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S. Heath Williams
The Effects of Sexually
Transmitted Illness (STI)
Stigmatization on Intimate
Relationships: Non-Infected
partners' perceptions,
reactions, feelings and
attitudes toward female
partners' disclosure of
Herpes Simplex Virus (HSV)
positive status

ABSTRACT

The purpose of this study was to explore in greater depth the effects of Sexually Transmitted Illness (STI) stigma on intimate relationships by examining the reactions of non-infected intimate partners to their female partner's disclosure of her Herpes Simplex Virus (HSV) positive status. The research question was: what are non-infected partners perceptions, reactions, feelings and attitudes to their female partner's disclosure of HSV positive status?

This exploratory mixed-methods study was informed by the extant literature on STI stigma and intimate relationships. The lens of stigma theory is used to frame the discussion of the findings. Forty-three participants responded to the predominantly quantitative online survey. Inclusion criteria required that the participant was over the age of 18 and had been disclosed to by his/her female Herpes positive intimate partner. Noteworthy findings point to both similarities and differences in gender responses to disclosure and speak to a general trend of partner positive emotional response to HSV+ disclosure in intimate relationships among this sample. Study findings further underline the importance of pre-intercourse disclosure, and the role of disclosure in supporting safe-sex practices and information seeking behavior.

THE EFFECTS OF SEXUALLY TRANSMITTED ILLNESS (STI)
STIGMATIZATION ON INTIMATE RELATIONSHIPS: NON-INFECTED
PARTNERS' PERCEPTIONS, REACTIONS, FEELINGS AND ATTITUDES
TOWARD FEMALE PARTNERS' DISCLOSURE OF HERPES SIMPLEX VIRUS
(HSV) POSITIVE STATUS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

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CHAPTER I

INTRODUCTION

It has been reported that currently in the United States the rate of Herpes Simplex Virus (HSV) increases by one million per year; every 30 seconds a new person is infected with Genital Herpes and over the last decade the reported rates of infection have increased by 30% (Herpes Clinic, 2009). According to the Center for Disease Control there are currently 45 million people living with HSV over the age of 12 within the United States and more people live with Genital Herpes than any other viral Sexually Transmitted Illness (STI) (Center for Disease Control, 2009). Rates of HSV infection are much higher among women (1 in every 4) than men (1 in every 5) ((Planned Parenthood, 2009; CDC, 2009).

As is shown above, HSV is a major health issue within the United States. One of the most effective ways of preventing the spread of the illness is for those who have been diagnosed with genital Herpes to disclose their STI status to their intimate partners. Unfortunately, women who are carriers of the illness are highly stigmatized and often afraid to tell their intimate partners about their positive status. This study was carried out in order to look at the ways that STI stigmatization, specifically HSV, play out within intimate relationships. The researcher hoped to shed light on the impact that disclosure has on the non-infected intimate partner in order to further understand the ways that the illness is seen within the context of an intimate relationship.

This is one of the only studies that examines the non-infected partner's reaction to STI disclosure. This exploratory descriptive study used mixed methods and was carried out online using SurveyMonkey.com. The findings of this study were hopeful for women living with Genital Herpes. They indicate that, within this demographic (white, not affiliated with organized religion, college educated, urban), if a woman shares her Herpes+ status prior to intercourse she is likely to be at minimal risk for experiencing a negative reaction from her non-infected partner. Many of those who participated in the study reported having admiration for their Herpes+ partner, feeling closer to her and being supportive of her. The few who reported feeling angry or betrayed reported that they had been informed of the illness after intercourse. This study is also one of very few that include participants in same-sex relationships, with findings showing little difference in emotional response between men and women to their female partner's disclosure. Findings did show differences by gender in that women were less likely to end physical relationship regardless of emotional response to female partner Herpes+ status. This study also reinforced the idea that those who are disclosed to are driven to seek out information about STIs and more likely to practice safe sex in current and future relationships regardless of their response to intimate partner disclosure.

The intent of this study was to further explore the impact of STI stigmatization on female Herpes disclosure in intimate partnerships thereby expanding the knowledge base for those who work with individuals impacted by STIs and those who are interested in sexual health issues on a policy level. Stigma acts as a major barrier to STI disclosure; several studies have examined the impact of disclosure on those who are living with an STI, but none have specifically examined the reactions of those who are informed of their

female partners STI positive status. This study sheds light on the possible ways that STI stigmatization plays out within intimate relationships.

CHAPTER II

LITERATURE REVIEW

This section will review the following areas: First, it will provide an overview of HSV – its epidemiology and incidence, the affected population, and current issues in treatment and prevention; second, it will address the area of stigma and stigma theory; third, the literature on stigma as it applies to HSV will be reviewed; finally, it will delve into the literature on disclosure of HSV and other STI's in intimate relationships.

Genital Herpes (HSV): An Overview

HSV is a viral STI that is spread through skin-to-skