship when she was diagnosed with herpes. Although she disclosed her infection to her partner, they continued to engage in unsafe sexual practices. This was due to Charlotte’s partner believing that he would have already contracted herpes from her. This belief outweighed both Charlotte’s and her partner’s concern to confirm this through sexual health screening or to prevent transmission if he had not actually contracted the infection:

I was in a relationship when I was diagnosed and that partner has never had an attack to my knowledge. He did not during the year we were together after my diagnosis anyway. ... After being diagnosed I continued having unsafe sex with my current partner, but I had told him that I was diagnosed with herpes. He was not concerned. His logic was that he had probably already caught it. Ironically, he never did while we were together.

Conclusion

Contracting STI/s caused these women to experience a disruption in their sense of self. This theme has revealed that the women had perceived themselves relatively invulnerable to STI/s. They had believed that their behaviours did not place them at risk and that they were not the ‘type of women’ who contracted STIs. When the women were diagnosed with STI/s their sense of self was disrupted. This was due to their perceived invulnerability and through their actions jarring with their previously perceived selves as responsible and careful young women. The women blamed themselves for their
behaviour and some also blamed themselves for the behaviour of the male partners involved, despite some situations being abusive. To preserve and restore their sense of self and integrity, the women utilised wishful thinking and denial as coping mechanisms. Further, although the women did not want to be perceived as women tainted by infections, they all subsequently felt stigmatised as revealed in the following theme.
**Theme two: Stigma and stereotypes**

Stigma was a dominant theme throughout all the women’s stories and was an underlying issue that influenced all aspects of these women’s experiences. However, this theme only encompasses how their felt stigma and the dominant stereotypes associated with these infections influenced the women’s self-perceptions and their perceived intimate relationships. The theme ‘Stigma and stereotypes’ consists of three sub-themes (see table 3). The first sub-theme: Tainted women: *Dirty and diseased* reflects how the women viewed individuals with STIs, which subsequently influenced how they felt about themselves. The second sub-theme: Deviant women: *Fear of rejection* illuminates the women’s fear of rejection by potential male partners. The final sub-theme in this section: Women unworthy of love: *I worry about being alone* reveals their fear of loneliness, with some believing they were not worthy of a loving relationship due to their perceived status as women with STIs.

**Table 3: Theme two**

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<thead>
<tr>
<th>Theme</th>
<th>Sub-themes</th>
</tr>
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<tbody>
<tr>
<td>Stigma and stereotypes</td>
<td>Tainted women: <em>Dirty and diseased</em></td>
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<td></td>
<td>Deviant women: <em>Fear of rejection</em></td>
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<td>Women unworthy of love: <em>I worry about being alone</em></td>
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Sub-theme: Tainted women: *Dirty and diseased*

All the women in this study felt stigmatised by having STI/s. They commonly expressed the typical stereotype of women with STIs as being dirty, promiscuous women with loose morals and subsequently they themselves felt dirty and tainted by having an STI/s. Lilly stated; *... I was now infected with this virus and would always be.... I felt tainted.* Ruby’s comment reveals how she perceived women with STIs, which subsequently influenced how she felt about herself:

*It made me sick and I felt disgusting. I was so ashamed to have gotten crabs and everything. He [Ruby’s husband] must have been sleeping with women who were riddled with disease.*

Similarly, it was Bree’s own negative preconceptions of people with STIs that led her to feel tainted and contaminated. Her comment highlights the dominant stereotypical view of people with STIs:

*And dirty, because my views on contracting an STD like this have been the same as the rest of society.... only someone who sleeps around regularly gets STDs etc etc. Dirty because I know how I would have perceived someone with HSV....*

The stigma felt by these women was intensified by how they perceived others viewed them. Because of their negative self-perception, these women believed that others would also view them as tainted if they revealed having an STI. Bree’s felt stigma led her to believe that she no longer fitted in with societal norms. Due to her stigmatising condition of having an STI she felt rejected by society: *... It’s like going from being a cool kid in the playground, to being an outcast, I’m on the other side of the fence, and it’s not nice.*
The stigma attached to STIs is so strong that even if the women were unaware of this stigma and did not initially feel stigmatised by having an STI, this soon changed, as in Cindy’s case. She was not aware herpes was an STI when she was diagnosed, but as she became more knowledgeable, she began to understand the ramifications of having this. She became aware that STIs are associated with promiscuity and dirtiness; discovering this led Cindy to keep her STI hidden:

\[ I \text{ was living with a friend at the time who knew as well as a few other friends who knew what was going on, but I slowly started to understand more and learnt to keep it quiet.} \]

Lilly discussed how she felt people would perceive and judge her for having an STI. She revealed her awareness of how powerful societal perceptions and norms can be, and how they can affect individual lives. Further, intensifying Lilly’s felt stigma was the perception that her friend passed negative judgement on her. Lilly commented:

\[ \text{Well all the stereotypical thoughts like... STDs are associated with promiscuous behaviour... diseased, dirty... In fact I have one other friend that I told which I kind of now wish that I hadn’t, as her response was very much like how I thought others would see me... We are pretty close and she knew something was up, but I feel like she saw me as a bit of [a] damaged egg really. ... It’s incredible that you don’t realise that your feelings are based on society’s expectations and ideas...} \]

Cindy experienced a similar situation when she chose to reveal having an STI to a close friend. Cindy was hesitant to reveal the STI to others due to her fear of stigmatisation. However, the STI and subsequent childbirth complications proved too burdensome to bear alone and Cindy revealed her secret to a friend. This disclosure is something Cindy
regretted as her friend exacerbated her felt stigma, which consequently contributed to the
deterioration of their friendship:

*People view you as dirty.... After I had my first child I was talking to my 'best friend'
who I had known for years, [and] who did not know [about the STI]. ... The deception of
telling everyone a lie about why I had to deliver by caesar [caesarean section] got the
better of me, and I decided to tell her the real reason.... A big mistake, the look of shock
and horror I will never forget- she has never mentioned it since. ... I think how she made
me feel then, along with other things has led to us not speaking that often now.*

Bree’s stigma had been amplified by how she believed her mother looked at her
sometimes. Bree occasionally felt rejected by her mother due to having a sexual
infection:

*It all comes back to the way society perceives a person with it [herpes]. And sometimes, I
see a bit of disgust in my mother’s eyes, and it just makes me feel shitty.*

In contrast, Sam had not revealed her STI to her parents. Sam did not want to risk being
perceived as dirty and tainted by her mother. Although she had tried to minimise her felt
stigma through broaching the topic with friends and trying to normalise having herpes,
she still could not reveal her secret. Sam perceived that both her friends and her parents
would view her negatively:

*The stigma well.... seeing as I don’t get any outbreaks, it’s not the physical issues of it.
It’s just when ppl [people] hear herpes they say EEWWWWWW I’ve even said a "friend"
of mine has H [herpes] to some ppl [people] and talked about it, and tried to make it
sound ok and ppl [people] are just like eewwww. Or when the H [herpes] ad [advertisement] comes on, ppl [people] say eewww that’s gross. A H [herpes] segment was*
on ... and mum said ewww there’s nothing worse than having herpes! And I’m like OMG
[oh my god] imagine if you knew what your daughter had! ... [I] wanted to tell my mum
and dad for support at the start but no way would I now, it’s nothing you can take
back.... coz [because] it doesn’t go away!

Cindy did not want others to view her as tainted as her friend had. She internalised the
typical societal view of women with STIs and on reflection perceived this to be true
about herself. She did not want this to be confirmed by being stigmatised by others, and
thus needed to conceal having an STI as much as she could, despite the dishonesty she
felt in doing so:

I have come to accept that it is something I have to live with but I do feel like I am
constantly deceptive. People do not understand what it means to have an infection like
this, I think they just assume its something dirty people have or sluts- which maybe I was
once upon a time.... but from my experience you limit the number of people who know.

Although Fleur did not believe that she was a woman with loose morals, this was how
she felt others would perceive her. The stigma felt by Fleur caused her to limit her
relations with men. Although society has become more accepting of women’s sexual
liberation, Fleur still felt the dominant societal discourses that exist to limit and label
women through their sexuality:

I don’t feel like I was a promiscuous person in my 20’s or 30’s, but I don’t have any
inhibitions about sex so I have had a number of partners, most leading to relationships.
... I miss the dating scene, I miss the freedom I had as a female in this day and age, I am
now stuck with something that has labelled me promiscuous to some, or it’s a joke to
others.
Some of the women believed that it is the incurable nature of herpes, which intensifies the stigma associated with this particular STI. Bree stated that if herpes was an infection that could be successfully treated, the stigma surrounding it would be minimised. Bree compared her experience of being diagnosed with herpes and chlamydia. The chlamydia was successfully treated, and therefore Bree was not overly concerned with feeling stigmatised; it was treated and she could move on with her life. In contrast, the herpes infection is life-long and cannot always be concealed from intimate partners due to the symptoms of the infection; hence, she felt she would always be tarnished by this infection. Bree asserted:

*Well, I think because it [herpes] is incurable at the moment makes it even worse, if AIDS was curable, it wouldn’t be a problem. I had chlamydia a few years ago, and although I was worried about having it and how I contracted it, I knew it was curable. Herpes was the one I was most worried about.*

Similarly, Charlotte’s stigma arose from both the dominant discourses associated with STIs and the physical aspects of the herpes infection. She felt it was the physical aspects, which would brand her a tainted woman. Charlotte commented:

*I felt dirty and diseased. Knowing enough about it [herpes] to know that it was a life-long virus scared me. The shock of realising this was never going to go away or get permanently treated was horrible. I immediately thought back to high school and in my minds eye saw the images I’d seen in the sex education books. My first thought was of my genitalia looking like that: “My fanny is going to rot and fall off!”*

Having herpes leaves a permanent mark for life. It is a mark that due to the stigma, spoils one’s character, and is a mark that no one wants to carry as stated by Melinda:
That’s what everybody thinks of people with herpes [that they are ruined] – it’s the next best thing to AIDS. I mean if people think of someone with herpes - they think 'run run as fast as you can' (as in, get away). ... There is a stigma attached to herpes. Unlike a lot of other STIs - herpes never goes away, so it’s not something you can get rid of - so nobody wants to 'catch' it.

Rita linked her feelings of being ‘dirty’ to the internalisation of the dominant societal views and stigma attached to women with STIs. Her comments revealed how the societal stigma attached to STIs is enhanced through these infections largely being a taboo topic within society. The stigma attached to STIs is extremely powerful and historically entrenched, which leads to these infections being mostly hidden. Therefore, the secrecy an individual engages in to conceal having STI/s, aims to prevent them being stigmatised. However, once Rita became aware of the high prevalence of STIs, her felt stigma was minimised, although not entirely eliminated. She realised that many people are affected by STIs, and if society were to realise this, the stigma attached to these infections would be lessened, as STIs would become a societal norm. Rita asserted:

*I felt dirty because I had an STI, I guess it stems from the stigma attached to the group of infections/viruses. People view STIs as dirty, or unsanitary diseases, they're not openly talked about. STIs are a topic that people leave locked up in a cupboard, it's not socially acceptable to discuss it. The cupboard door only gets opened when someone is brave enough to talk about their diagnosis. ... As I became more educated on my STI and learned how common it really was, the feeling of dirtiness subsided because I realised that if I was in an elevator with 5 people chances are that up to 4/5 of them would have an STI at some point in their lives. When I realised STIs were common I didn't feel so dirty anymore. I suppose the feeling of unclean comes hand in hand with feeling dirty, and I would describe them identically.*
Similar to Rita, through becoming aware of the high prevalence of STIs, Charlotte’s felt stigma was minimised. However, Charlotte was aware that to avoid the stigma and labels associated with STIs, many people deny having herpes. She concluded that the longer you have an STI and the more accepting you become of yourself, the more the felt stigma fades:

Finding out how common it [herpes] is … 1 in 8, which is probably more like 1 in 5 (with all those who are still in denial), it seems less & less of a big issue, it gets easier to live with the longer you have it.

Sub-theme: Deviant women: Fear of rejection

Due to the stigma attached to STIs, the women feared rejection from male partners. Their internalisation of stigma made these women believe they were deviant and subsequently felt this is how men would view them. The women felt that they would be characterised by having an STI rather than being perceived as individual women. This is clear in the following comment by Bree: Well, because my biggest fear is rejection. Not being accepted by people, wondering how they will think of me if I tell them. The women feared rejection partially because they would themselves reject someone with an STI. Cathy acknowledged her fear of rejection and the anguish caused by revealing having an STI to potential male partners. The fear of rejection became a reality for Cathy, through a previous experience:

Scared, sick, upset, worried ... I was scared and worried of what they would think of me, sick because of the previous guys running, and upset because it hurts every time you’re rejected, and the fear of rejection hurts before it happens.
Sam concluded that it is not the physical aspects of STI/s that deters others from forming partnerships with women with these infections; it is simply the stigma that no one else wants to carry. It is the stigma that creates the fear of rejection and causes the hurt and anguish when rejection occurs from a male partner. Sam’s statement reveals that although herpes can manifest itself on the face through cold sores, the stigma of this condition is not remotely comparable to the stigma of genital herpes. Sam commented:

*So it’s not the fact of having it [herpes].... just that no one wants to be rejected for having an STD. ... Yeah the stigma is the only issue. Like I’ve only ever had one proper outbreak. I get a tingle every now and then.... and an itch, and then take a couple of Valtrex® and it goes away in a few hours. So it’s not havin’ [having] it that’s the problem. I’d prefer to [have] oral cold sores truthfully...*

In discussing how she perceived people with STIs, Bree clearly stated that she would reject, and avoid anyone with an STI:

*I would not have gone near them [people with STIs]. I would have thought that they were promiscuous, easy, and that’s the image in my mind that I had of people with STDs like this one [herpes].*

Due to the stereotypes allocated to people with STIs, Melinda felt that she could identify whether or not a male partner had an STI. She therefore did not perceive her male partner as a sexual risk. However, when her partner revealed to her that he did in fact have genital herpes Melinda’s perception changed. It was her partner’s fear of rejection by her that fuelled his concealment. Melinda stated:
I guess I thought also - that he wasn’t the ‘type’ to have an STD. ... Well, he was a nerd ... but so I’ve found out that anybody can get an STD. It turned out that he had gotten it from his ex-wife and that every person he had any type of relationship [with] afterwards - he had never told. I was the only one he told. He said that if he had told me at the beginning - that I never would have slept with him.

The fear of rejection made Bree wary of choosing potential male sexual partners. She elucidated that she now needed to get to know a man and develop trust to minimise the possibility of rejection. She expressed needing to determine the likelihood of rejection from a partner and needing to gauge whether or not she should put herself at risk of being stigmatised. However, Bree had minimised and avoided her fear of rejection and felt stigma by keeping her STI a secret:

Well, I went from being someone who had a bit more sexual freedom, to someone who has to be extremely careful, and selective. And it isn’t a bad thing, it is just hard. But, in saying that, I get treated the same as everyone else because not everyone knows my little secret. … Selective…. well, to tell someone, a partner, I need to trust them and try to gauge their reaction ...

Sam revealed that the stigma and fear of contracting an STI is so strong that she herself would avoid being sexually involved with someone with this type of infection. However, her thoughts were conflicted, as despite her own situation she would expect a man to still have sexual relations with her. Her comment illuminates the notion that people do perceive individuals within the context of their stigma, which in turn can cast a shadow over a person’s character. Sam conceptualised rejection in terms of how much an individual cares for another person. Sam commented:
Well I have a few friends with H [herpes] and they have had both reactions. It just depends on how much that person is into you. Coz [because] I know I would have run a mile if I knew this guy had it, and if I was in the situation where someone told me they have another STD I wouldn’t be with them. Which is really rude seeing as I expect them to be with me.... it’s such a tough subject.

Prior to her infection, Charlotte would not have entertained the idea of being with a man infected with herpes. She explained that it was her own feelings and views of people with STIs that exacerbated her felt stigma. Despite Charlotte’s continued efforts to overcome her felt stigma, it was the perception of being characterised by having an STI that reminded her of her perceived ‘tarnished’ self:

In all honesty if I was still “clean” & met a guy who told me he had it [herpes] I would be a bit turned off, so this also makes you feel something is seriously wrong with you now you have herpes. But it has helped me feel strong in the face of potential lovers reactions to being told, as I can be so honest with myself, I can’t judge them for reacting the same way I would have. It is only because I now have & suffer from it that I know it is not that big a deal. As a general rule I feel less & less bothered but it is still a hard task to tell someone you like, & know it is those instances that are the only times I can still feel a bit “dirty”.

Lilly’s story revealed the difficulty in revealing having an STI to a male partner. Her story sheds light on how wanting to conceal having an STI is in conflict with the moral values of trust and honesty. Lilly cared deeply for her partner and could no longer keep her STI status from him, although she feared rejection. However, despite her STI status, her partner chose to continue the relationship. Although, if he had ended the relationship based on her STI, Lilly would have accepted and understood, as she herself would not be sexually involved with a man with an STI. Lilly stated:
In January I met the most amazing man…. at first I was petrified! I really like him and knew if things were going to continue that I would have to tell him. I had read a lot about this moment and knew that it was a huge step and I had to be prepared for the worst…. As much as I wanted to keep it from him and I could somehow get round it, I knew that if I really cared and wanted to have an honest and trusting relationship I knew I had to tell him before things went any further. It is one of the hardest things I’ve had to do! … I felt so embarrassed and wanted to run, but he is such a gentle person he made me feel comfortable…. … However…. he was hit hard by this information and he did consider jumping ship for which I don’t blame him at all!

Fleur stated she had not found a man with whom she was interested in pursuing a partnership. Having herpes is something that Fleur cannot hide from others due to her constant outbreaks, and she was well aware that having herpes is an undesirable characteristic and a reason to fear rejection:

I am not dating because of continual outbreaks, because I do not wish to pass this on and because people are not happy to have a relationship with you when they find out, also I have not found anyone I like.

Sub-theme: Women unworthy of love: I worry about being alone

The women’s fear of rejection and their felt stigma at times led them to perceive that they were unworthy of love. Many feared being alone and never sharing a loving intimate partnership again. These women feared loneliness, yet some felt they were destined for a life of solitude. Through both their own and societal perceptions of women with STIs, the women perceived themselves as less than ideal partners. Due to these perceptions, the women felt contaminated and undesirable and thus unworthy of a loving relationship. This is evident in Sam’s statement:
... one minute I think I’m ok with it and then some days, when I feel any symptoms etc. I think it’s the end of the world, I’ll never find a guy ...

When diagnosed with herpes, Fleur was concerned for her wellbeing; however, as time passed she became more aware of just how onerous having the infection can be. She stated that on diagnosis she felt fine, a little rattled but generally ok. I think you feel worse as time goes on because you realise that it will impact on your relationships. The combined concerns regarding the physical aspects of the infection, and the impact it could have on a potential loving relationship and family, intensified Bree’s felt stigma and feelings of unworthiness. She was so fearful of being alone and continued to feel anger towards herself:

*There are times when I get upset because I think about having it [herpes] and how it will affect my future eg, relationships, children etc, and I hate myself. I just don’t want to be alone.*

Bree’s thoughts of loneliness were amplified by her knowledge that many people who have herpes are not involved in relationships. Knowing this increased Bree’s felt stigma and fear of rejection:

*Well, there are days where I don’t worry about it, but others when I dwell on it and think about it, and get online and see all the people who have it and aren’t in relationships, and just get sad about what my future holds with this.*

Similarly, the stigma intensified Cathy’s fears of loneliness. When she was diagnosed she felt that her world was crumbling down around her. She felt that everyone would
know that she had contracted an STI and this would make her unworthy of love. She felt that she deserved to have an STI and that through contracting such an infection she was labelled as contaminated and an infectious sexual risk. Cathy’s diagnosis led her to believe that her infection signified how undeserving she was:

*I was shocked at first. I cried when I got back to the car and was extremely upset, worried, stressed, depressed and I felt dirty. I thought my life was over because at 20 who would want to risk having any sexual contact if it would mean they may get it [herpes]. At first I saw it as an external thing that people would see. I couldn’t get it out of my head that I was worthy of anything else. ... I didn’t feel that I deserved anything to do with relationships. I didn’t think I deserved to be loved or wanted by anyone.*

The thought of being alone forever further deepened the women’s emotional burden and pain. Fleur commented *It has changed my life, I worry I will be alone, but I try and take a day at a time.* When Lilly discovered that the herpes infection was an incurable virus, her emotional pain was exacerbated. Lilly’s comment reveals her feelings of unworthiness and perceived tarnished self:

*After being diagnosed, I went in to research overdrive.... I tried to find out everything I could about GH [genital herpes] and this made me even more upset knowing that there was no treatment and it would be something that I would always have. As I was single at the time I knew this would inhibit my chances of finding a partner.... as who would ever want someone who was contaminated! I was so ashamed about it and obviously didn’t want anyone to know about my problem.*

Like Lilly, Sam’s fears of loneliness and unworthiness were intensified by the incurable nature of herpes. She perceived herself as undesirable to men; *thinking no guy would ever want me again.* Lilly contemplated joining a website that enabled people to meet
others with an STI; she felt this was her only option to meet a potential partner. Lilly felt that only these individuals would be interested in a potential partnership with her. Lilly’s fear of rejection, and the perception that men would view her in a negative light, was so strong that she withdrew from dating and avoided engaging with potential male partners just after her diagnosis:

... I did not access this [website] although the thought crossed my mind.... I felt like I might have no other choice, as I feared what a prospective partner might think. ... Since my diagnosis my dating behaviour ceased and I became so much more reserved in social situations.... I dreaded ever having to tell anyone about GH [genital herpes] ever.

Fleur outlined the belief that it is human nature to fear loneliness, asserting that every human wants to find a companion. However, although Fleur expressed desire to find her ‘one’, her thoughts and desires were in conflict. Fleur did not want to pass her burden onto someone that she deeply cared for, yet she did not want to live a life of loneliness:

Every human worries about being alone, finding ‘the one’. They are a liar if they say they don’t. I now have an obstacle: I can make ‘the one’ very sick. It’s a burden to carry around.

Having an STI, particularly a life-long infection was burdensome on all these women, and having an infection that carries societal stigma exacerbated the burden and pain these women felt.

**Conclusion**

The women’s stories revealed that the stigma attached to women with STIs is so profound and entrenched that they internalised the stereotypical views of women with
STIs as promiscuous, loose, and dirty and subsequently carried these thoughts about themselves. The stigma and societal stereotypes of women with STIs led these women to fear rejection from men. The women felt they were deviant; hence they felt that they were women who were undeserving of love due to having STI/s. In addition to the stigma felt by these women, the following theme reveals the extent of the burden, which these women carried due to having an STI.
Theme three: Burdensome emotions, responsibilities, and consequences

The theme ‘Burdensome emotions, responsibilities, and consequences’, consists of three sub-themes as depicted in table 4. The first sub-theme: Damaged and devastated: Yuck and ruined reveals the extent of the emotional pain these women have experienced due to having an STI. This sub-theme illuminates their emotions felt on diagnosis and their resentment towards themselves and their partners. The second sub-theme: Transmission and disclosure: I would be horrified if I infected someone reveals the women’s fear associated with transmitting their infections to a partner, and the responsibility the women felt in disclosing their infections prior to intimacy. The third sub-theme in this section: Motherhood and reproductive health: I just worry elucidates the women’s fear and concern for jeopardising both their own reproductive health as well as their babies’ health. Due to having an STI, some women felt they may have shattered their future dreams of having a family.

Table 4: Theme three

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
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<tbody>
<tr>
<td>Burdensome emotions, responsibilities, and consequences</td>
<td>Damaged and devastated: Yuck and ruined</td>
</tr>
<tr>
<td></td>
<td>Transmission and disclosure: I would be horrified if I infected someone</td>
</tr>
<tr>
<td></td>
<td>Motherhood and reproductive health: I just worry</td>
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</tbody>
</table>
Sub-theme: Damaged and devastated: Yuck and ruined

Being diagnosed with an STI caused these women immense anguish and distress. The emotional pain that came with being diagnosed was overwhelming, and the fact that it was a sexual infection amplified the women’s burden and pain. Once the women had been diagnosed, they were devastated; they felt that their world had been shattered and damaged; they felt their lives would never be the same again. Comments such as the following highlight the devastation and damage felt by these women: *I was 20 and thought my life was over* [Cathy]. In response to their devastation and perceived damaged lives, and despite the women’s self-blame, they expressed resentment and anger at both themselves and their male partners. The combination of these feelings, led to them being overwhelmed with emotions. Although Lilly acknowledged there were worse health conditions than herpes, she could not help but be overwhelmed by contracting this infection. Even though she experienced painful outbreaks of the virus, the emotional burden outweighed the physical aspects of the virus:

*I say devastating virus and perhaps I’m a little insensitive in saying that as people experience much worse such as HIV, hepatitis and other such issues! ... The physical pain is one thing. But the emotional and ongoing difficulty is even worse.*

Similarly, although Bree experienced physical pain from the initial herpes outbreak, her emotional anguish and felt stigma exacerbated her pain. Bree stated *I felt like shit.... I was sick.... very sick and emotional, and became quite depressed. I felt dirty.... pissed off....* Likewise, the stigma felt by Melinda intensified her emotional pain. Melinda felt that both herself and her life were so damaged that she would never be the same again:
I would wake up every morning, and that was the first thing I would think about "herpes" - and then I would begin to cry. I cried every time I thought about it. ... I guess - 'yuck' would describe it pretty well. Yuck and ruined.

Ruby’s pain that accompanied her STI diagnoses was intensified by being married to the man responsible for transmitting these infections to her. The betrayal by her husband caused Ruby immense grief and shame, despite him being solely responsible for transmitting the STIs. Ruby also revealed that being given a diagnosis of several STIs whilst pregnant amplified her feelings of devastation and disgrace:

Believe it or not, I found out when I found I had pubic crabs. That was the first thing. I was distraught and called him at work to ask if he had been having an affair, which he denied. I was pregnant at the time. ... A couple of days later [I went to a doctor] and had a series of blood tests and was really heartbroken when I got told the list of STD[s] I had. ...I had only ever had sex with him. By then we were married and I was pregnant with our second baby. ... Well I can’t tell you how devastated I was. I had loved and trusted this man for years and to find this out was terrible. Initially he denied he had been sleeping around but then did admit to it. I felt so ashamed to have got all these things and this is the first time I have really told anyone about it since then. At the time I told him and the dr [doctor] knew. But I felt so ashamed I changed drs [doctors] and tried to put it behind me.

Rita felt that the physical and emotional pain she endured was the penalty she had to suffer for contracting an STI. She felt that because she had put herself in a position to contract an STI, she had to accept the consequences. When Rita discovered the physical adverse affects of HPV on her health she was distraught. She felt that she had no control over her health or the STI; she felt frightened and helpless:
I felt in a way it was punishment for taking risks. I struggled with the physical aspects of the virus. When I later learned that it had caused pre-cancerous cell changes on my cervix, the feeling of being dirty diminished and I was devastated. I felt vulnerable. I was overcome with emotions on both occasions and frightened for my health. ... The feeling of vulnerability I find hard to elaborate on, I'll just put it down to this, when I was receiving treatment for the physical warts, it was painful, the doctor told me to let her know when it began to hurt, I didn't tell her, I just put up with it because I felt I deserved it.

In contrast to Rita and despite the blame they had placed on themselves for contracting STIs, some of the women questioned what they had done to deserve such damaging and devastating infections. Having contracted an STI was a foundation of anger and resentment both towards themselves and their male partners. Fleur was still resentful about contracting herpes, although she had realised that she could not change her situation: I still get a little angry at the “why me” but there is nothing I can do so I just get on with it ... Likewise, although Cindy felt there were worse infections and illnesses she could have, she was still angry and resentful for contracting herpes, however she was also somewhat relieved:

Yes, I may be a little bitter- a little ‘why me’ but it could have been HIV- so on the other hand a little thankful if it had to be anything it was that, and the fact that I don’t have that aggressive ... strain of the virus.

Although some of the women were angry at the time of their diagnosis, this anger had not entirely subsided at the time of this study. Melinda commented ... I was absolutely furious with my then partner. It took me about two years to get used to the idea that I was infected. In the following comment, although Melinda’s anger is directed at herself
through her feelings of regret, she remained resentful of her ex-partner. Melinda went on to say I think everybody who gets infected regrets having anything to do with the person who ruined their lives! Despite her self-blame (revealed in theme one), Ruby also continued to feel contempt for her ex-husband. Although she had tried to move on from her STI experience, she has been constantly reminded, as her ex-husband is the father of her children. Ruby stated:

I am a strong person and have tried to move on. To be honest whenever I think about it, I just want to go after him and let him know how much I hate him. I try not to think about it, because I still see him sometimes because of the children.

Melinda’s anger was so fierce that she needed to make her partner feel the emotional burden that she continued to feel. She wanted him to feel her shame and stigma. Melinda’s need for revenge was fuelled by her resentment for her ex-partner, and by feeling she could never disclose her infection to others due to the stigma surrounding STIs. She commented:

I sent emails ... saying he had herpes. I also sent postcards ... saying the same thing. I’m so bad! But I had heard he was seeing other people. I thought he deserved to be found out. And also because he never said sorry. I wanted him to pay! I’ve heard ... others have taken revenge in similar ways. It’s all that anger that you can’t tell anybody about because it’s something you can’t tell people about.

Like Melinda, part of Bree’s anger stemmed from the stigma she felt. She resented contracting an STI and was angry. Bree perceived that society would reject her due to having an STI, and just after receiving her diagnosis, she felt vengeful. Bree stated:
... Although I am ashamed to admit it, I wanted to [deliberately transmit herpes to others] when I first found out I had it, I think because I was so angry, and I think that if everyone has it, it would be easier.

Charlotte’s initial anger was directed towards herself for compromising her health and contracting an STI. She stated I was angry, but my immediate anger was directed at myself for being so stupid by not having safe sex. I thought “You idiot!!!” about myself. On reflection and having come to terms with having herpes, Charlotte realised she may have unknowingly passed her infection onto others prior to her diagnosis. In contemplating directing anger towards others for transmitting the virus Charlotte commented:

I realise now that I don’t really know who gave it to me for certain. It has also highlighted, for me, the fact that I very well may have given it to others without knowing I had. This fact definitely helps if you are initially angry about having caught it because you realise that the person who gave it to you may have done so quite innocently, rather than thinking they had purposely not informed you.

**Sub-theme: Disclosure and transmission: I would be horrified if I infected someone**

Although many of the women were angry about contracting an STI, they did not want others to endure what they felt. Nor did the women want to compound their burden through feelings of guilt they believed they would experience if they transmitted these infections. For some women the thought of transmitting STIs was so burdensome that they could not bear the thought of doing this, thus they considered sexual abstinence their only option. This is clear in Sam’s statement, which reveals how she did not want anyone else to feel the burden of an STI. Sam stated transmission is my only issue not wanting anyone else to get it and have the surrounding emotions ... The women were
aware that being sexually involved with someone carried the risk of transmission, and hence, some felt that they had to disclose their infection. However, due to the stigma some women could not bring themselves to reveal having an STI to sexual partners. As simply stated by Melinda: *I cannot tell anybody about H [herpes] - so I would not sleep with anyone.... if that makes sense.* Although not all of the women in this study had disclosed having an STI to intimate partners as previously discussed, the women were aware of the responsibility of doing so. Even though Ruby had engaged in unprotected sex since her diagnoses, the perceived guilt associated with transmission outweighed the choice to disclose having STIs and her desire for an intimate relationship:

... *[I] don’t feel I can tell anyone about it, yet I would feel terrible if I passed it on so I feel I cannot have any sexual relationship. So I feel very lonely sometimes.*

As with Ruby’s comment, Fleur’s story highlighted the guilt and blame of transmission, which can effect the decision of whether or not to disclose. Fleur highlighted the fact that by disclosing she had an STI, she would risk being blamed for her sexual partner’s ill-health if transmission occurred. Fleur stated:

*When you are first infatuated with someone you say and do things that will come back to bite you! It’s like looking through rose coloured glasses. People may say they do not mind about this, but they will if they get it. You feel a lot of anger and “why me” when you get this, and I do not want to be the person that someone can blame for making them ill.*

The physical effects of herpes have prevented Fleur from being intimate with anyone. However, it has also been her fear of transmission that has prevented her from forming
romantic attachments with a man. Fleur expressed how she does not want others to feel
the burden and pain she has experienced due to having an STI:

*I do not date (have been celibate for 18 mnths [months] now) at this stage and would not
date a person who does not have this, I will not take responsibility for passing this on. It
is human nature for one to say they don’t mind, but if they were to get it, they would feel
very different.*

At the time of the study, Lilly was in a relationship. She felt affection towards her
partner and the burden of her infection had become apparent. Lilly was immensely
burdened with the fear of transmitting herpes to her partner and her outbreaks have been
a constant reminder. The burden of having an STI had also limited her sexual
spontaneity within the relationship:

*Yes we have been intimate but this is one of the most frustrating aspects and feelings of
regret. We have used protection every time and by this stage in a relationship we both
would have felt comfortable, and been tested and know that it is safe to not use condoms.
But as it is we have no choice! I feel extremely frustrated and it really takes away the
spontaneousness of things! ... Yes [he has been tested] so far he’s clear. And my worst
fear is that he will contract this as condoms aren’t guaranteed to stop transmission.... ... I
have come to accept this situation.... still extremely regretful and probably always will
be. More so because I have someone in my life who it could affect. I find that when it is
suppressed I don’t think about it as much.... apparently within the first two years you
have the most recurrences and I’ve had a few, and when they happen I get bit upset
about it.*

Although not all the women felt able to disclose having an STI when engaging in sexual
activity, and others had chosen to remain abstinent, some did express the responsibility
associated with disclosure. Charlotte illuminated the inherent difficulty in disclosure, when she stated: *Meeting new partners is really hard because I feel obliged to tell any prospective lovers prior to us having sex, even prior to us having safe sex.*

The women expressed gender differences concerning disclosure and illuminated the perceived lack of responsibly and disregard that men have towards sexual health. Sam reflected on her experience and the man she contracted herpes from, and she wondered whether he disclosed to his new girlfriend as he did not disclose to her: *The guy I caught it off has a new gf [girlfriend] now and I wonder if he told her or denies it with her too.* Melinda had a similar view to Sam, feeling that women would be more likely to disclose than men, perhaps because she was not aware of her long-term partner’s infectious status:

*I would be horrified if I infected someone - with (or without) their knowledge. I’m guessing a lot of men don’t have such a conscience. I think a lot of men wouldn’t tell their partners - but a lot of women would.*

Bree was burdened with the thought of transmitting her infection to others but suggested that men lack similar concern:

*Honestly, I didn’t know the guy I got it from.... and I feel bad for that because he might still be passing it on unawares or he might not have a conscience and be doing it deliberately.*

Charlotte was aware that STIs can be transmitted from one person to another with neither person being aware of this and acknowledged the possibility of her passing on
the herpes virus to intimate partners. However, because Charlotte did not intentionally transmit the virus and was unaware if she had done so in the past, she did not feel guilt associated with possible transmission:

*The fact that I may have passed it onto someone else only occurred to me later when I thought about what the doctor had said regarding her presumption I had had previous attacks. ... I did not feel guilt about the fact I may have passed it on, as I had not done so intentionally, but more concern for others.*

For these women, the burden that came with the thought of transmission was immense, yet for some, the heaviest burden was the effects of having an STI on their future dreams of having a family.

**Sub-theme: Motherhood and reproductive health: I just worry**

One of the greatest burdens on some of the women was the thought of transmitting an infection to their offspring, and the health consequences of having STIs on their reproductive health. The women who wanted a future with children feared that this dream was shattered, as they were concerned that the infections would compromise their reproductive capabilities. The women who were yet to experience childbirth conveyed the belief that due to these feelings they would not be able to fulfil a biological motherhood role; the STI/s had taken this ‘womanly rite’ from them. Sexual infections have the capacity to hinder fertility as well as having potentially adverse consequences for pregnancy and unborn babies. Two participants spoke of the pain and anguish experienced during their pregnancies due to the fear of compromising their babies’ health.
Although Melinda had always dreamt of having a family, she felt that having an STI had taken this from her; this is something she had come to accept. Melinda had not been intimate with anyone since being diagnosed with herpes and felt she could never be again. Melinda stated:

*Also, I always wanted to get married and have children - but that has changed. I have resigned myself to a life of singledom [not being involved in a partnered relationship]. ... I don’t entertain the idea of even going out on a date, etc.*

Similarly, Bree conveyed that she would like to have children in the future, however she feared that a pregnancy as well as a partner’s health could be jeopardised by her having herpes. She expressed fear of being an infectious risk to an unborn child. Bree commented:

*Well I know that it is only passed onto the child if you have an outbreak when you give birth via the birth canal. I just worry about the extent to which I could get it, or pass it onto someone else, because everyone is different.*

Although Rita did not specify that she wanted to have a family in the future, having HPV had a vast effect on her life and reproductive system. Rita needed to undergo specialised healthcare treatment, which caused a financial burden for her. Having an STI that jeopardised her reproductive health contributed to Rita’s emotional distress. Rita stated:

*Apart from the roller coaster of emotions I felt at the time I was diagnosed, it has had an impact on my life up until today. Because I developed cervical cell changes evident on a Pap smear I had to see a gynaecologist regularly. I had to have 6 monthly Pap smears*
and pay for biopsies, DNA [deoxyribonucleic acid] testing etc. as well as the hefty specialist bill. It is only now physically that I have the 'all clear' and can continue with my normal Pap smear at my GP [general practitioner].

Sam discussed the consequences of having asymptomatic chlamydia. She felt heartbroken by contracting this from a loved partner. Sam acknowledged the different outcomes STIs can have on men and women. Her statement reveals that a man is less likely to be burdened with the consequences of the inability to conceive; however, a woman is left with the physical scars of an STI and also the possible fear that she may not be able to conceive; a defining characteristic of womanhood and femininity within society. Sam stated:

[When I was diagnosed with] C [chlamydia] I was so upset coz [because] it was from someone I loved and really cared about and trusted and coz [because] I had it so long, I had the chance of it leading to infertility seeing as it got to the pain stage. ... You don’t know [the effects on fertility] until you try and have babies - expensive tests to have - but there’s no point until I'm at that point in my life but there’s definitely that possibility. It’s fine for him coz [because] he has a new partner who is now pregnant!

Ruby’s burden was intensified by the thought of raising her children alone. She already felt tarnished by having STIs and did not want her perceived marginalisation to worsen by being a single mother. However, ultimately Ruby felt that she had to do what was best for herself and her children:

I felt like having an abortion. I did not want to be a single mother. ... For a while, I tried to keep the marriage going out of fear of having two babies and no partner but it didn't work out and I ended the marriage before the second baby was born ...
Both Ruby’s and Cindy’s stories reflected the inherent burden that women are ultimately responsible for their unborn child’s health, hence ultimately (in their cases) responsible for transmitting STIs to the foetus. As women biologically carry children, they tend to be blamed for complications of pregnancy and childbirth, particularly those arising from STIs. Although the time spanning between pregnancy and childbirth is supposed to be a special time, it was a time of anguish for these women. Ruby felt her pregnancy was ruined by her STI diagnoses and her betrayal by her husband. Her fear and burden is clear in her comment:

_I was worried sick and was also upset at the medicines I had to take to get rid of the infections; worried they could harm the baby. … I said I would go back [to the doctors] but took the prescription and fled out of the office, but was sick with worry for the whole rest of the pregnancy. That’s another thing, the whole thing ruined my pregnancy, which is a special time. … I was worried that the baby might have something wrong because of the infections or the medicines. I was so relieved when he was born and was ok._

Similarly, Cindy feared for her babies’ lives. She felt that the herpes infection was responsible for compromising the labour and birth of her two children. She blamed herself for her birth complications. Cindy stated:

_I have had repeated episodes [outbreaks] over the years but not as severe as I think others get it. My last attack was at the time of my first child’s birth which meant I could not deliver vaginally and having a caesar [caesarean] … led to resp. comp [respiratory complications] for not only my first but my second child, which I blame on the fact that I have this infection. … Yes both kids were caesars [caesareans]. My first child had a dusky episode at about 4hrs [hours] old, and because I had active lesions at the time, they [healthcare staff] went into full blown panic mode thinking he may have contracted the herpes virus during delivery, which is generally fatal- from what I know. So we_
endured 10 days of torture for him and for us wondering if because of me he would not survive. Then we chose to have another caesar [caesarean] for my second because there is less chance of contracting the virus delivering this way. Which lead to resp [respiratory] distress, which lead to him having to go on to cpap⁶ to help him breathe, which led to a pneumothorax, which lead to them having to resuscitate him in front of me, and then he was transferred... [to] NICU⁷ where he recovered thankfully, but you can understand why this virus has had such a significant impact on my life.

When Cindy was diagnosed with genital herpes, she was unaware of the sexually transmissible nature of the virus. She stated that I did not know what it was, so not very distressed. However, after experiencing complications during childbirth Cindy realised the devastating consequences of this virus. Cindy perceived that the guilt and anguish she felt through having difficult childbirth experiences as a result of having herpes, contributed to her depression. Cindy commented:

The other ways it has affected my life is that it has I think contributed to my postnatal depression and antenatal depression while pregnant with my second child (because of the worry of going through that again and the guilt of it being my fault that my son went through all that pain because of me). ... I have been seeing a psychologist since I was pregnant with my second and am on a higher end of the scale dose of AD's [anti-depressants] and some mood stabilisers.

Conclusion

These women conveyed that having an STI was an immense burden. The women spoke of their emotional pain and anger in response to having STI/s, with some women wondering what they had done to deserve such an infection. Intensifying their emotional

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⁶ CPAP: Continuous Positive Airway Pressure
⁷ NICU: Neonatal Intensive Care Unit
burden was the thought of ever transmitting their infection to another person. This thought, as well as the fear and guilt associated with transmission, was so burdensome that some of the women had resigned themselves to sexual abstinence. Moreover, because the women were aware of the responsibility of disclosure, they spoke of the pain and conflict they felt when contemplating disclosing their STI status to an intimate partner. The women expressed anguish and sorrow when thinking about having future relations with a partner and beginning a family. Further, the women elucidated the fear and pain they felt associated with possible reproductive health consequences and the effects of having an STI on their babies’ health.

**Summary**

This chapter has revealed the effects of having an STI on these women’s lives. It has also illuminated how they conceptualised themselves as women with STI/s. The women initially perceived themselves invulnerable to STIs and it was for this reason that when the women were diagnosed they experienced a disruption in their sense of self. The women subsequently felt shamed, and blamed themselves for acquiring STI/s. Although some of the women used denial and wishful thinking to preserve their self-perception, all the women felt tainted by having this type of infection. This occurred through the women perceiving themselves within the context of the dominant societal discourses attached to women with STIs and thus, feeling this about themselves. Due to the stigma, some of the women perceived themselves as undesirable and unworthy of love from a male partner. Further contributing to the women’s burden was both the impact the STIs have had and may still have on their reproductive health and that of their children. The women feared transmitting STIs to others and for some, the associated emotions that
accompany disclosure and transmission proved such a burden that they have resigned themselves to a life of abstinence. The following findings chapter reveals how the women were in fact vulnerable to contracting STI/s and identifies the sources of support the women have drawn on to overcome the adversity of having a sexual infection.
CHAPTER FIVE: FINDINGS CHAPTER

Chapter abstract

This chapter focuses on the remaining two themes of the findings as depicted in table 5. The first theme reveals how the women were in fact vulnerable to STI/s, and for various reasons, were unable to protect themselves from STI/s through condom use. The final theme elucidates the women’s healthcare experiences and the support networks the women drew on to gain support in living with having an STI. This theme also highlights the contradictions within the women’s stories, in that although the women expressed their devastation in having STI/s, some of the women conveyed their ability to see a positive aspect to their experiences, despite the emotional pain and adversity having an STI had caused them.

Table 5: Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>Violated and vulnerable</td>
<td>Violation and betrayal: <em>How could someone think I’m so worthless</em></td>
</tr>
<tr>
<td></td>
<td>Condom initiation: <em>Unable to speak up</em></td>
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<tr>
<td></td>
<td>Wary of men: <em>I feel I am too vulnerable</em></td>
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<tr>
<td>Strength and support in the face of adversity</td>
<td>Healthcare professionals: <em>It made it worse</em></td>
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<td></td>
<td>Sources of support: <em>Strength to carry on</em></td>
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<td></td>
<td>Drawing on strength and resilience: <em>I feel like a stronger person</em></td>
</tr>
</tbody>
</table>
Theme four: Violated and vulnerable

The theme ‘Violated and vulnerable’ comprises of three sub-themes as depicted in table 6. The first sub-theme, Violation and betrayal: How could someone think I’m so worthless reveals how the women were vulnerable to STI/s through male dominant relations and traditional gender norms. The second sub-theme, Condom initiation: Unable to speak up reveals that due to these traditional gender norms, the women’s ability to initiate and negotiate condom use was hindered. The third sub-theme: Wary of men: I feel I am too vulnerable illuminates how the women were cautious of engaging in intimate relationships due to their experiences and how through contracting STI/s some of these women had become even more vulnerable to male domination within their heterosexual relationships.

Table 6: Theme four

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<tr>
<th>Theme</th>
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<tr>
<td>Violated and vulnerable</td>
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<tr>
<td></td>
<td>Wary of men: I feel I am too vulnerable</td>
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Betrayal and violation: *How could someone think I’m so worthless*

The women were subordinate within their relationships, which made them vulnerable to contracting STI/s. The women were vulnerable due to either being with older partners, wanting and believing in love, and/or experiencing emotional and physical abuse. Four of the women spoke of their experiences of abuse and coerced sex through which they had contracted STI/s. Through this violation; the women’s ability to protect their sexual wellbeing was hindered. Contracting an STI through abuse or coerced sex amplified the emotional pain felt by these women.

Cindy’s story reveals how vulnerable young women are to sexually predatory men. Cindy believed that she was drugged, allowing men to exert their sexual dominance, whilst oppressing Cindy and forcing her to be sexually submissive. These men not only emotionally injured Cindy, but also left her with an incurable infection that she must endure for the rest of her life. Cindy commented:

*Well I have genital herpes type one, which I was diagnosed with in my late teens I think 18 due to from what I can remember a sexual assault while under the influence of something. I did not know [what] I was given- some sort of drug I assume. I am 28 now. ... It was more like 5 [men] all who were involved but there was one specifically I found out later was said to have an infection...*

Similar to Cindy, Rita felt violated by her partner from whom she contracted an STI. Although Rita wanted to protect her sexual wellbeing through condom use, she felt she was unable to do so due to her partner exerting dominance over her. Within their relationship, it was her partner’s sexual pleasure that was the dominant concern, rather
than Rita’s request to use condoms, which was disregarded. Due to the abusive nature of her relationship and contracting an STI, Rita felt that her partner had taken her innocence. Rita stated:

*When I originally found the warts I felt really dirty, I felt unclean and violated amongst an array of strange feelings. … I guess because the person I blamed for giving me the virus was also physically abusive. I felt that something so sacred was taken from me, not only did he emotionally scar me but he left me now with physical scars, which each day I had to deal with the consequences. Also because on several occasions with this guy I'd tried to initiate condom use but he pressured me emotionally against the use, something I used to feel so strongly about was not respected by him.*

Some of the women’s stories illuminated the classic notion that women hold on to love and hope. The women trusted in love and an idealistic romance, which led some of the women to believe that men would not take advantage of them. Charlotte believed this. However, as time passed, and as Charlotte became aware of and experienced betrayal and deception, she learnt otherwise. Her youth and innocence made Charlotte vulnerable to men and subsequently to STIs:

*I was a romantic in that I thought if a man was interested in me it was genuine & not just sex for him. Being an open & honest person myself I presumed that others would be open & honest also. Since then I have had my eyes opened in regard to how deceitful/sly men or women can be, especially about issues that involve any possible feelings of shame.*

Similarly, it was Ruby’s desire for idealistic love that made her vulnerable to STIs. Despite the pain she endured associated with her husband’s abuse, Ruby desperately wanted her marriage to work. She clung to hope and to her desire for love and happiness.
with her husband, which gave her a reason to endure the maltreatment she experienced.

Ruby stated:

_He was abusive in all ways. He was physically and sexually abusive and coerced me into things I didn’t want to do. He also raped me sometimes. Once anally, which was agonising. But I still clung on to the belief that he did love me. And that we could have a good life together._

Ruby was extremely young when she began a relationship with an older man. Her age alone made her vulnerable to this man and STI/s. At such a tender age Ruby looked up to her husband and thought that he would always care for her:

_Yes I had been in this relationship for a really long time. Since I was 14 and when I look back it was a very abusive relationship. I had been totally faithful to him and trusted him 100%. I was foolish. I think I was vulnerable going into the relationship and got abused in all sorts of ways and then got a lot of STDs as well._

Melinda’s partner was also older than her. She put her trust and faith in a man who she felt ill-used her. As long as Melinda was fulfilling his sexual needs, she felt her sexual wellbeing was neither a concern nor priority to her partner. It was only when Melinda realised her partner had been deceitful, when she became symptomatic with herpes that her partner revealed his STI status. Melinda commented:

_I guess he was about 41 at the time - and he was a geeky nerdy [type] ... We discussed STDs at the beginning of our relationship - but he didn’t come clean. He did tell me later on though, but by then it was too late. ... He told me casually one day that he had herpes. I asked him why he hadn’t told me before - he said that I wouldn’t have slept with him. I had been experiencing a symptom (like a small nick or cut) and I had_
complained about it - but he had never said anything. He only told me about having herpes because he said "what would you do if you got herpes" and I said "whoever gave it to me would have to marry me". I found out soon after when I got another small nick - and checked it out at the doctor. I had done some reading on herpes. We never had sex again after he told me about having herpes. The trust was gone - and I hated him instantly but the relationship dragged on for almost another year. ... The betrayal. How could someone think I’m so worthless not to inform me.

Both Ruby’s and Melinda’s STI experiences have contributed to their mistrust in men. They were both extremely vulnerable to men before contracting STI/s. Reflecting on their experiences; both women felt the men they were involved with took advantage of their vulnerability. Melinda commented: *I’ve always had issues with trust in men. I was sexually abused as a child. This herpes experience just adds to the 'all men are arseholes' list.* Ruby simply wanted love and protection and wanted to escape her past. Ruby asserted:

*I don’t really trust men anymore. When I think back I think he took advantage of me. I had an unhappy home life and was looking for love I suppose, and was naive about men, as I had no father in my life so was foolish, and not able to see this man’s bad qualities. I was only 14 and he was older and seemed wonderful to a shy and insecure 14 year old.*

The women’s experiences of violation and their desire for romantic love made these women vulnerable to STI/s. Amplifying this vulnerability was the women’s inability to initiate and negotiate condom use.

**Condom initiation: Unable to speak up**

Due to the gendered dynamics that existed within these women’s relationships, condom negotiation and use was not always a viable option. Even those women who did consider
practising safer sex were hindered due to being in unequal gendered relationships. Others simply trusted in their partners and their relationships. The women were all vulnerable to STIs due to their own and their partners’ behaviour. Some women relied on their male partners to initiate condom use. If these women had taken a more assertive stance in negotiating safer sex, they felt they may have run the risk of being viewed as sexually experienced or even promiscuous.

Rita asserted that society expects women to practise safe sex but it's presumptive that the man will initiate it. Her statement reveals the tension inherent in the presumption that women will practise safer sex through condom use, despite the unequal power balances within their relationships and the associated gender norms that can hinder the use of condoms. Bree stated that we were both drunk, and protection never came up, it was highly sexual, and got "caught up in the moment", to be honest, I never really practised 'safe' sex religiously. Bree’s comment reveals that she was in fact vulnerable to her male partner. Bree did not initiate barrier protection, thus a condom was not used. Her male partner did not take responsibility for this and subsequently transmitted genital herpes to her.

Similarly, Lilly did not initiate condom use. Her comment reflects that she relied on her male partner to initiate condom use in order for it to be used. Her remark illuminates the view that it is easier for a man to initiate and use condoms due to the characteristics of the male condom being designed for male use. It is due to these characteristics that require women to be assertive in negotiating condom use, whereas this is not necessarily the case for men as they can readily apply the condom. Lilly commented:
It’s hard to say…. I would like to think yes [used a condom]…. I definitely would have if he had just taken the initiative and put it on…. stupid I know but now I have to live with this mistake for the rest of my life. … Well I didn’t so no [would not initiate condom use]…. It was an extremely unexpected encounter and I don’t usually carry protection.

In contrast to Lilly, although Rita wanted to initiate condom use with her then partner, she felt that she could not exercise this choice. She was vulnerable to her partner’s emotional and physical abuse. Rita placed trust in her partner, which in turn made Rita submissive and subsequently her partner had the dominant stance in the relationship.

Rita stated:

On several occasions I tried to initiate condom use with him, he was a dominant personality and I’ve since realised that even before the physical violence he used to emotionally bully me. He used to reassure me that it was "fine" he didn't "have anything" and used to turn it back to "well if you love me". I never had the guts to say otherwise.

Due to their experiences and exposure to abusive relationships, two of the women felt disempowered and were unable to initiate condom use with other partners. The abuse Rita had experienced from her ex-partner made her extremely vulnerable to subsequent sexual encounters. She was unable to protect her sexual health through condom use; her sexual wellbeing was in the hands of these men. The effects of the abuse made her feel disempowered, which hindered her ability to protect herself:

I know it sounds stupid but any ounce of confidence I had was shattered when this relationship ended abusively, so on the other 2 occasions of unprotected sex if the guy didn't initiate the condom I didn't bother.
Like Rita, Ruby lost faith in herself. The abuse she experienced made her fragile and even more vulnerable to men. She expressed not being able to initiate condom usage; she trusted men to not transmit further STIs to her. Although Ruby portrayed being a strong single mother, on the opposite end of the continuum, she was a fragile woman; her sexual wellbeing was subordinate to men’s:

*I can’t explain it. I think a lot of things came flooding back, and I just felt totally disempowered even though I am strong in other ways, when it comes to this stuff [condom initiation] I don’t feel I can speak up. ... Because I feel unable to speak up in sexual intimate relationships with men.*

In discussing the sexual relations she had been involved in since her diagnoses, Ruby felt that she was the one responsible for condom use; not the men. Due to her inability to initiate condom use, the only way Ruby looked after her sexual health was through sexual health screening. In recounting her more recent sexual encounters, Ruby commented:

*I didn't tell them about the diseases. ... I felt intimidated and could not bring it up [condom use]. I tried to protect myself by getting them to tell me if they had any diseases. I don't think they lied but after every one of them I went to the dr [doctor] - a dr [doctor] I didn’t know and got tested for STDs and HIV.*

Ruby’s fear of being at risk of abuse and contracting further STIs was so painful for her to bear that she prevented further exploitation by no longer engaging in intimate sexual relationships. Ruby expressed not wanting to relive her past:
I have tried and I can’t do it [condom initiation]. I just don’t feel I have the personal power to do it. ... The fact I don’t feel I can be assertive about it is why I feel I am not empowered enough to be in a relationship. I fear I will be abused again. ... I could never stand up for myself before and got taken advantage of badly. Now I have two kids I can[not] risk it in case they would be affected.

Ruby perceived the use of condoms was not required as she assumed she was in a monogamous marriage. However, Ruby’s sexual health was not protected within her marriage to an older man:

Well no because when I met him I was very inexperienced. [I] had never had sex b4 [before] and as the relationship developed I thought it was just him and me. It turned out that he had been playing up all along and I suppose I was lucky not to get a whole lot of worse diseases. I mean we were married when I found out.

Similarly, Melinda was planning to marry her partner and placed trust in him. Within the relationship, condom use ceased after a 12 month period, as it was deemed unnecessary due to having a monogamous long-term partnership. Like Ruby, Melinda’s sexual wellbeing was not protected within her long-term partnership and she was betrayed:

Yes, we were together about 2 years - but it all fell apart when he told me about him having herpes (that was a year into our relationship). We lived together - it was a long-term type thing, and we planned to marry. We used condoms for about a year - but I had already contracted herpes during that time.

Charlotte’s trust in others led her to forgo condom use after a period of time. She trusted in her sexual partners’ honesty. It was her trust that made her vulnerable:
If I was going to have a relationship or ongoing sexual activity with the person we would cease to use condoms after the first few encounters, as it was presumed we were both “clean” of STDs & had intentions of starting a relationship.

These women’s experiences of contracting an STI through not practising safer sex and in some instances the abuse they had endured, made these women wary of future intimate relationships with men. Furthermore, through their experiences of contracting STI/s some of the women’s vulnerability to male dominant heterosexual relationships increased. This occurred through some women feeling a loss in self-confidence and due to their fear of loneliness.

**Wary of men: I feel I am too vulnerable**

Contracting an STI from male partners had made these women more vulnerable to men. Some of the women disclosed feeling the need to ‘settle’ for any man willing to be involved with someone who has an STI. Other women had become wary of engaging in emotional relationships with potential male partners for fear of rejection and further abuse. As stated by Sam: [I] *have found myself backing away from guys I really like that I think wouldn’t take it well, hence not having a serious boyfriend for over 2 years now.*

It was the women’s fear of loneliness, thoughts of being tainted and their loss of confidence that increased their vulnerability following STI diagnoses. Ruby believed that her abusive past and STIs would provide a man with the opening to abuse her, and that men would perceive her as a woman not worthy of respect:

*Um, I feel I am too vulnerable to get into an intimate situation as I cannot insist on condoms, and feel I could get hurt again or catch more diseases, and I also feel that if I*
told anyone the truth they would think I am a slut so that would give them the opening to treat me badly.

Ruby’s experience caused her to lack faith and trust in men. Her experience of contracting the STIs made Ruby fear intimacy: *As I said I don’t trust men, and have become afraid of intimate relationships and don’t feel I can tell anyone about it* ...

Likewise, having an STI had also made Cathy fear intimacy. This fear was exacerbated by her thoughts and feelings of being tainted, in addition to her experience of being rejected by men. Cathy expressed that it is easier for her to keep her distance rather than to form a romantic attachment to a man:

*I try to avoid relationships with guys, I occasionally get upset when a guy wants stuff to happen but because I don’t want to tell them the whole story over again I push them away and say I’m not interested. I feel obligated to tell a guy my situation because I believe they have the right to choose what happens … I have told quite a few people…. the majority have only taken a few seconds to leave but there have also been quite a few who are very understanding.*

Sam expressed fearing emotional involvement with men. She feared that if she were to form romantic attachments, her reputation could be jeopardised through disclosure. Sam acknowledged that her reputation could be controlled through a potential partner and was wary of taking this risk:

... *Like at the moment I like one of my brother’s friends. He has asked me out and I said I’ll let him know coz [because] I couldn’t imagine my family finding out ... so that’s why I’d wait soooo long before telling someone like that, otherwise everyone would find out and it’s not something you can ever take back.*
Some of the women experienced a loss in confidence and damaged self-esteem after contracting an STI. Bree had lost confidence in herself and feared that if she was unable to satisfy a man he would leave her. This has increased Bree’s vulnerability to men:

Well, I don’t feel as confident in myself as a person as I used to. I feel like I need to really please them for them to stay, and I hate feeling like that. I know I am who I am and you can take it or leave it.

Although Cathy stated that she had come to terms with having the herpes infection, she remained wary of being involved with men due to her fear of rejection. Even though Cathy felt that a man needed to accept the infection to accept her, having an STI had made her emotionally vulnerable:

Yep…. over time I have accepted that it is not something I can change. If someone wants to be with me they [need to] accept me for who I am and everything that comes with that. ... The ones [men] that have stuck around have accepted that it is a part of me and if they can’t accept it then it’s their problem. ... On my part I think maybe I hold back in letting the guy get too close too fast ... cautious of being hurt. ... From experience, younger guys who have sex on the mind aren’t willing to risk anything and will go and find someone else to do that with. That’s fine with me....

Bree’s experience also made her particularly fragile in relation to men. Her self-esteem had been damaged, and although she was aware that she needed to find strength to protect herself, her partner still held the dominant stance in their relationship. Bree stated:

I think it has made me wary of who I can trust, and made me look at who I am, inside, I put my guard up, try not to put myself out there like I used to. I think it has made me
realise I need to respect myself more and stand up for who I am and what I want. I just have trouble saying what I mean, or want, in relation to this guy.

Despite their own affections and desires, both Sam and Bree felt that they may have to settle for, and be involved with any man that is willing to accept them having an STI. As simply put by Sam ... and thinking that I’d have to settle with whatever guy accepts that I have it [herpes]. In discussing how she felt about disclosing having an STI to a male partner, Bree felt vulnerable. She felt that by disclosing having an STI, her partner held the dominant stance in the relationship as he was risking his sexual wellbeing through the possibility of contracting herpes; ultimately if the relationship was to continue it was her partner’s choice. Bree felt that due to her STI status she could not choose a man to be with her; rather a man needed to choose her:

It wasn’t as hard as I thought it would be, and I said that he could take it or leave it. I basically felt like I was putting myself on a shelf.... you decide if you want me after I have told you.

Bree expressed that it was her responsibility to make her partner want to continue a relationship. Bree believed that she needed to give her partner more, as the STI made her less than an ideal woman. This could expose Bree to ill-treatment through her partner taking advantage of her vulnerability. Bree asserted:

... I think I have given him a bit of the control in the relationship, because it is easy with him, he knows, so it is up to him and I hate letting him have the reins. ... Well, I don’t even know if it is because I have an STD, and he knows that it would be risky if I saw anyone else. ... I just feel that if I was in a relationship that I would give in a lot because there is something that I could have thrown back into my face. ... Yes, I am here, come
and go as you please, and I HATE feeling like that, but I like the fact that he knows and is accepting.

**Conclusion**

All the women in this study were vulnerable to contracting STI/s. Some of the women were positioned subordinately within their relationships, and it was due to these gender dynamics that they were vulnerable. Even if the women wanted to use condoms to protect themselves from STI/s, some were not given the choice. Several of the women were particularly vulnerable due to experiencing violation through coerced sex and abuse; their sexual health was in the hands of their male partners. In addition to the abuse experienced by some of these women, contracting an STI made them even more vulnerable to future intimate heterosexual relations. This occurred through the women experiencing a loss of self-confidence and feeling that they had to settle for any man that would accept them. The following concluding theme focuses on the women’s healthcare encounters and the sources of strength and support the women drew on to cope with having STI/s.
Theme five: Strength and support in the face of adversity

The theme ‘Strength and support in the face of adversity’ is comprised of three sub-themes as depicted in table 7. The first sub-theme, Healthcare professionals: *It made it worse* elucidates the women’s experiences when encountering healthcare professionals for STI treatment. The second sub-theme: Sources of support: *Strength to carry on* reveals the support networks the women drew on to help deal with having an STI. The concluding third sub-theme; Drawing on strength and resilience: *I feel like a stronger person* illuminates how the women needed to draw on their own strength in order to gain something positive from their experiences.

**Table 7: Theme five**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength and support in the face of adversity</td>
<td>Healthcare professionals: <em>It made it worse</em></td>
</tr>
<tr>
<td></td>
<td>Sources of support: <em>Strength to carry on</em></td>
</tr>
<tr>
<td></td>
<td>Drawing on strength and resilience: <em>I feel like a stronger person</em></td>
</tr>
</tbody>
</table>
**Sub-theme: Healthcare professionals: It made it worse**

The majority of women in this study expressed receiving inadequate healthcare when encountering healthcare personnel for diagnosis and treatment of the infections. Some women described their healthcare encounters as negative experiences, which added to their distress. Many were not provided with information about their infections, with one woman (Cindy) leaving the doctor’s surgery not knowing she had been diagnosed with an STI. Others expressed receiving inaccurate or incomplete information and some of the women felt their consulting physician was either insensitive or that they were stigmatised by having an STI. Melinda felt her doctor was insensitive, and perceived she stigmatised and passed judgement on her. This added to the emotional pain she felt at the time. Melinda asserted:

*I went to the doctor when I was home ... on holiday. I remember I couldn’t stop crying - and I looked up to see her [doctor] rolling her eyes at me. It made it worse. She asked questions like how long did all my past relationships last (etc). I felt like she was just trying to reaffirm what a slut she thought I was.*

Similarly, Charlotte felt that the doctor she had initially consulted was insensitive to her diagnosis. The doctor’s comments made Charlotte feel that she may have had multiple STIs. This added to her shock and distress:

*The doctor who informed me knew simply from looking that I had herpes. She didn’t even need to wait & confirm swab tests. I presume that with STDs being so rampant in the small town I was living in, she just knew. She was a bit abrupt with me in regard to how strongly I reacted explaining “It is really quite common, I don’t know why you are*
so upset & shocked. 1 in every 3 adults in this town has an STD of some sort.” Not very comforting at the time, I immediately thought “What else might I have?”

On the other hand, Lilly found one of her treating doctors to be too sympathetic, which led to Lilly feeling worse about herself. Further impacting on Lilly’s distress was the information that she received from her doctor concerning the cost of medication. The doctor did not inform her that the medication was subsidised by the government, which caused Lilly undue stress and anxiety:

As I said the first doctor wasn’t very helpful but that may have been because I was so sure that it was just thrush…. but [on] my second visit the female doctor was more sensitive to the situation…. However she was very sympathetic, which kind of made me feel like this was a terrible thing…. which it is but she really didn’t help look on the bright side of things…. but I guess if she did then I probably would … of thought she was insensitive. She did prescribe me some antiviral medication, which supposedlysuppresses GH [genital herpes] and rids you of symptoms quicker but she told me that it was extremely expensive like about 230 dollars for a packet of 24. She did not tell me that it was on the pbs [pharmaceutical benefits scheme], which I later found out myself! I went through a lot of anxiety about the medication…. cost, having to take pills everyday just to keep this thing at bay.

Likewise, Charlotte experienced anxiety adhering to medication used to treat genital herpes. Despite experiencing severe physical pain as a consequence of a herpes outbreak, she was not able to access any treatment due to a false negative result. Charlotte was also misinformed about the cost of medications used for herpes and subsequently turned to other alternatives to minimise outbreaks. Charlotte commented:
Also 2 years later I had the most severe attack I’ve ever had. Because the swab test came back negative (even though I had sore, red & open blisters at the time of the swab), my doctor was not legally allowed to prescribe me the drug I needed so desperately at the time. I found this ridiculous. Apparently the health system works in this fashion: You have to have a positive swab result to get any prescription, otherwise the only advice your doctor can give you is to buy some cold sore cream. Unbelievable that when you would need the drugs the most you can’t get them. I have been told you need to be registered on some list somewhere in order to get relief & the reason is that the drug is so expensive for the government to buy. This means too that it is very expensive for us to buy, that is if you can get a prescription! As a result I have changed my diet & lifestyle to ensure I get less attacks. ... For all those who suffer worse than me, it would be horrible to have no help.

In discussing her healthcare treatment whilst pregnant, Cindy explained how she felt the medical staff lacked knowledge regarding herpes. She felt that although she knew she was getting a herpes outbreak the medical staff did not necessarily agree with her and did not provide her with medical treatment. Cindy stated that the healthcare personnel did not seem to acknowledge the seriousness of the infection, it was only when her baby’s health was compromised that they showed concern. Adding to Cindy’s distress was the physically disempowering position she was placed in whilst being treated. Cindy explained:

The nurses in general were good but by that stage my knowledge was better than theirs—even the doctors did not know that much I thought- When I was 36 weeks with my first [baby] I went to the delivery suite ‘cause [because] I had developed [herpes] symptoms. I knew it was there ‘cause [because] I could feel it (it feels different to anything else). But because there were not these great big spots that were easily visible through hair etc. they would not give me the meds [medications] to try and clear it up and told me to come in the next day for my appt [appointment], and they would have another look. I came in
the next day and saw the birth centre nurse who asked me where it was, I showed her and she confirmed she could see something and went and asked a different dr [doctor] to come and have a look. The dr [doctor] asked if she could try and find the lesion herself and could not find it again. I had to point it out (all this time with my legs in the air while people tried to figure out what they were looking for). When I left the room I saw the first dr [doctor] who examined me talking to the second dr [doctor] who examined me and I felt very uncomfortable just from the look. The second dr [doctor] was good but the first dr [doctor] made me very upset the night before because they just sent me home with a virus that could potentially kill my child if my water broke. One midwife said to me if your water breaks just drop everything and get in here.... But on the other hand they were playing it down- I received very mixed signals- but the worst was after my son went dusky and the panic to get this antiviral into him shocked me because how little of an issue it was while I was pregnant...

Cindy further explained how the initial doctor that treated her made her feel. Cindy felt dismissed by the doctor who did not treat her outbreak:

... The original dr [doctor], when she first saw me said she could not treat what she could not see, and would not help me, even though I had had the virus for years and knew when I was getting an attack. The following day when I saw her, it was like she was annoyed because I had proved her wrong and the lesions were there.

Melinda felt that a female doctor may have been more sensitive to her needs. However, she explained that the nature of her infection led the doctor to pass judgement on her:

Also, doctors and medical staff come with their own set of belief structures. For example - the first doctor I went to see (although a woman), looked like she had stepped straight out of a catholic church (wearing a big cross around her neck and all!). She was absolutely judging me.
When two of the women became symptomatic and consulted a doctor, they received an incorrect diagnosis. Lilly needed to consult with two doctors before being diagnosed with herpes. Both Lilly and her initial consulting doctor did not think that the pain she was experiencing could have been an STI and she was treated for thrush. Although Lilly was experiencing considerable physical pain she needed to wait for a positive herpes diagnosis before she could receive appropriate treatment. Lilly asserted:

*I had no idea what it might have been and after much hesitation, I got myself off to the doctor. I thought it was thrush and the first doctor didn’t even suggest it might be an STD.... Well it was a day or two after the initial itching began.... but then the pain began to be so extreme that I had no choice.... After my first visit to the doctor and treating myself for thrush, I then went back and saw a female doctor who inspected me closer and tested me for HSV.... I had to wait about 4 days for the results in which time I was in extreme pain.... Urinating was almost impossible and the swollen glands in my groin were so painful.*

Similarly, Cathy needed to consult with two doctors before being diagnosed with herpes. Like Lilly, she was experiencing pain and was initially incorrectly diagnosed:

*I knew it wasn’t normal ... and I knew that anything down there should be checked out. ... After a couple of days, it got worse and worse. I could barely walk; it hurt to sit down so I went to the doctor.... They first said it was chlamydia and referred me onto another doctor to double check.... the second doctor knew immediately it was HSV.*

Although Bree was diagnosed with herpes promptly on her initial consultation, she was not provided with emotional support. The treating physician provided Bree with some information regarding the herpes virus, yet Bree was unsure where to turn for support
after leaving the doctor’s clinic. She needed more information to gain a better understanding of the virus in addition to support. Bree commented:

*Yes, she gave me a little ‘Facts Pack’, I looked up most of it on the net ... It was fine [treatment received from doctor], but I wasn’t offered any support services. I left there [the doctor’s clinic] not really knowing what to do or who to talk to, I just wanted someone who was in my situation, in my town, to talk to. Family and friends are fine, but they really don’t know how I feel.*

Cindy left the doctor’s clinic not actually knowing what her diagnosis was, let alone the consequences of an STI. She expressed not feeling rapport with the doctor with whom she consulted:

*I went to the doctor, she gave me the medication I went away having no idea what I had or the complications of it... I went to any old gp [general practitioner] they did swabs and wrote a script. No information given. ... From memory [I] think she was older and ... came across a bit put off by myself and my friend that came with me.*

In contrast to the negative experiences mentioned, two of the women expressed receiving only positive healthcare treatment from their consulting doctors. These women felt they were treated professionally and therapeutically whilst receiving emotional support. Cathy stated:

*She [the doctor] was really really nice. She provided me with a lot of information and support. She made me feel comfortable. The dr [doctor] didn’t make me feel like I was a burden on her time and my privacy with everything ie tests was protected.*
Rita’s consulting physician was sensitive to her needs and situation. Having a supportive doctor made a difference to how Rita felt at the time of diagnosis. The support she received from her treating doctor made Rita feel more relaxed, which enhanced her ability to cope with her situation. Rita commented:

... I didn't contact the guy that assaulted me [a partner who she had been living with and who she believed transmitted HPV to her]. I spoke to my doctor about it, she was fantastic, I explained to her the situation and how the relationship ended and she said it was [not] a notifiable disease and people like that are best left out of your life. ... I went to my local GP [general practitioner], she was absolutely fantastic, she put my mind at ease and treated me effectively.

Only two of the women stated that they had attended a sexual health clinic for treatment after their initial diagnosis. The majority of the women went to general practitioners, not all of whom provided participants with therapeutic care, information, and emotional support. On reflection, Lilly expressed her belief that sexual health clinics are superior in the treatment and care of STIs:

Just my GP [received initial treatment].... I have recently visited the sexual health clinic and in hindsight would have gone there in the first place as they are much more geared to [effective in] dealing with these specific conditions.

Cindy also attended a sexual health clinic on the recommendation of a friend and found attending this clinic to be effective. They provided her with factual information, yet as Cindy explained it is she who knows her body best:
My friend that lived with me took me to the sexual health clinic ... she was probably the biggest help at understanding what was going on. I think progressively from going to the doctor with recurrent attacks and knowing my own body I have learnt what’s going on. ... I think ... the sexual health clinic are the ones who told me it does not go away- that’s devastating.

Due to the majority of the women experiencing negative encounters with treating physicians, the women needed to draw on other support networks to help cope with their felt devastation and the emotional burden of having an STI/s. The women felt that they could not effectively discuss having an STI with the doctors; as stated by Melinda: ... *I don’t feel comfortable talking to doctors about it. They don’t understand.* Hence, the women drew on family, friends, and other sources to help deal and cope with their experience.

**Sub-theme: Sources of support: Strength to carry on**

By drawing on additional sources of support, the women’s experiences were made more bearable. The women drew on the support of family, friends, partners, and other individuals who had experienced having an STI. In doing so, the women felt that they were not entirely alone and found they were still accepted by these individuals despite having an STI. Cathy stated ... *all the girls I have told have been close friends and they have been really supportive.* Although some of the women did experience stigma from friends and family in the past as revealed in theme two, the benefits of gaining support from friends, family and other support networks was immense. They revealed having an STI to those closest to them and to those they trusted. As stated by Lilly:
Yes I was able to tell my close circle of friends.... one in particular took me to the doctor so she knew. My sister and another close friend were the only girls I could tell as I feel that I can trust them and I know that they wouldn't judge me.... even if they were the same girls always telling me to protect myself!

Rita found solace in telling her mother about her diagnosis. Rita’s mother did not judge her and provided her with the emotional support she needed. By disclosing having an STI to her mum, Rita felt that she could overcome the anguish she felt:

My mum was a saviour. I found the warts late one night and went to the GP [general practitioner] the next morning, after the treatment etc, I rang my mum bawling my eyes out and told her I had an STI. Mum was great, she reassured me ...

Likewise, Charlotte found comfort and received support from both her mother and friends. Although Charlotte initially feared condemnation from them, after disclosing her diagnosis to her mother and friends, Charlotte’s burden was reduced. Through the support she received, Charlotte’s burden of shame and stigma that came with having herpes was minimised. Charlotte commented:

It took me ages, 2-3 months before I was able to tell my mum & friends, as I was ashamed. Funny thing is they were all a fantastic support when I finally spat it out!

Receiving support from friends and family when faced with adversity helped these women cope with their negative experiences and gave them strength to overcome their pain. This can occur through drawing on positive emotions to make a situation more bearable, which is revealed in Sam’s statement; ... yeah my two best friends they helped lots I joke about it with them and stuff ... Through their support, Sam was able to find
comfort and use the positive emotion of humour to cope with having an STI. Similarly, Cathy’s story revealed just how important it is to have support from close friends. Her story revealed how having support from friends can facilitate the drawing on positive strength in the face of adversity. Cathy stated:

I was all alone in ... I had no friends and no family. I spent most of my days alone or working. I tried dealing with it on my own and I realised that problems are easier when you can have advice from other people. After about a month I told my best friend. It was a big relief that I had someone to talk to, that I had support, that someone accepted me no matter what. And telling people now it makes me see that people do still accept me for who I am and yeah in a way gives me the strength to carry on.

Although some of the women had experienced rejection from partners in the past, others spoke of the comfort and support they found in some male partners when they had disclosed having an STI to them. Cathy found comfort in a partner as she felt he understood the herpes infection, she stated he knew from the beginning that I had HSV2 and he didn’t care. He understood about HSV as he is a pharmacist. Rita found comfort in the fact that although she had an STI, this did not change her relationships nor her partners’ affections toward her; my partners were fine, neither of them asked any questions and both assured me that it didn't change anything. Lilly had also found solace and support in her male partner at the time of the study. She explained that having a supportive partner made a difference to how she has coped with having herpes and how she feels about herself. Lilly explained:

Well it’s been a few months now and he has been so supportive and understanding I couldn’t have asked for anything more. ... I must say that having a supportive partner
has helped immensely and I hope that anyone else that experiences GH [genital herpes] has the same amount of acceptance and support that I have experienced. It’s invaluable. I guess it’s helped to have talked about it in recent weeks with my doctor and my partner…. He is really supportive and always makes me feel loved regardless of GH [genital herpes].

Though some of the women spoke of the support they received from others, they did not feel that these individuals fully understood the experiences of having STIs. As stated by Lilly; *honestly my friends and particularly my sister made this experience so much more bearable…. with their total support…. even with this though, I still felt so alone and angry* … Similarly, although Bree’s family and friends have provided her with support, she felt that they did not completely understand what she has experienced as a result of having genital herpes. Although Bree has tried to make them understand, they have not experienced it so they cannot reach full understanding. Bree asserted:

*Yes [told someone], my mum was with me at the doctor (because I was incapable of driving), and I told her as we left, then I told my sister and cousin who were at home at the time and wanted to know why I was so sick. I have also opened up to quite a few of my friends, and they have all been really supportive. Most of them were clueless as to what HSV was and how it affected me. … They were a little shocked…. like how could you get this? I told them so that I could gauge their responses, and let them know that it is something you need to be aware of and for them to understand it. … Well they understand the virus, how it is contracted, what the symptoms are, but really understand…. no, but it isn’t their fault. They are supportive.*

Like Bree, Melinda felt that it is only through actually experiencing having an STI that you can completely understand what it is like. She stated *you can only understand if you experience it yourself - and I know that from being a 'before' person and an 'after'*
It is for this reason that several of the women utilised internet support groups to draw on support. Sam had not only received support from this medium, she had also struck up friendships with others from this group; and two people online [who I have become friends with] ... I'm going to meet her in a fortnight when I'm over ... [it is] good to talk to ppl [people] with the same thing. ... Yeah they understand the ups and downs like no one else does. Charlotte also commented on how she had developed many friendships via this avenue. Charlotte stated that support websites had put her in contact with others who had experienced having an STI, and were also a source of information. Although, as Charlotte pointed out, these support websites are not well advertised, so many individuals may be unaware of the availability of this support, hence many women may be suffering in silence. Charlotte asserted:

As a source of information & just as a reminder you are not alone in this. We actually feel a kind of comradeship & there are definitely some classic characters so I’ve met new friends & had some good times too. Hearing different stories has taught me some stuff I would not have found/learnt through any other avenue. The only disappointment has been the lack of numbers & also the lack of media support in regard to the fact that these services are available.

A further benefit of these internet support groups is that it allowed the women to remain anonymous if they wanted to. Melinda had not disclosed having an STI to anyone other than her treating physicians, and anonymously on the support group’s website. Like Charlotte, she found this avenue an excellent source of information as well as support:

Only [told] the doctors - and other people with herpes. I joined the site ... ages ago. ... I think that getting in contact with others in the same boat is the best thing you can do. ...
It puts you in contact with others who have experienced exactly what you have. Also, herpes is something that a lot of people keep to themselves - and so it is a good, anonymous way to get any questions answered - and get advice about who's a good practitioner – what’s a good medicine, etc.

This medium also benefited Lilly. She gained support and understanding from others and did not fear being stigmatised and judged because of the anonymity this medium provided. Lilly also found the availability of dating options for people with herpes an excellent support option:

The only other support I accessed was an online chat group…. ... I went online and read other peoples experiences and expressed my own under a pseudonym and had really supportive feedback from others who were experiencing the same thing. They even have dating services for people with herpes so you don’t have to go through the anxiety of telling a new partner or fearing rejection....

**Drawing on strength and resilience: A stronger person**

The women not only drew on others for support, they also relied on their own strength. Some of the women needed to find and draw on their own strength to overcome their anguish and in doing so, they demonstrated their personal resilience. That is, despite the pain and anguish felt by these women, some could use their experience in a positive sense. Lilly tried to focus on what she had learnt from her experience rather than the adversity it had caused her. She described how being diagnosed with an STI had contributed to her future life through knowledge enhancement:

I had some knowledge of STDs but nothing to the extent of which I have now strangely I am grateful for it as in the future ... I will have a good foundation of information.
know that some STDs were treatable whilst others are not but I had no idea which ones were or weren’t.

The pain and distress Sam felt due to having an STI, made her realise that she needed to be aware of how she treats others. Her personal strength revealed her resilience:

*I feel like a stronger person now, more compassionate.... Made me stronger realising that we don’t know what is going on in everyone’s lives so to treat people nicer and see things from their view coz [because] you don’t know what is going on in their lives.*

Drawing on her experience to guide and reassure others in similar situations showed Rita’s resilience. Rita can potentially minimise the loneliness that can accompany having an STI among women by providing support to others:

*Now I use the situation to teach others. ... Well [my friend] ... had the same STI and I have had a few phone calls from her in tears in the same position I was in 4 years ago, so I share my knowledge, and reassure her. I act like her mum.*

Throughout Rita’s story, she continued to emphasise the positive aspects that arose from having an STI, although this was in confliction with the pain, disempowerment, and the effects she also expressed through her story. She continued to reflect on her experience and how she has learnt from it, and needed to draw on positive emotions to overcome the pain that the experience caused her. Cindy continued to feel the pain and burden of having an STI in her life. However, like Rita she drew on positive emotions and resilience to make her experience more bearable. She felt that prior to contracting an STI, she was vulnerable and lacked confidence. Cindy expressed that since living with
an STI, she has become stronger and has greater independence, particularly within the context of heterosexual relations:

*It may have made me a stronger person also - I have taken a lot of crap in my earlier years that has led to me now being able to stick up for myself a little more and no longer do I take so much. ... I was a bit of a door mat- like putting myself in that situation with those guys, doing whatever I could to make others happy - I was an approval seeker - now I would like to think of myself as intelligent, independent and not needing the approval especially of a man.*

**Conclusion**

Although a majority of the women spoke of their encounters with healthcare professionals as negative and many were not provided with the support they needed, the women drew on friends, internet groups and family to gain support. The support the women received from others helped make their experiences more bearable. From the support received as well as drawing on their own strength and personal resilience, the women have been able to cope with the adversity and anguish that having an STI caused them.

**Summary**

In summary, this chapter has revealed how all the women in this study were vulnerable to STIs. This occurred due to being violated, experiencing abuse, trusting in romantic love, and their inability to initiate condom use. Due to their experiences of contracting STIs from male partners, the women became wary of engaging in future intimate relations, with some of the women feeling they needed to settle for any man that would accept them. Some of the women experienced a loss in their self-confidence, which
made them even more vulnerable within male dominated heterosexual relationships. The findings from this study have revealed the emotional pain associated with contracting STI/s felt by these women. Through having an STI, the women had come to perceive of themselves as damaged and tainted women, and expressed their fears associated with future relationships and the possibility of not having families. However, despite their vulnerability, and the inadequate support from healthcare personnel, these women drew on both their own personal resilience as well as various support networks to cope and deal with having an STI.
CHAPTER SIX: DISCUSSION

Chapter abstract

This chapter discusses the underlying issues revealed in the women’s stories in relation to the existing literature. These issues are discussed under the following headings: ‘The shame and stigma of STIs’, which encompasses a discussion on shame, the social construction of self, stigma, secrets and denial; ‘Disempowerment and vulnerability’ which relates to male dominance in intimate relationships, and the difficulty the women experienced in negotiating condom use, and ‘Seeking healthcare and support’ which focuses on the avenues sought by the women to overcome the adversity associated with living with an STI. Please note that content from this chapter has been submitted and undergoing peer review for publication (East, et al., 2008a, in press).
Introduction

The experience of having an STI for these women was both physically and emotionally multi-faceted. However, foremost in these women’s stories was the gendered, oppressive, and stigmatising nature of STIs. In addition to the women’s experiences of seeking healthcare and the support networks, which they drew on to overcome their adversity. This chapter begins with a discussion on the shame and stigma associated with STIs in relation to these women’s stories.

The shame and stigma of STIs

Shame

Shame elicits emotional pain and feelings of unworthiness (M. Lewis, 2003), and was evident throughout all these women’s stories. Historically, sexuality has been linked with shame (Tangney & Dearing, 2002). Women’s sexuality is particularly likely to be a source of shame because of competing discourses that call for women to be both chaste and desirable (Schur, 1983; Tangney & Dearing, 2002). Within society, there is an expectation for women to be pure and virginal, however, although these attributes are socially valued (Lebowitz & Roth, 1994), men may consider these women prudish. In contrast, women who are considered desirable seductresses and who exhibit sensuality, may be perceived as promiscuous (Schur, 1983; Tangney & Dearing, 2002) and thus devalued (Lebowitz & Roth, 1994). These dichotomies oppress women’s sexuality and create a foundation for shame. Further to this, women who contract STIs are perceived to be promiscuous and are considered to be shameful (Tangney & Dearing, 2002), which is consistent with the views held by women in the current study.
The women in the current study had themselves perceived women with STIs as deviant and promiscuous, and because they did not identify themselves as promiscuous, they did not believe they were at risk of contracting an STI. This belief aligns with literature that asserts many young women do not readily identify with the characteristics that are associated with these infections (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1990). Due to these women’s perceptions, contracting an STI created feelings of shame, which has also been found in previous research focused on women with STDs (for example Nack, 2002).

Shame evokes self-blame (Tangney & Dearing, 2002), and is intensified when an individual perceives they had control over the situation which elicited the self-blame (Alicke, 2000). Societal constructs influence self-blame among individuals, in particular women (A. K. Miller, Markman, & Handley, 2007). Within society, women, more than men, are blamed for unwanted outcomes associated with sex (Schur, 1983). For example, although rape is viewed as an extreme violation and objectification of women’s sexuality, throughout history, women (rather than the perpetrators), have often been punished and blamed for rape (Schur, 1983). This, in turn provokes self-blame among women by perceiving rape as a consequence of their failure to exert control over the situation, partially due to patriarchy positioning men’s sexual needs as superior to women’s (A. K. Miller, et al., 2007; Schur, 1983).

Women are blamed for the transmission of STIs, partly because they are capable of transmitting infections to their offspring; a factor that strengthens the perception that women are responsible for the spread of these infections (Lekas, Siegel, & Schrimshaw,
Shame is an emotion that involves the self (Crozier, 1998; M. Lewis, 2003; Tangney & Dearing, 2002), influences individual behaviour, and shapes personal views and self-perceived worth (Tangney & Dearing, 2002). Feelings of shame can be attributed to an individual believing they have breached or failed to fulfil societal and/or their own expectations (M. Lewis, 2003), as was experienced by the women in this study. This belief of failure then evokes the perception that they are inadequate and flawed (Crozier, 1998; Ferguson, Eyre, & Ashbaker, 2000), causing an individual to have a sense of a devalued self (S. Miller, 1985).

**The self**

The term ‘self’ is a nebulous term that has been used ambiguously throughout the literature (Baumeister, 1998). The self or a person’s *sense of self* has been referred to as the self-concept (Baumeister, 1998; Reed, 2002), the ‘I’, the ‘me’ (Epstein, 1973; Gecas, 1982), and a person’s ‘individual identity’ (Ellemers, Spears, & Doosje, 2002). Surrey (1991) defines the self as “a construct useful in describing the organisation of a person’s experience and construction of reality that illuminates the purpose and directionality of
her or his behaviour” (p 52). Thus, for the purpose of this study the term *sense of self* is used to represent the social construction of the self and encompasses the women’s self-perceived individual characters.

A person’s self cannot be disaggregated from their social environment, interactions, and the influences these have on their sense of self and individual life (Baumeister, 1998; Ellemers, et al., 2002; J. B. Miller, 1991; Sanford & Donovan, 1984; Stets & Burke, 2000). Due to the self being fundamentally interconnected with the social environment, societal views and social interactions influence and shape self-perceptions and the perceptions individuals hold of others (Belenky, Clinchy, Goldberger, & Tarule, 1997; Cederstrom, 2002; Sanford & Donovan, 1984). For example, within a social context a female child is socialised to become a young woman possessing the attributes ascribed to the female gender such as being attractive and gentle and therefore, should behave accordingly (Sanford & Donovan, 1984). Hence, people are socialised to behave, to conform, and to become the individuals that they are expected to represent within a given social context (Cederstrom, 2002).

Failure to fulfil social expectations and self-perceptions creates emotional pain and fear that one’s self has been, or will be revealed as flawed (Cederstrom, 2002). When women feel they have failed to fulfil expectations, they may begin to question their capabilities and experience self-doubt (Estés, 1992; Fisher, 2008). The perceived failure caused by not fulfilling an individual’s expected, perceived and desired self can create a disruption within a person’s sense of self, as the women in the current study revealed through their stories.
The physical body is a fundamental component of the self (Ussher, 2006). How the feminine body is experienced and perceived, in addition to the social meaning that the body carries, profoundly affects one’s sense of self (Jack, 1991; Ussher, 2006). As stated earlier, the feminine body is expected to be attractive, pure and chaste (Nelson, 2005). Perceiving their body as diseased and unclean disrupted the sense these women held of themselves. Women who experience a disruption within their sense of self may begin to perceive themselves through their flaws rather than their individual characters (Estés, 1992). Due to the body being indivisible from the sense of self, these women felt that the STIs had come to characterise who they were.

Following diagnoses of STIs, the women in the current study perceived themselves as tainted women. This was a perception that was in contrast to the beliefs they had previously held of themselves (prior to diagnoses). Because these women now viewed themselves within the context of having an STI, they felt unworthy of love; a finding that was also evident in a study of HIV positive women (K. Siegel, Lekas, & Schrimshaw, 2005). The finding of experiencing a disrupted sense of self also concurs with work by Doyal and Anderson (2005) who found that women’s internalisation of stereotypes and stigma caused them to feel that by having an STI their identity and character had become tarnished (Doyal & Anderson, 2005). However, the current study extends on earlier work and sheds light on how shame and the social construction of the self influenced the perception of being tarnished among these women with STIs.
Stigma

Society dictates and determines socially acceptable norms. According to Goffman (1963), society ascribes and identifies individuals by their ‘social identity’. When an individual possesses an undesirable characteristic or attribute that deviates from the norm, the individual is perceived to be inferior compared to other societal members (Goffman, 1963). This negative attribute, and the associated effects of being devalued, exemplifies stigma (Goffman, 1963). Hence, “social stigma is a function of having an attribute that conveys a devalued social identity in a particular context” (Crocker, Major, & Steele, 1998 p. 506).

Existing literature has asserted that the stigma attached to STIs has divided communities and societies into ‘us’ and ‘them’; with ‘them’ being the inferior, deviant ‘others’ (Gilmore & Somerville, 1994). The division between ‘them’ and ‘us’, occurs due to the perception that the stigmatised differ from ourselves (Bunting, 1996). Accordingly, within the context of STIs, and due to the perception that these infections are strongly associated with the inferior ‘other’, it is difficult to contemplate that we (or the self) would contract an infection that is inherently linked with deviance and immorality. Therefore, those ‘others’ who contract these infections must differ from ourselves and ‘us’ (Bunting, 1996). Further to this, STIs are contracted through behaviour, rather than being an attribute or a stigma that an individual cannot help but possess, thus rendering STIs preventable and controllable (Breitkopf, 2004; Crocker, et al., 1998). It is for this reason that the status of ‘having’ an STI is particularly stigmatising and is associated with certain negative stereotypes (Breitkopf, 2004; Crocker, et al., 1998).
Link and Phelan (2001, 2006) conceptualise stigma as a process. Part of this process involves associating the ‘labelled’ individual with ‘undesirable characteristics’, which they refer to as stereotyping the individual. To be stereotyped, a person must possess an undesirable attribute that is recognised as belonging to a particular group that deviates from societal norms (Gilmore & Somerville, 1994). The affected individual is then perceived to belong to the group that collectively possess the same undesirable characteristic, and is labelled and stereotyped accordingly (Biernat & Dovidio, 2000).

Traditionally, (as previously stated), patriarchal society has expected women’s sexuality to encompass virtuousness, chastity, and submissiveness (Nelson, 2005). However, women who deviate from societal norms are stigmatised, stereotyped, and subjected to pejorative labels. Because women who have STIs do not conform to the traditional ideal of being chaste, they are labelled as deviant immoral women. These labels, which commonly tarnish a woman’s character (Schur, 1983), and promote disempowerment by damaging women’s reputations (Holland, et al., 2004), exist to uphold men’s sexual dominance by oppressing and sanctioning women through their sexuality. These detrimental labels assigned to women are entrenched within society and are the reason the women in the current study felt that having an STI had tarnished their characters. Furthermore, although some of the women in this study had not been stigmatised and stereotyped by others, their internalised stigma was so strong that they believed others would stigmatise them. This finding resonates with research focused on HIV positive women (Lekas, et al., 2006), and among women diagnosed with chlamydia (Mills, et al., 2006). Both these studies found that the fear of stigma among participants stemmed
from the existing stereotypes associated with women and STIs (Lekas, et al., 2006; Mills, et al., 2006).

The stigma experienced by the women in this study (among others) can arise from the societal assumption that women with STIs contract these infections through promiscuity and the unwillingness to practise safer sex (Kahn, et al., 2007; Lekas, et al., 2006; Sandelowski, et al., 2004). However, it is the social construction of STIs and the associated stereotypes of women that lead to the perceived and actual stigmatisation towards women with these infections. In the current study it was not until Cindy became aware of the ramifications of having an STI and the stigma associated with these infections that she made the decision not to disclose having an STI to others.

Most stigmatised individuals wish to keep their stigma a secret (Smart & Wegner, 2000). According to Goffman (1963), an individual who possesses a stigma that is readily evident is referred to as the ‘discredited’, whereas those who possess a stigma that is not obvious, and can be concealed are referred to as the ‘discreditable’. The following discussion is focused on the latter; as the women of this study could and did actively conceal having an STI.

**Secrets and denial**

The shame and felt stigma among some of these women was so strong that revealing having an STI, particularly to potential partners, was simply not an option. Keeping secrets is a mechanism used to protect women from further anguish and exacerbation of pain. A woman may keep secrets in order to protect herself, or others, from a perceived
threat or harm such as being socially condemned, ostracised, and chastised (Estés, 1992; Wegner & Lane, 1995). The women in the current study felt that by concealing having an STI and avoiding stigmatisation, their sense of self could be preserved and they would be protected from further adversity.

However, keeping secrets can have adverse consequences (Newton & McCabe, 2008a; Smart & Wegner, 2000; Wegner & Lane, 1995). These consequences include isolation, negating possible sources of support, and jeopardising personal relationships (Estés, 1992; J. D. Lee & Craft, 2002). Within the women’s stories, it was revealed that by maintaining the secrecy of an STI some felt they were destined to be alone. Furthermore, the shame and stigma felt by these participants was so ingrained, that the feeling of being ‘damaged goods’ prevailed. Estés (1992) states:

> Women have been advised that certain events, choices, and circumstances in their lives, usually having to do with sex, love, money, violence, and/or difficulties rampant in the human condition, are of the most shameful nature and are therefore completely without absolution. This is untrue. (pp. 376-377).

True or untrue, the women’s stories resonated with this statement. The women clearly expressed the feeling that they were not absolved of their shame and stigma; they felt condemned, from both a social perspective as well as their own personal perspective. They perceived that they had no choice but to keep their STI hidden, or risk being revealed as diseased and immoral. In addition to concealing having an STI, these women
adopted the self-preservation mechanism of denial to minimise their felt stigma and shame.

Denial aids in the diminishing, and can buffer the effects of shame (M. Lewis, 1992). Further, it is a mechanism which dispels the detrimental effects associated with a perceived threat (Robinson, 1999). Although denial has been described as an unconscious response (Robinson, 1999), it is a term commonly used “to express ways of escaping consciously and unconsciously from painful events and feelings” (Vos & de Haes, 2007 p. 13). For the purpose of this thesis, the term denial refers to the conscious act of suppressing the thought of having an STI. This is because all the women acknowledged they had an STI, and they used the term ‘denial’ and expressed wishful thinking to mitigate their shame and their burden of having an STI. In doing so, these women could maintain and project a healthy self, and reinstate their previously held self-perceptions.

The findings of denial in the current study concur with previous literature focused on women and STIs. For example Nack (2000) found women participants had denied their STD to themselves and others, which facilitated them in maintaining a healthy social sexual status, rather than being labelled ‘dirty’ or promiscuous. Other research has indicated that denial may occur particularly among those who lack symptoms (Melville, et al., 2003); as found to be the case with Ruby in this study; and Kahn et al. (2005) found that women choosing not to disclose a HPV positive result to partners was associated with shame, stigma, and the fear of rejection.
The women’s denial facilitated their rationalisation and decision not to disclose having an STI to partners. The denial used by the women in the current study is similar to what Goffman (1963) terms as ‘passing’. ‘Passing’ refers to an individual concealing their flaws from others, as their perceived flaw is not readily evident (Goffman, 1963). Several of the women in this study used ‘passing’ or concealed having an STI to avoid rejection. Some of the women could conceal and deny having an STI as they were asymptomatic, with no overt signs of an STI, thus allowing them to ‘pass’ as women unaffected by such infections. Other women took stronger actions including abstaining from sexual relations, whilst others were wary of engaging in sexual relationships due to their reluctance to disclose having an STI to partners.

Individuals who wish to conceal their flaws avoid situations where their shortcomings will be revealed (Smart & Wegner, 2000). Therefore, the actions taken by these women allowed them to avoid revealing their secret to others; by avoiding intimate relationships these women did not have to disclose having an STI. Reluctance to become involved in future sexual relations in order to avoid disclosure and the risk of rejection has also been found among individuals with genital herpes (Inhorn, 1998; J. D. Lee & Craft, 2002; Melville, et al., 2003; Newton & McCabe, 2008b), and in the stories of HIV positive women (Lather & Smithies, 1997). Further, this finding also concurs with Nack’s (2002) study which found that some women chose celibacy rather than risking rejection and stigma from potential male partners. This, as Nack proposes, illustrates the fear of the consequences and rejection some women have due to the stigma attached to these infections.
Contributing to these women’s secrecy and denial was their fear of rejection from partners; a finding also evident in Lee and Craft’s (2002) research. Fear of rejection arises from an individual’s belief that people are rejected because they possess a stigmatising condition. If the individual then develops the same condition, this rejection becomes a personal possibility (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). The women in the current study expressed this fear, as they stated that they themselves would have rejected a sexual partner had they known the partner had an STI.

As Link et al. (2001) state “a fear of rejection can have serious negative consequences. It is undoubtedly threatening and personally disheartening to believe that one has developed an illness that others are afraid of” (p. 1621). The women felt that by concealing having an STI, they could avoid the reality of rejection. Moreover, although the women expressed a desire to protect themselves from further STIs, the disempowerment that arose from their shame, stigma and oppression led to their inability to effectively negotiate condom use in subsequent relationships.

**Disempowerment and vulnerability**

Contracting an STI, the unequal gender dynamics within their relationships, and these women’s experience of abuse, caused varying degrees of disempowerment for the women in this study. Disempowerment encompasses feelings of vulnerability, lack of power, and lack of self-efficacy (P. Reid & Finchilescu, 1995; Young, Vance, & Ensher, 2003). Feelings of disempowerment can cause fear and withdrawal among individuals, and arises from interpersonal, social, and political power structures (P. Reid & Finchilescu, 1995; Young, et al., 2003). These women expressed vulnerability arising from unequal gender dynamics and male domination within their intimate relationships.
Their vulnerability and the effects of having an STI further intensified these women’s vulnerability, which was revealed by their continued inability to negotiate condom use resulting in continued and ongoing unsafe sexual practices.

Domination and abuse perpetrated by men within heterosexual relationships exists to oppress and disempower women (Gamache, 1998; Travis & Compton, 2001). Within a patriarchal society men are perceived to be the dominant and superior gender (Dobash & Dobash, 1979; Gamache, 1998; Hanmer, 2000). Forms of abuse and domination inflicted against women occur as a result of societal constructs, based on power, that exists to maintain the dominant stance the male holds within patriarchal society (Bograd, 1988; Dobash & Dobash, 1979; Gamache, 1998; Yodanis, 2004). Although not all men inflict violence and domination on women, the male gender benefits from domination arising from abuse by the knowledge, vulnerability and fear this can provoke in women (Bograd, 1988; Yodanis, 2004). Abuse and domination experienced by women perpetrated by men both outside and within their relationships occurs and is experienced in various ways by women and includes sexual, emotional, verbal and physical abuse (Mooney, 2000). The experience of any form of abuse can affect and disempower women (L. Kelly & Radford, 1996). Abuse such as sexual assault, physical and emotional abuse and the perceived dominant stance their male partners held within their intimate relationships affected and hindered the women’s ability to negotiate condom use and practise safer sex.

Prior to their diagnoses, the women were vulnerable to STIs due to their lack of condom use. As stated previously in this thesis, condom use is influenced by the power and
gender dynamics that exist within a relationship (Luke, 2005). Within sexual relationships, the more power men exert and possess within the context of condom use, the more a woman’s assertiveness and decision to use condoms is hindered (Wingood & DiClemente, 1998). Further, the more women perceive their partners as dominant, the less likely they will be at successful condom negotiation and use (Buysse & Van Oost, 1997). Other research has suggested that the greater control a young woman feels over a sexual encounter the greater self-efficacy she will possess to negotiate condom use (Bryan, et al., 1997). Therefore, reduced self-efficacy within a sexual encounter can lead to the reduced ability to negotiate condom use among young women. Although self-efficacy was not assessed in this study, the disempowerment that the women expressed as a result of their subordination and abuse indicates that they did in fact lack autonomy and self-efficacy in relation to negotiating and initiating condom use.

The abuse and domination experienced by some of the women in this study contributed to their disempowerment in negotiating condom use within their relationships, making them more susceptible to contracting STIs. Even if these women were equipped with the knowledge and skills to negotiate condom use, they were unable to successfully draw on this information to practise safer sex due to abuse and the inferior position they held within their relationships. This is consistent with research that concluded male threat or force within a sexual relationship is associated with unprotected sex and hence, places women in abusive relationships at increased risk of STIs (S. Hoffman, et al., 2006). Moreover, this also suggests that condom negotiation skills and strategies are not useful in sexual circumstances where women have limited control or agency, such as those in
the context of abuse or relationships in which women take a subordinate stance (C. A. Campbell, 1995).

The current study cannot conclude a direct link between abusive relations experienced by women and the subsequent contraction of STIs. However, the participants who experienced intimate partner violence and assault were made vulnerable to STIs due to the inability to protect themselves. This supports assertions in the literature that suggest women who experience sexual and physical abuse from a partner are more likely to be diagnosed with an STI than those not exposed to abuse, due to the sexual risk behaviours within these relationships (Bauer, et al., 2002; Decker, et al., 2005; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003). Furthermore, women’s fear of abuse and the associated vulnerability extends understanding into why having a past or present STI does not predict condom use as found in previous studies (for example Lindberg, 1999; Rana, et al., 2006).

Even after the women’s abusive relationships had dissolved, two participants expressed feeling disempowered to use condoms in subsequent relationships. As previously identified, experiencing abuse within a relationship hampers women’s ability to protect their sexual wellbeing (Pequegnat & Stover, 1999). For example, although Rita wanted her partner to use condoms prior to contracting an STI, she could not exercise this choice, nor did she attempt to negotiate condom use in two of her subsequent sexual encounters. One explanation of this is that their past experiences of abuse led the women in the current study to feel they were unable to negotiate condom use due to fear of a
negative reaction from their present or subsequent partners, a finding that has been
documented in previous research (Gómez & Marin, 1996).

Male dominance in the context of condom use does not only create sexual risk for
women but also for men themselves. Some men may be more concerned with gaining
sexual gratification rather than the prevention of STIs. For example, Stevens and Galveo (2007) found that even if HIV positive women continuously endeavour to negotiate
condom use with partners, condom use still may be rejected by male partners, despite
they themselves being HIV negative. This suggests that women’s efforts to negotiate and
use condoms may be in vain due to the continued resistance of a dominant male partner
(Stevens & Galveo, 2007).

Although not all the women in this study revealed experiencing abuse, they were still
vulnerable to STIs due to gendered constructs influencing their ability to practise safer
sex. Some of the women who were involved in casual sexual encounters (pre and post
diagnoses) did not discuss condom use with their partners, nor did they state that their
partners suggested practise safer sex. Therefore, if the women did not initiate condom
use, safer sex was not practised. This finding concurs with Pulerwitz and Dworkin
(2006) who found the majority of their participants indicated a belief that it was a
woman’s responsibility to discuss condom use in order for safer sex to be practised, and
previous research that has revealed condom use is associated with female initiation (J. A.
Carter, et al., 1999). An explanation of why the women in the current study chose not to
initiate condom negotiation or use is that they did not want to run the risk of being
perceived as promiscuous due to this being in conflict with feminine ideals. The
expectation that women are empowered enough to initiate and practise safer sex, is in contrast to traditional gendered constructs. Seemingly, this can make it impossible for young women to practice safer sex due to the juxtaposition between feminine ideals and societal expectations.

Another possible reason for the women choosing not to practise safer sex following STI diagnoses is that forming a romantic relationship can take precedence over safer sex practices among young women. This occurs due to women fearing loss of a potential or existing partner if condom use is asserted (D. Rosenthal, et al., 1998). Asserting and negotiating condom use for these women may have caused fear of partnership loss, considering the women perceived themselves as tainted and therefore less than sexually adequate.

Condom use within sexual partnerships can also signify mistrust, and the negotiation of condom use can indicate suspicion of the presence of an STI (V. Hoffman & Cohen, 1999; Holland, et al., 2004; Sobo, 1995, 1998). Additionally, women may find it difficult to negotiate safer sex and disclose STI status within established relationships, therefore disclosure within new partnerships can be significantly challenging; particularly since trust is required for open and honest sexual health discussions to occur among young women and their sexual partners (Cleary, et al., 2002). Thus, because these women already feared rejection, initiating condom use had the potential to jeopardise the possible formation of a romantic partnership, which may have been compounded by having an STI. Further, by practising unsafe sex and not negotiating
condom use, these women did not raise suspicion that they posed a sexual risk to their male partners; instead, they projected an image of being women untainted by STIs.

The ambivalence and minimisation of the effects of having an STI within their relationships also reflected the women’s desire to remain attractive, sexually available, and exhibit their ability to fulfil men’s needs (and their own). Apart from some of the women negating condom use despite their fear and guilt associated with transmission, they also minimised their burden of having an STI in order to remain sexually available to their partners. Gendered constructs have emphasised the importance to women of having a male partner (Hayter & Harrison, 2008; Sanford & Donovan, 1984). Women who are coupled with a male are perceived to have fulfilled one of their many gendered roles and requirements (Sanford & Donovan, 1984). Further to this, previous research has reported that women will risk their sexual wellbeing, in order to preserve the ideal image of women’s sexuality to male partners (Gifford, et al., 1998; S. Reddy & Dunne, 2007). In addition, other literature has suggested that women’s sexual needs are fulfilled only when their partners’ sexual needs and desires have been met (Peart, et al., 1996; S. Reddy & Dunne, 2007). This indicates that men’s intimate relationship needs take precedence over women’s needs and desires.

Within this study, the fulfilment of the desires and needs of the partners took precedence over the women’s pain. These women needed to remain available and have the ability to fulfil their partners’ needs. In doing so, the women could mask their perceptions of themselves as being damaged and diseased. Clearly, the effects of socialisation within patriarchal society influenced these women in perceiving that a valued and worthy
woman is one who can provide for male needs, with this leading to the continuation of their oppression and disempowerment. However, although these women experienced varying degrees of disempowerment within their relationships and as a result of contracting an STI, these women sought avenues to overcome their disempowerment and adversity.

**Seeking healthcare and support**

Although some of the women in this study had not revealed having an STI to anyone, some had disclosed to significant others as a way of seeking strength and support. Sharing and speaking of a secret to a supportive and understanding individual can promote emotional healing and aid in the dissipation of shame (Estés, 1992; M. Lewis, 1992; Tangney & Dearing, 2002). For the women in this study, reaching out to others for support and disclosing their burdensome secret of having an STI was the beginning of a healing process, despite their expressed lack of support and information received from their healthcare professionals.

Eight of the ten women in this study described receiving inadequate healthcare from their initial treating physician. This was expressed through their stories of being misdiagnosed (a finding also documented among a sample of participants with genital herpes) (Swanson & Chenitz, 1993); lack of support, the perception of negative judgement, and receiving inadequate information. Although healthcare professionals have codes of ethics and professional standards to ensure all individuals are provided with effective healthcare without judgement or bias, findings from the current study indicate that healthcare professionals have the ability to intensify feelings of shame and
stigma. Perceiving stigma and discrimination from healthcare professionals has also been reported among persons who are HIV positive (Dlamini, et al., 2007; Lekas, et al., 2006).

Individuals who perceive their healthcare professionals and the healthcare encounter as positive are less likely to be traumatised through their diagnosis of an STI (Swanson & Chenitz, 1993). This indicates that the provision of adequate information provided, and the way healthcare professionals relay the information to patients, has the ability to influence felt stigma. Considering this, if the women in the current study felt they had received therapeutic care and support, and perceived their healthcare encounter as more positive, the distress and stigmatisation these women felt may have been reduced.

Numerous studies have found that the stigma associated with STIs act as a barrier to STI testing (for example Barth, et al., 2002; Fortenberry, 1997; Fortenberry, McFarlane, et al., 2002; Lichtenstein, 2003). In addition, other literature has identified that attending a sexual health clinic can create and exacerbate feelings of stigma among women (Duncan, et al., 2001). However, although the women in this study felt stigmatised by having STI/s, they did not delay healthcare treatment when their symptoms became apparent. The women also did not hesitate to proceed with STI testing after consultation with their physician, regardless of their perceived invulnerability to these infections. Therefore, this study cannot conclude that the stigma associated with STIs acted as a barrier to STI treatment as found in the fore-mentioned studies. This study also cannot conclude that attending sexual health clinics alone exacerbated the women’s felt stigma, In fact, in contrast to Duncan et al. (2001), Lilly expressed that sexual health clinics
were much more effective in providing care and treatment for STIs in comparison to
general practitioners. This finding could be attributed to the acceptance and
understanding healthcare workers may acquire whilst working in this type of specialised
healthcare setting.

The majority of participants expressed that they had not received sufficient information
and support from their consulting physicians. This concurs with previous research that
found insufficient information was received from physicians among women with
chlamydia (Faxelid, 1993), and literature that has suggested healthcare professionals
provide ambiguous information pertaining to STIs (Oster & Cheek, 2008). Likewise, in
more recent literature, it has been reported that lack of support and counselling by
physicians was expressed among a Brazilian sample who had contracted STI/s (Malta, et
al., 2007). The lack of support and information from healthcare physicians as found in
this study as well as other studies is concerning, as healthcare providers are one of the
most common sources of information about genital herpes (L. M. Lewis, et al., 1999).
Malta et al. (2007) suggests the lack of information and support provided by healthcare
physicians can influence disclosure of STIs to partners. Although many of the women in
this study did not disclose having an STI due to their shame, stigma, and denial, if they
had received adequate information regarding STIs, the difficulty associated with STI
disclosure may have been reduced.

Half of the women expressed fear and concern about their future reproductive
capabilities, a finding that has been reported previously among HSV positive pregnant
women (Melville, et al., 2003). Some STIs are capable of having significant detrimental
effects on women’s reproductive health (Burst, 1998) and the health of unborn babies (Morris, Bauer, Samuel, Gallagher, & Bolan, 2008; Perozzi, Zalice, Howard, & Skariot, 2007; Sandhaus, 2001). For example, some STIs are associated with spontaneous abortion, PID, premature delivery and infant encephalitis (Burst, 1998; Majeroni & Ukkadam, 2007; Perozzi, et al., 2007; Sandhaus, 2001).

Despite the devastating effects STIs can have on women’s fertility and their offspring, none of the women in this study disclosed receiving information about the effects of STIs on pregnancy or fertility from their treating physicians. The women’s expressed anguish and concern for their future reproductive capabilities was a source of considerable distress, which was exacerbated by their lack of knowledge and information given to them. This finding resonates with previous literature, which found a significant source of anxiety among women who have contracted an STI was the possible impact and effects on their fertility and/or future pregnancies (Darroch, et al., 2003; Duncan, et al., 2001; Faxelid, 1993; McCaffery, et al., 2006; Melville, et al., 2003; Mills, et al., 2006; Perrin, et al., 2006). The reproductive health consequences of STIs are more severe for women than men, and this could explain why previous studies (such as Darroch, et al., 2003; Melville, et al., 2003) have found that women are more concerned with the effects of STIs on fertility than men. Considering the devastating effects that STIs can have on women’s reproductive health and the immense burden of having an STI revealed by the women in this study, emotional support and referral to appropriate services was essential.
Reaching out

Even though the women in this study expressed not receiving adequate support from treating physicians, they turned elsewhere to gain support. The women relied on close friends, family, and others with whom they could share their experiences of having an STI. Although the women were initially anxious about disclosing their STI to others, due to fear of rejection or attracting negativity, most of them needed to share their experiences in a safe way in order to cope and reduce the enormity of their burden. Further to this, disclosing to trusted confidantes including in one case the male partner Lilly was involved with at the time of the study, assisted in the reaffirming of their personal identities.

Although previous research has identified disclosing an STI to others can aid in gaining support and the restoration of perceived moral worth (for example Duncan, et al., 2001; J. D. Lee & Craft, 2002; Nack, 2002), a new finding of this study is the value some of the women found from participating in online support groups for people with STIs. Internet support groups are becoming increasingly common, and have the benefit of negating judgements that can occur within face-to-face interactions (King & Moreggi, 2007). Online support and self-help groups function for individuals with a similar attribute to share their stories and gain support from others, which can assist in learning about and coping with their condition (Colón & Friedman, 2003; King & Moreggi, 2007). STI support groups provide support, advice, information and confidantes to individuals in time of need (Inhorn, 1998). These groups are particularly useful for individuals who possess a stigmatising condition such as STIs, as they have the ability to
aid in the normalisation and acceptance of conditions (McKenna & Bargh, 1998), which is vital since perceived stigma can lead to isolation and the inability to gain support, particularly among women (Pitts, et al., 1995). Further, through relating to others with the same stigma, and being accepted within the group, self-acceptance and empowerment can occur (Gladding, 2008; King & Moreggi, 2007).

STI support groups can be the foundation of supportive relationships (Colón & Friedman, 2003). The participants who engaged with others on the online groups found comfort in the fact that others had shared and understood their experience, had accepted having an STI, and were coping and managing successfully. Many of the women expressed that discussing their experience with individuals who were also living with an STI was therapeutic. Likewise, among a sample of individuals living with genital herpes, being a member of a genital herpes self-help group, aided in the normalisation of genital herpes and the confirmation of personal identity (J. D. Lee & Craft, 2002). Similarly, among HIV positive women it was found that support groups were a source of comfort, information, a place to meet other women, reduced felt isolation through establishing connection to others (Doyal & Anderson, 2005), a place to gain supportive relationships, and aided in coping with the virus (Lather & Smithies, 1997). Having this form of support network was greatly valued by the women in this current study, and may be an important component in coming to terms with living with an STI, particularly for women. This is supported by recent research indicating that more HIV positive women than men utilise support groups and seek social contact with individuals also living with HIV (Thorpe, McDonald, & Grierson, 2007).
Resilience

When faced with adversity, individuals often draw on their positive emotions and mechanisms to effectively cope with and overcome their adverse experiences (Bonanno, 2004). Although all the women in this study expressed having an STI was and is an adverse experience, four of the women demonstrated resilience in individual ways to gain something positive from their experience. Resilience can be defined as the capacity for individuals to overcome adversity (Dyer & Minton McGuinness, 1996; Rutter, 1999). That is, resilience refers to the ability of individuals and groups to develop and achieve positive outcomes following serious detrimental events and experiences that have the potential to generate adverse effects and outcomes (Dyer & Minton McGuinness, 1996; Hauser, Golden, & Allen, 2006; Rutter, 1999). Personal resilience consists of various traits and characteristics, including drawing on positive emotions in the face of adversity and drawing on supportive networks (D. Jackson, Firtko, & Edenborough, 2007).

The women in this study demonstrated their personal resilience in various ways. Cindy and Rita expressed that their experience of having an STI had made them stronger. Lilly stated that through her experience she had become more knowledgeable about STIs, which could potentially benefit her career, and Sam drew on positive emotions and had the ability to joke about herpes with friends. These assertions from the women revealed how they looked into themselves and found personal attributes and emotions that created a sense of wellbeing in the face of their adverse experiences. Through this resilience,
these women had begun to accept and move on from the adversity they felt when they were first diagnosed with an STI.

Some of the women participants drew on supportive networks including internet support groups, and close friends and family, to overcome their anguish and strengthen their resilience. Supportive networks and relationships are an important component in developing personal resilience (Chadwick, 2004; Tusaie & Dyer, 2004). These networks encompass the support that an individual gives and receives within a relationship (Tusaie & Dyer, 2004). Through supportive networks and the interactions within these networks, individuals gain a sense of connectedness and belonging. It is this feeling of connectedness, which is an essential facet in the development of personal resilience (Chadwick, 2004). Similar to the women in the current study, personal resilience was evident in Grossman Dean’s (1995) work that focused on stories within a HIV/AIDS support group. Through the sharing of their stories with one another, participants were able to form a connectedness and bond within a supportive environment (Grossman Dean, 1995). Within the group context, humour was sometimes used to frame personal stories, and Grossman Dean noted the apparent therapeutic effect of humour in this context. The use of humour made bearable the personal illness stories that might otherwise have been too painful to share (Grossman Dean, 1995). By sharing their stories, individuals who were facing an uncertain future within the context of HIV/AIDS were able to make sense of their lives and develop personal resilience (Grossman Dean, 1995).
The finding of demonstrating personal resilience when experiencing an STI in the current study also aligns with other existing STI/HIV research. For example, within the stories of women with HIV it was found that through contracting HIV some women spoke of gaining something positive including supportive relationships, and forming and strengthening existing and new friendships with other HIV positive women (Lather & Smithies, 1997). Findings from research focused on individuals living with genital herpes and HPV revealed that some participants felt the self reflection that accompanied having an STI was a positive outcome of their experience (Newton & McCabe, 2008b). Other research has also indicated that taking responsibility for sexual wellbeing and preventing further STIs was a positive outcome expressed by HPV patients (Kahn, et al., 2005). In summary, although the women in the current study expressed adversity through their experience of having a sexual infection, the women’s strength and resilience was revealed through the experience of having and living with an STI. This is an important finding of this study, as many individuals with STIs suffer in silence. As these findings indicate, having supportive networks that are equipped to assist people finding strength to overcome their adverse experience can potentially reduce the adverse effects of having an STI.

However, for some of these women, the achievement of resilience in the face of adversity was never complete. For example, since being diagnosed with an STI, some of the women expressed their loneliness, enforced celibacy, and the inability to disclose having an STI to others due to fear of rejection and stigmatisation. Although celibacy and the inability to disclose having an STI can be viewed as evidence of oppression and
disempowerment as experienced by the women in this study, it can also be seen as an empowered personal choice to foster resilience, personal strength, safety, and healing.

Although some of these women felt a sense of enforced celibacy due to having an STI, by remaining celibate, and thus not placing themselves in a position to disclose having an STI, these women can avoid oppressive sexual relationships, which could potentially foster their own sexual wellbeing. In the future, and following this period of abstinence and withdrawal from romantic relationships these women may well decide to re-engage in sexual/romantic relationships. Thus, though empowerment may not be a direct outcome of having an STI, and is contrary to women’s experiences of abuse, Holland et al. (2004) suggest the associated disempowerment that accompanies such an experience can create personal resistance to male domination, and offer some future protection against similar adversity.

Concluding comments

This chapter has discussed the issues raised through these women’s stories in relation to the existing literature. The discussion has demonstrated how the shame, stigma, and stereotypes associated with women and STIs are so entrenched within society that these women internalised these views and subsequently experienced a disruption in the sense they had of themselves prior to STI diagnoses. Although past literature has concluded that internalisation of stereotypes and stigma is common among persons who contract STI/s, this study has extended understanding into how women live with and manage the stigma within their day-to-day lives. These women felt condemned and feared condemnation from others. Due to their fear of rejection, these women felt that they
needed to conceal having an STI from others. Fostering their secrecy was the self-preservation mechanism of denial, which facilitated them in re-establishing a positive sense of self; by concealing and denying having an STI the women did not risk being revealed as flawed and thus avoided rejection by others. While the women blamed themselves for contracting an STI, these women were all vulnerable to these infections due to lack of condom use caused by the unequal gender dynamics that existed within their relationships. Although women are expected to practise safer sex, some of these women were unable to do so effectively, because of lack of empowerment, and the physical, sexual and the emotional abuse they had experienced.

Finally, the women revealed their strength and personal resilience through their stories. Despite the negative healthcare experiences some of these women expressed, they drew on both close and anonymous (online) confidantes and networks to gain support and facilitate personal healing and resilience. The benefits of engaging in online support networks found in this study, in addition to issues discussed in this chapter have numerous healthcare implications, which are outlined in the following chapter.
CHAPTER SEVEN: CONCLUSION

Chapter abstract

This chapter summarises the findings of this study. Implications for healthcare professionals and education in relation to this study are offered, and suggestions for the direction of future research are provided. Further, the strengths and weaknesses of this study are included. Please note that some of the content from this chapter has been previously published (see East, et al., 2007).
Recapping the findings

The aim of this study was to explore young women’s stories of having an STI from a feminist perspective. Ten women participated in this research and their personal stories were collected via CMC. The use of a feminist approach facilitated the illumination of the social and gender influences and issues that were present within the women’s stories. Data analysis was guided by K. Anderson and Jack’s (1991) techniques, which revealed the similarities, contradictions, and the effects that social constructs had on the women’s experiences and their self-perceptions. Researcher reflexivity, a hallmark of feminist research, was fostered in this study by participation in a feminist group, regular reflective discussions with supervisors, and maintenance of a journal to reflect and develop insight into the women’s stories and into my own personal experiences, emotions and thoughts throughout the research process.

Findings from this research revealed that none of the women had perceived themselves at risk of STIs due to their own strongly held perceptions about the nature of women who contract these infections. Subsequently, when they themselves contracted an STI, the women experienced a disruption in their self-perception and attributed considerable blame to themselves for contracting the infections. To facilitate the restoration of their disrupted sense of self, these women engaged in wishful thinking and denial. Although these mechanisms aided the women in projecting a positive self-image to others, all the women felt spoiled and stigmatised by having STI/s. The women disclosed their fears of rejection by men, as this rejection could confirm their own perceptions of being tainted women. Moreover, their fear of rejection was directly linked to their own stigmatising
and stereotypical views of people with STIs. Due to their felt stigma and fear of rejection, many of the women expressed that they felt undesirable and unworthy of love.

Even though these women did not believe STIs posed a personal risk, all the women were vulnerable to these infections due being positioned subordinately within their sexual relationships, which affected their ability to negotiate condom use and practise safer sex. Although some of these women contracted STI/s within the context of abuse, other women expressed difficulty in negotiating condom use, both before and after their STI diagnosis. This was a result of traditional gender roles existing within the women’s relationships, which limited their assertiveness to negotiate condom use. Even if the women had initiated safer sexual practices, they risked placing themselves at risk of being perceived as promiscuous, or dirty and diseased.

The women in this study not only described the physical pain associated with symptoms of the infections, but their stories were also replete with the emotional pain that the STIs had caused them. The women expressed fear for their reproductive health and in some instances their existing and future babies’ health and wellbeing. Their emotional pain was intensified by the thought of transmitting an STI to sexual partners and the perceived guilt that would subsequently follow. However, despite their fears associated with STI transmission, and the responsibility they felt pertaining to disclosure, many of the women had unprotected sex following STI diagnosis without disclosing their STI status to their partners.
Exacerbating these women’s anguish was their experience of a lack of healthcare support and information. Several of the women’s stories revealed how these encounters were generally experienced as negative and exacerbated the women’s emotional distress. To alleviate their distress the women drew on those closest to them and made contact with others who could understand their situation through having experienced an STI themselves. Moreover, some of the women’s stories revealed that despite their pain, they needed to gain something positive from their experiences. In the face of adversity, several of the women drew on the strength and resilience within themselves to overcome their anguish.

**Implications for healthcare professionals and education**

The findings of this study have multiple healthcare and educational implications. These findings indicated a detrimental impact on the wellbeing and sense of self among these young women. Healthcare professionals working with young women who have contracted STI/s can facilitate the preservation of the sense of self by recognising the negative responses that arise from the stigma attached to STIs. Recognition of these responses can assist in the development and application of appropriate interventions such as:

- providing an accepting non-judgemental environment;
- providing accurate information;
- using appropriate and unambiguous language to discuss contraception and safer sex;
- offering information regarding online support networks;
- providing information about strategies to reduce STI risk; and,
• providing a space for women to discuss their personal experiences and concerns.

Through interventions of this nature, personal resilience can be fostered and this can potentially assist women in managing both the physical and emotional components of living with an STI. Further, healthcare professionals can support women by providing education that minimises the shame and stigma attached to these infections and emphasise that all sexually active persons are at risk of STIs regardless of background and social status.

The lack of safer sexual practices among these young women (as well as other groups) is cause for concern for nurses working with young people, particularly in areas such as sexual health, adolescent health, and women’s health. Safer sex campaigns and education should consider gender issues and acknowledge the difficulties young women can face when attempting to initiate and negotiate condom use. Healthcare professionals who adopt a non-judgemental stance, provide a forum for women to discuss social and cultural pressures associated with condom initiation, and reinforce women’s rights to negotiate safe and consensual sexual activity, can assist and promote the practice of safer sex among young women. Further, because men often hold the balance of control within heterosexual relationships and can control decisions about whether or not a condom will be used, health promotion strategies aimed at men that focus on the implications and accountability of this behaviour may result in safer sexual practices both for men and young women.
When working with young people, healthcare professionals also need to recognise the powerful influence of romantic love (particularly among young women) and the emotions that exist within dyadic partnerships that impact on safer sex practices. Acknowledgement of the role of the strong positive emotions that accompany romantic love on sexual risk and health disclosure is essential in determining accurate and complete risk assessment. Being aware of, and understanding the role these emotions play in decision-making and risk perceptions, can assist healthcare professionals in developing and providing options for minimising personal health risk during sexual activity.

The women in this study clearly blamed themselves for contracting STI/s, yet many felt unable to protect themselves from these infections. Half of the women contracted STI/s in the context of emotional and/or physical and sexual abuse. Awareness of the differing situational circumstances that can lead to the transmission of these infections and creating an environment where women can disclose and discuss these events can promote the provision of therapeutic care and support for these women. In light of findings from this study and others (for example Coker, 2007), nurses working in areas of domestic violence and abuse should acknowledge the heightened risk of STIs among affected women and facilitate sexual health education and services to maximise these women’s health and wellbeing.

Acknowledgement of the possible vulnerability and oppression that can arise among young women who have contracted an STI is vital in the provision of support and in facilitating the wellbeing of these women. Findings from this study indicated that
through their experience of having an STI, some of the women lost confidence in themselves, and perceived that if they wanted to engage in intimate relations they would have to accept any man that would be willing to be sexually involved with a woman who had an STI (dependant on their choice to disclosure). These feelings, combined with having low perceived moral worth, and the effects that STIs can have on the sense of self, all have the potential to promote disempowerment and oppression, and expose women with STIs to further abuse and domination by male partners. Therefore, providing these women with the opportunity to discuss relationship issues, including fear of abuse and oppression, can provide a supportive environment in which healthcare professionals can offer and promote individualised strategies to overcome these issues and promote a positive sense of wellbeing.

The lack of support and care these women perceived from healthcare professionals is a cause for concern. Nurses and other healthcare professionals should be aware of the adverse effects having an STI can have on young women, and provide care in a non-judgemental manner in order not to exacerbate these effects. Healthcare professionals can better serve patients by providing emotional and therapeutic support and information about the possible long-term sequelae of STIs. Provision of this support may minimise possible adverse health outcomes and reduce the anxiety associated with the possible adverse reproductive effects STIs can cause as a result of lack of knowledge among women with STI/s.

Many women in the current study acknowledged the benefits of participating in online forums for persons who experience an STI. In providing care to women with these
infections, healthcare professionals could provide information and encourage contact
with these forums. Providing this information could help enable women to gain support
from people who have experienced similar adversity (whilst remaining anonymous),
which has the capacity to enhance wellbeing. The connection to others that have shared
similar experiences has the potential to reinforce to these women that they are no
different from others within society, therefore potentially reducing stigma and helping to
protect women’s sense of self. Further, providing support that facilitates and fosters a
positive sense of self can minimise the denial and non-disclosure that occurs among
young women who have contracted STIs.

**Implications for future research**

The findings from the current study indicated that having an STI had a detrimental
impact on the wellbeing and the sense of self among these young women. Future studies
should address the lasting impact these effects have on the emotional and psychosocial
development of women. Additionally, further research is needed to explore and compare
the effects and impact different STIs have on young women. For example, although past
literature has asserted chlamydia carries a degree of stigma (for example Duncan, et al.,
2001) there is a paucity of literature that compares this stigma with, for example, the
stigma attached to life-long infections such as genital herpes. Gaining insight into the
possible differing effects that various STIs can have on women, has the potential to
recognise and facilitate appropriate (ongoing) support and interventions to assist the
overcoming of adversity associated with having STI/s.
Further research into the experiences of men who have STI/s is required to gain additional knowledge into the differing experiential effects that exist between the genders. Moreover, research that explores and compares STI experiences between different age groups and between persons involved in a partnership with those who are not can provide insight into how these factors influence the experience of having an STI. Other studies, which explore the experiences of having STI/s among both men and women from diverse backgrounds, are also needed to identify the possible influences culture and ethnicity can have on these experiences. Finally, the benefits gained from participating in online support networks revealed in these women’s stories, indicates a need to gain greater insight into the beneficial as well as any possible detrimental aspects associated with this participation.

**Limitations of this study**

A limitation of the current study was the requirement of participants to communicate fluently in English, which potentially limited the sample size as well as the possible exploration of the effects of culture and ethnicity on these women’s experiences. Participants were also volunteers who responded to the advertisements developed for this study; therefore women who did not see these advertisements did not participate. In addition, this research only focused on women who had experienced an STI between the ages of 18 and 30 years, therefore no data was obtained focused on women’s experiences of having an STI at other life stages, which limited the focus of this research.
Strengths of this study

The use of CMC was considered a strength of this research. By using CMC, recruitment of women that otherwise may not have participated was achieved, and through this communication medium, freedom of expression was facilitated by protecting the women’s anonymity. The feminist lens enabled the exploration of how social constructs and the positioning of women’s sexuality within society influenced and impacted on these women’s experiences of having STI. Additionally, use of K. Anderson and Jack’s (1991) techniques to analysis the women’s stories was also considered a strength of this research. Using these techniques assisted in the recognition of contradictions within the women’s stories, such as the women’s expression of having an STI in a positive light and the benefits the experience had afforded them, which was contrary to their stated pain and anguish. Further, conducting this research within the qualitative paradigm and using a storytelling approach, afforded data richness and facilitated the exploration of these young women’s experiences.

Concluding comments

The detrimental impact of STIs on young women should not be underestimated. Findings of this study have revealed the detrimental effects of having an STI on young women’s sense of self. The lack of information, support and sensitive treatment these women received has highlighted the possible lack of awareness of the experiential aspects of having an STI among healthcare professionals.
This study has provided insight into the shame and stigma that can accompany diagnosis of an STI and how societal influences impact on and effect self-perceptions. The current research has illuminated the difficulties the women experienced in negotiating condom use and their vulnerability to STIs as a result of traditional gendered norms that shaped their heterosexual relationships. This research has provided further insight into the reasons for non-disclosure of STIs to partners, and the tension women experience between the desire not to transmit STIs and their continued practice of unsafe sex. Additionally, new findings from this study have revealed the benefits that are associated with the participation in online support networks for young women with STI/s. These findings contribute to and expand on existing literature associated with women’s experiences associated with these infections, and offers direction for future research.

The incidences of STIs continue to rise throughout the world, and young women are a particularly vulnerable group to contracting these infections. This research has provided insight into the experiential aspects of having an STI among this group and revealed that having an STI caused these women emotional pain and adversity. They experienced a disruption in their self-perceived views and considered themselves within the context of the dominant stereotypes associated with these infections. The women feared transmitting STI/s to intimate partners, yet expressed apprehension in disclosing having an STI due to the fear of rejection they felt may result from potential male partners. For some women, having an STI had a disempowering effect on their ability to initiate and implement safer sexual practices and intensified their vulnerability within heterosexual partnerships. However, despite their expressed pain, and lack of therapeutic healthcare, some of these women drew on personal resilience to minimise and overcome the
adversity that was associated with their experiences of having an STI. Providing young women with therapeutic care that encompasses accurate information and emotional support has the potential to minimise the adversity that accompanies having an STI for this vulnerable group.
REFERENCES


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Australian Government Department of Health and Aging Communicable Diseases

Australian Government Department of Health and Aging Communicable Diseases

Australian Government Department of Health and Aging Communicable Diseases

Australian Government Department of Health and Aging Communicable Diseases

Australian Government Department of Health and Aging Communicable Diseases

Australian Government Department of Health and Aging Communicable Diseases


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Gifford, S. M., Bakopanos, C., Dawson, M., & Yesilyurt, Z. (1998). Risking for protection: Discourses around 'safe sex' among Chilean, Turkish and second-
generation Greek women living in Melbourne, Australia. *Ethnicity & Health*, 3(1/2), 95-116.


APPENDICES
### Appendix A: STI table

#### Table 8: STI table

<table>
<thead>
<tr>
<th>Condition</th>
<th>Causative pathogen</th>
<th>Signs &amp; symptoms</th>
<th>Complications Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chlamydia</strong></td>
<td>Chlamydia trachomatis</td>
<td>Females: Asymptomatic, vaginal, cervical, discharge</td>
<td>Pelvic inflammatory disease, infertility, ectopic pregnancy, abortion, transmission to neonate causing conjunctivitis and possible blindness</td>
<td>Infertility, Reiter’s syndrome, epididymitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Males: Asymptomatic, dysuria, testicular pain, urethral discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>Neisseria gonorrhoeae</td>
<td>Females: Asymptomatic, vaginal discharge</td>
<td>Pelvic inflammatory disease, infertility, ectopic pregnancy, transmission to neonate causing ophthalmia neonatorum</td>
<td>Infertility, epididymitis, prostatitis, nephritis, urethritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Males: Asymptomatic, dysuria, urethral discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Genital herpes</strong></td>
<td>Herpes simplex virus type 1 and/or 2</td>
<td>Genital itchiness, genital vesicles followed by ulcers, pain and discharge from ulcers, dysuria</td>
<td>Death of neonate/foetus, cervical cancer, reoccurring infection, herpetic keratitis</td>
<td>Urethral stricture, herpetic keratitis, myelitis, meningitis</td>
</tr>
<tr>
<td><strong>Genital /HPV Warts</strong></td>
<td>Human papillomavirus</td>
<td>Single/multiple warts on genitalia, cervical abnormalities</td>
<td>Urinary obstruction, cervical cancer, birth canal obstruction, transmission to neonate causing respiratory papillomatosis</td>
<td>Urinary obstruction</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong></td>
<td>Trichomonas vaginalis</td>
<td>Females: asymptomatic, vaginal discharge, pruritus, erythema, genital itchiness, urethritis, cervical ulcers</td>
<td>Premature pregnancy, recurrent infections</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Males: asymptomatic, urethritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nongonococcal urethritis</strong></td>
<td>Chlamydia trachomatis, Trichomonas vaginalis, herpes simplex virus, urea plasma urealyticum</td>
<td>Dysuria, discharge, asymptomatic</td>
<td>Urethral stricture, pelvic inflammatory disease, transmission to neonate causing ophthalmia neonatorum</td>
<td>Urethral stricture, epididymitis</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>Treponema pallidum</td>
<td>Primary: chancre Secondary: skin rash, lymphadenopathy, alopecia, condylomata lata Tertiary: central nervous system degeneration, aortitis, aneurysm, benign syphilis</td>
<td>Death, heart failure, liver failure, central nervous system damage, female transmission to neonate</td>
<td></td>
</tr>
<tr>
<td><strong>Chancroid</strong></td>
<td>Haemophilus Ducreyi</td>
<td>Asymptomatic, lymphadenopathy, genital ulcers</td>
<td>Chronic ulcers, recurrent infection</td>
<td></td>
</tr>
<tr>
<td><strong>Lymphogranuloma venereum</strong></td>
<td>Chlamydia trachomatis types L1, L2, P3</td>
<td>Genital ulcers, lymphadenopathy</td>
<td>Perianal/inguinal abscesses, sinus and fistulas form ruptured abscesses</td>
<td></td>
</tr>
<tr>
<td><strong>Donovanosis</strong></td>
<td>Calymmatobacterium granulomatis</td>
<td>Genital ulcers</td>
<td>Secondary infection, inflammatory scarring, tissue necrosis, orifice occlusion</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Hepatitis B virus</td>
<td>Jaundice, abdominal pain, anaemia, anorexia, nausea, vomiting, myalgia</td>
<td>Chronic hepatitis, liver dysfunction, cirrhosis, hepatocellular carcinoma, Death, transmission to neonate</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td>Hepatitis C virus</td>
<td>Jaundice, abdominal pain, anaemia, anorexia, nausea, vomiting, myalgia</td>
<td>Chronie hepatitis, liver dysfunction, cirrhosis, hepatocellular carcinoma, Death, transmission to neonate</td>
<td></td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>HIV-1, HIV-2</td>
<td>Fever, headache, rash, myalgia, lymphadenopathy, oral ulcers, vomiting, diarrhoea, lymphadenopathy</td>
<td>AIDS and associated illnesses, death</td>
<td></td>
</tr>
</tbody>
</table>

(Sources: Freedman & Groopman, 1996; G. Lee & Bishop, 2006; Lehne, 2001; LeMone & Burke, 2000; Mehring, 2002; Pratt, 2003).
Sexually transmitted infections affect millions of young women and men worldwide and are capable of causing significant physical and emotional distress. A PhD study is being undertaken at the University of Western Sydney to explore women’s experiences of having a sexually transmitted infection.

If you are a woman who experienced a sexually transmitted infection between the ages of 18-30 years and are interested in participating in this research please contact Leah for further information on 9685 9069 or 9685 9070 between 9 am-3.30 pm Tuesday-Thursday or email anytime to l.s.east@student.uws.edu.au
If you do choose to take part you will be asked to participate in an interview lasting between 1-2 hours. The interview can be on-line or in person. Anonymity will be assured.

This study has been approved by the University of Western Sydney Human Research Ethics Committee and all information will be held in strictest confidence. Project team: Leah East (PhD Candidate), Prof Debra Jackson, A/Prof Louise O’Brien, Dr Kath Peters (supervisors)
Appendix C: Media release

Epidemic sparks sexual health study of young women

A study of young women’s experiences of having a sexually transmissible disease will be conducted by the University of Western Sydney to determine the impact the diagnosis and treatment has on their lives.

School of Nursing PhD candidate, Leah East, says women are particularly vulnerable in the current epidemic of sexually transmissible infections (STIs) which is hitting young Australians.

“It is estimated that up to four out of five women will get a sexually transmissible infection, with young women under the age of 25 years being disproportionately affected. Yet very little is known about the personal experiences of these young women,” says Ms East.

“Understanding the impact more fully, will contribute to knowledge to inform services to better meet young women’s physical, psychological and social concerns.”

Ms East is calling for females aged 18 to 25 who have been diagnosed with an STI to participate in the study. Women with infectious diseases which can be passed on via blood or other non-sexual pathways - such as HIV and hepatitis - are excluded from this study.

“Previous research has shown young people perceive themselves invulnerable to STIs despite having adequate knowledge. They consciously or subconsciously choose to ignore the very real risks,” she says.

“Young women, in particular, are at greatest risk because of biological factors and because they may be less confident negotiating safe sex with their sexual partner.”

STIs can have more severe consequences for women than men, and are capable of causing infant death, infertility, and cervical cancer.

Ms East says previously published research found women in particular feel the burden of stigma and that this may prevent them from seeking treatment.

This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you wish to participate in this study please contact Leah East on 02-9685-9069, 02-9685-9070 or via email: l.s.east@student.uws.edu.au Confidentiality will be assured.

Ends
Appendix D: Internet posting

SUBJECT: Research on women’s sexual health

Content

Hello my name is Leah and I am currently doing a PhD. My research is about women’s experiences of having a sexually transmitted infection. I am currently looking for any aged women who have experienced a sexually transmitted infection between the ages of 18 and 30 years, such as warts (HPV), herpes, chlamydia, etc. to participate in this study. Participation involves having a single interview in which you will be asked to describe your experiences around contracting the STI as well as being diagnosed and treated with an STI. The interview can take place either in person or via the internet. Confidentiality will be assured.

For further inquiries about this study please contact me on l.s.east@student.uws.edu.au at anytime.
IMPORTANT: Do not reply through this discussion page as this is a public site. Please contact me directly to ensure confidentiality.
Appendix E: Letter to clinics

28/03/2007

Dear _____________,

My name is Leah East a PhD candidate at the University of Western Sydney. I spoke to you this week about displaying an advertisement in the clinic to participate in research I am conducting for my candidature.

The research is focused on exploring women's experiences of having a sexually transmitted infection between the ages of 18-30 years.

I have included some copies of the poster advertisement to be displayed, the ethics approval letter, and a participant information sheet to give you an overview of the study. I will be happy to forward you the findings of this study upon completion. If you have any further queries please do not hesitate to contact me via the phone numbers (Tuesday-Thursday) or email at anytime.

Thanking you for your time and resources

kind regards Leah

Leah East BN (Hons)
PhD candidate
School of Nursing
College of Health & Science
University of Western Sydney
Building ER, Parramatta campus
Locked Bag 1797
Penrith South DC NSW 1797 Australia
Phone: 02 9685 9069 / 02 9685 9070
email: l.s.east@student.uws.edu.au
Appendix F: Introductory letter

INTRODUCTORY LETTER

Thank you for your inquiry into participation in the study ‘A feminist study of women’s experiences of having a sexually transmitted infection’.

Please find enclosed

1. an information sheet
2. a consent form
3. an instruction sheet for conducting an interview via MSN messenger
4. and a copy of the research questions

If you have any further queries in regards to this study and/or wish to organise an interview please contact Leah East on (02) 9685 9069 or (02) 9685 9599 between 9.30 am – 3.30pm Tuesday-Thursday or via email: l.s.east@student.uws.edu.au

Thanking you for your time

 Regards Leah
Appendix G: Information sheet

INFORMATION SHEET

‘A FEMINIST STUDY OF WOMEN’S EXPERIENCES OF HAVING A SEXUALLY TRANSMITTED INFECTION’

RESEARCHER: Ms Leah East
Email: l.s.east@student.uws.edu.au
Phone: 9685 9070, 9685 9069

SUPERVISORS: Professor Debra Jackson, 9685 9505
Associate Professor Louise O’Brien, 9840 3530
Kathleen Peters, 9685 9567

You are invited to participate in the research study ‘A feminist study of women’s experiences of having a sexually transmitted infection’. This study is being conducted by Leah East as a part of a PhD program through the University of Western Sydney School of Nursing. The study is focused on exploring women’s experiences and perceptions of having a sexually transmitted infection. The aims are to gain insight and understanding into women’s experiences of having a sexually transmitted infection in order to raise awareness of young women’s experiences with these infections. In addition, information can be gained to assist healthcare personnel in providing therapeutic care to women who acquire a sexually transmitted infection.

To participate in this research you need to be:

- A woman of any age who experienced a sexually transmitted infection between the ages of 18 and 30 years
- Have a medical diagnosis of a sexually transmitted infection, that is an infection that was contracted exclusively through sexual intercourse (through heterosexual anal or vaginal intercourse)
- Be able to converse fluently in English
- Be willing to participate in an interview with the researcher lasting between 1-2 hours, which will be focused on discussing your experiences and perceptions of having a sexually transmitted infection.

The interview can be conducted in one of two ways.
In person at a private and comfortable location situated on one of the four University of Western Sydney Campuses. The interviews conducted in person will be audio-taped.

Via the internet using MSN Instant Messenger Service. To participate in the interview via the internet, you will need to download MSN Messenger and create an address and password to use this service. It should also be noted that although conducting the interview through this program is a private forum, the internet is a public domain and at times is subjected to breaches. If you choose to use this method to participate in an interview, no personal identifiable data will be asked from you during the interview process and the researcher recommends the use of a false name for the user address.

All interview data will be transcribed and analysed.

If you become distressed during a face-to-face interview the interview can be temporarily suspended, re-scheduled, or terminated at any time. Due to the sensitive nature of this research all participants will be provided with a list of publicly accessible professional counselling services that will bear no cost to participants, if required following the interview.

Participation in this study is voluntary, you will be offered no material incentives for participation, and you are free to withdraw from this study at anytime without obligation or detriment.

All data will be held in the strictest confidence, only the researcher, the researcher’s supervisors and the professional who will transcribe audio-tapes (although this person will not have access to any identifiable personal data) will have access to the data that will be labelled with a pseudonym. The research results will be disseminated through publications and appropriate conference presentations.

If you wish to receive the results of this study in the format of a publication, you can indicate this on the consent form. Prior to receiving the results, you will be contacted via email to determine if you still wish to receive the research findings.

If you have any queries or require any further details please do not hesitate to contact the researcher on the above contact details

THANK YOU FOR YOUR TIME AND PARTICIPATION IN THIS RESEARCH

SIGNATURE

Leah East

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is HREC 06/192
you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers tel: 02 4736 0883. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix H: Possible areas of discussion and prompts

Research questions

• Tell me your story of having a sexually transmitted infection

• Did you think you were at risk of a sexually transmitted infection?

• Do you know how you contracted the sexually transmitted infection?

• Were there other parts of your life affected by the sexually transmitted infection?

• How did the infection affect your relationships with intimate partners?

• Were you able to tell anybody that you were being treated for a sexually transmitted infection?

• How did you perceive yourself in the context of having a sexually transmitted infection?

• How did you perceive healthcare personnel and how did the healthcare personnel impact on your experience?
Appendix I: Consent form

CONSENT FORM

I ___________________ have agreed to give my voluntary consent to participate in the study titled ‘A feminist study of women’s experiences of having a sexually transmitted infection’ being conducted by Leah East as part of a PhD program through the University of Western Sydney’s School of Nursing.

I am aware that I:

• Must be a woman who experienced a sexually transmitted infection between the ages of 18 and 30 years
• Have the ability to converse fluently in English
• Have received a medical diagnosis of a sexually transmitted infection that was acquired through heterosexual intercourse.
• Will be participating in an interview with Leah East lasting approximately 1-2 hours
• Have the choice of whether the interview will be conducted either in person at the appropriate University of Western Sydney’s Campus or via the internet using MSN Messenger.
• Will receive a list of professional counselling services in the event that I experience distress in discussing my experiences associated with having acquired a sexually transmitted infection.

I am aware that I will not be given any material incentives for participating in this study and that I am able to withdraw from this study at anytime without detriment and obligation. I am aware that my confidentiality will be maintained at all times and that I will be given a pseudonym to protect my personal identity within the research findings. I am also aware the results of this study will be presented through appropriate publications and presentations and if I wish to receive the research results, I will be contacted via my corresponding email to determine if I still would like to receive these results.

I have read the information sheet and agree with the above information and give my voluntary consent to participate in this research.

__________________________________            ____________________           ____________
(Participant’s signature)               (Print name)                             (Date)
☐ Please tick this box if you wish to receive a copy of the research results in the form of a publication
Corresponding email address: ____________________________
Appendix J: Internet instruction sheet

INTERVIEWS CONDUCTED VIA THE INTERNET
Interviews conducted over the internet will be conducted through the use of MSN Messenger. For the interviews to take place it is necessary to download and install MSN Messenger software. To download the software and use MSN Messenger can be done through the following steps:

1. Connect to the internet and go to http://webmessenger.msn.com
2. Click on the download and install MSN Messenger
3. Proceed to step one and get a .Net Passport and follow the prompts to create your address and password, and the reading of the privacy and agreement terms for MSN Messenger
4. Sign into MSN Messenger through the messenger icon and your address and password
5. Click on the add contact link
6. Add my address
7. Contact me via email or phone and let me know your Messenger address

When our interview is about to proceed:

1. Connect to the internet and sign into MSN Messenger
2. Click on my Messenger address underneath the online status and await my greeting
3. The interview can now commence through typing in the window messenger box and pressing the send button following typing
4. Following the interview, you can choose to save the interview through the save button
If you encounter any difficulties, or require further information regarding the interview please do not hesitate to contact me.
Appendix K: Ethics clearance

Leagh East
c/- Debra Jackson
School of Nursing
Building ER, Parramatta Campus
University of Western Sydney NSW 2797

Dear Leagh

HREC 06/192 A feminist study of women’s experiences of having a sexually transmitted infection

The Committee has reviewed the responses to the issues raised for the above mentioned project and the project has been approved.

You are advised that the Committee should be notified of any further change/s to the research methodology should there be any in the future. You will be required to provide a report on the ethical aspects of your project at the completion of this project. The report form is located on the Research Services Ethics Web Page.

The Protocol Number HREC 06/192 should be quoted in all future correspondence about this project. Your approval will expire 28 February 2009. Please contact the Human Ethics Officer, Kay Buckley on tel: 02 47 360 883 if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

[Signature]

Associate Professor Christine Halse
Chairperson
UWS Human Research Ethics Committee
Cc Professor Debra Jackson
Appendix L: Professional counselling services

PROFESSIONAL COUNSELLING SERVICES

Sydney

Sexual Health Services

Livingstone Road Sexual Health Centre
182 Livingstone Road, Marrickville, NSW 2204  Phone: (02) 9560 3057

Parramatta Sexual Health Clinic
162 Marsden Street, Parramatta, NSW 2150  Phone: (02) 9843 3124

Parramatta Sexual Health Clinic
Grounds of Mount Druitt Hospital, Mount Druitt
NSW 2770  Phone: (02) 9881 1733

Sexual Health Clinic Blue Mountains
Blue Mountains Hospital, Katoomba
NSW 2780  Phone: (02) 4784 6560

Sexual Health Clinic
Cnr Elizabeth and Biggs Street, Liverpool
NSW 2170  Phone: (02) 9827 8022

Nepean Sexual Health and HIV Service
The Annexe Nepean Hospital
Somerset Street, Kingswood
NSW, 2747  Phone: (02) 4734 2507

St George Sexual Health Clinic
Ground Floor, Pritchard Wing Short Street
Kogarah NSW 2217  Phone: (02) 9350 2742

Sydney Sexual Health
Sydney Hospital, Nightingale Wing, 3rd Floor
Macquarie Street, Sydney 2000  Phone: (02) 9382 7440

Community Health Centres

Bankstown Women’s Health Centre
74 Restwell Street Bankstown, NSW 2200  Phone: (02) 9790 1378
Blacktown Women’s and Girls Health Centre
6 Prince Street, Blacktown, NSW 2148 Phone: (02) 9831 2070

Family Planning Clinics

Family Planning NSW Phone: 1300 658 886

Fairfield FPA Health Multicultural Services
Suite 5, Level 2, Neeta City Shopping Centre,
Smart Street, Fairfield, NSW 2165 Phone: (02) 9754 1322

Other Services

Lifecare Counselling and Family Services Phone: 1300 130 225
Lifeline Phone: 131 114

Sexual assault

NSW Rape Crisis Centre Phone: 1800 424 017
Bankstown Community Health Centre
36-38 Raymond Street, Bankstown, NSW 2200 Phone: (02) 9780 2777
Liverpool Hospital Level 3, Health Services Building
Campbell and Goulburn Streets
Liverpool, NSW 2170 Phone: (02) 9828 4844
Blacktown Community Health Centre
Unit 1 Marcel Crescent, Blacktown NSW 2148 Phone: (02) 9881 8700

BRISBANE SERVICES

Sexual Health clinics

Brisbane Sexual Health Clinic
Floor 1, 270 Roma Street
Brisbane Q, QLD, 4000 Phone: (07) 3837 5611

Counselling line Phone: (07) 3837 5799

Princess Alexandra Sexual Health Clinic
Princess Alexandra Hospital
Woollongabba, Brisbane, QLD
Phone: (07) 3240 5881

Sexual Assault Services

Sexual Assault Services
Phone: 1800 010 120
Phone: (07) 3636 5207

Brisbane Sexual Assault
Phone (07) 3636 5206

Other services

Lifeline
Phone: 131 114

Rape Crisis Service
Phone: 1800 657 501

Women’s Information and Referral Line
Phone: 1800 017 382

Health Information Line
Phone: 1800 017 676

Women’s Infolink
Phone: 1800 177 577

HIV/AIDS Infoline
Phone: 1800 177 434

Townsville Services

Sexual Health Centres

Townsville Sexual Health Unit
35 Gregory Street
North Ward, QLD, 4810
Phone: (07) 4778 9600

Palm Island Sexual Health Clinic
Beach Road, Joyce Palmer Health Services
Palm Island, QLD, 4816
Phone: (07) 4752 5100

Other Services

Family Planning Qld
45 Eyre Street
North Ward, QLD, 4810
Phone: (07) 4771 2005
Women’s Centre
50 Patrick Street
Aitkenvale, QLD, 4814 Phone: (07) 4775 7555

Lifeline Phone: 131 114

Rape Crisis Service Phone: 1800 657 501
Sexual Assault Services Phone: 1800 010 120
Women’s Information and Referral Line Phone: 1800 017 382
Health Information Line Phone: 1800 017 676
Women’s Infolink Phone: 1800 177 577
HIV/AIDS Infoline Phone: 1800 177 434

MELBOURNE SERVICES

Melbourne Sexual Health Clinic
580 Swanson Street
Carlton, Victoria, 3053 Phone: (03) 9347 0244
1800 032 017

Lifeline 131 114
Women’s Information and Referral Line 1800 136 570
Centre Against Sexual Assault (03) 9433 2210
(03) 9349 1766

PERTH SERVICES

Sexual Health Clinics

Royal Perth Hospital Sexual Health Clinic
Wellington Street
Perth, WA, 6000 (08) 9224 2178

Fremantle Sexual Health Clinic B2
Infectious Disease Department
Fremantle Hospital, Alma Street
Fremantle, WA, 6160 (08) 9431 2149
Other Services

Sexual Assault Resource Centre (08) 93401828
Health Information Line 1300 135 030
Crisis Care 1800 199 008 (08) 9223 1111
Women’s Information Referral Service 1800 199 174 (08) 6217 8230
Lifeline 131 114

ADELAIDE/ SOUTH AUSTRALIAN SERVICES

Sexual health services

Clinic 275
1st Floor, 275 North Terrace
Adelaide, SA, 5000 Phone: (08) 8222 5075
(08) 8226 6025
1800 806 490

The Second Story Youth Health Centres

57 Hyde Street
Adelaide, SA, 5000 Phone: (08) 8232 0233

Gillingham Street
Elizabeth, SA, 5113 Phone: (08) 8255 3477

50A Beach Road
Christies Beach, SA, 5165 Phone: (08) 8326 6053

Women’s Health Centres

Dale Street Women’s health Centre
47 Dale Street
Port Adelaide, SA, 5015 Phone: (08) 8444 0700

Northern Women’s Community Health Centre
28 Phillip Highway
Elizabeth North, SA, 5112 Phone: (08) 8252 3711
Southern Women’s Community Health Centre
Alexander Kelly Drive
Nourlunga Centre, SA, 5168
Phone: (08) 8384 9555

Other Services

Sexual Health Hotline
Phone: (08) 8364 0444

Rape and Sexual Assault Service
Phone: 1800 817 421

Lifeline
Phone: 131 114

Youth Healthline
Phone: 1300 131 719

Sexual Healthline
Phone: 1300 883 793
Appendix M: Amended information sheet

INFORMATION SHEET

‘A FEMINIST STUDY OF WOMEN’S EXPERIENCES OF HAVING A SEXUALLY TRANSMITTED INFECTION’

RESEARCHER: Ms Leah East
Email: l.s.east@student.uws.edu.au
Phone: 9685 9070, 9685 9069

SUPERVISORS: Professor Debra Jackson, 9685 9505
Associate Professor Louise O’Brien, 9840 3530
Kathleen Peters, 9685 9567

You are invited to participate in the research study ‘A feminist study of women’s experiences of having a sexually transmitted infection’. This study is being conducted by Leah East as a part of a PhD program through the University of Western Sydney School of Nursing. The study is focused on exploring women’s experiences and perceptions of having a sexually transmitted infection. The aims are to gain insight and understanding into women’s experiences of having a sexually transmitted infection in order to raise awareness of young women’s experiences with these infections. In addition, information can be gained to assist healthcare personnel in providing therapeutic care to women who acquire a sexually transmitted infection.

To participate in this research you need to be:

- A woman of any age who experienced a sexually transmitted infection between the ages of 18 and 30 years
- Have a medical diagnosis of a sexually transmitted infection, that is an infection that was contracted exclusively through sexual intercourse (through heterosexual anal or vaginal intercourse)
- Be able to converse fluently in English
- Be willing to participate in an interview with the researcher lasting between 1-2 hours, which will be focused on discussing your experiences and perceptions of having a sexually transmitted infection.

The interview can be conducted in one of three ways
♦ In person at a private and comfortable location situated on one of the four University of Western Sydney Campuses. The interviews conducted in person will be audio-taped.

♦ Via the internet using MSN Instant Messenger Service. To participate in the interview via the internet, you will need to download MSN Messenger and create an address and password to use this service. It should also be noted that although conducting the interview through this program is a private forum, the internet is a public domain and at times is subjected to breaches. If you choose to use this method to participate in an interview, no personal identifiable data will be asked from you during the interview process and the researcher recommends the use of a false name for the user address.

♦ Or via electronic mail. On completion of the interview, all data obtained via this medium will be deleted from the electronic software and stored on a password protected file to ensure confidentiality. It is also recommended that participants delete this data from their electronic mail.

All interview data will be transcribed and analysed.

If you become distressed during a face-to-face interview the interview can be temporarily suspended, re-scheduled, or terminated at any time. Due to the sensitive nature of this research all participants will be provided with a list of publicly accessible professional counselling services that will bear no cost to participants, if required following the interview.

Participation in this study is voluntary, you will be offered no material incentives for participation, and you are free to withdraw from this study at anytime without obligation or detriment.

All data will be held in the strictest confidence, only the researcher, the researcher’s supervisors and the professional who will transcribe audio-tapes (although this person will not have access to any identifiable personal data) will have access to the data that will be labelled with a pseudonym. The research results will be disseminated through publications and appropriate conference presentations.

If you wish to receive the results of this study in the format of a publication, you can indicate this on the consent form. Prior to receiving the results, you will be contacted via email to determine if you still wish to receive the research findings.

If you have any queries or require any further details please do not hesitate to contact the researcher on the above contact details

THANK YOU FOR YOUR TIME AND PARTICIPATION IN THIS RESEARCH

SIGNATURE
NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval Number is HREC 06/192. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers tel: 02 4736 0883. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
CONSENT FORM

I _______________ have agreed to give my voluntary consent to participate in the study titled ‘A feminist study of women’s experiences of having a sexually transmitted infection’ being conducted by Leah East as part of a PhD program through the University of Western Sydney’s School of Nursing.

I am aware that I:

• Must be a woman who experienced a sexually transmitted infection between the ages of 18 and 30 years
• Have the ability to converse fluently in English
• Have received a medical diagnosis of a sexually transmitted infection that was acquired through heterosexual intercourse.
• Will be participating in an interview with Leah East lasting approximately 1-2 hours
• Have the choice of whether the interview will be conducted either in person at the appropriate University of Western Sydney’s Campus, via the internet using MSN Messenger or via electronic mail
• Will receive a list of professional counselling services in the event that I experience distress in discussing my experiences associated with having acquired a sexually transmitted infection.

I am aware that I will not be given any material incentives for participating in this study and that I am able to withdraw from this study at anytime without detriment and obligation. I am aware that my confidentiality will be maintained at all times and that I will be given a pseudonym to protect my personal identity within the research findings. I am also aware the results of this study will be presented through appropriate publications and presentations and if I wish to receive the research results, I will be contacted via my corresponding email to determine if I still would like to receive these results.

I have read the information sheet and agree with the above information and give my voluntary consent to participate in this research.

_______________________            _________
(Participant’s signature)            (Print name)            (Date)
Please tick this box if you wish to receive a copy of the research results in the form of a publication.

Corresponding email address: __________________________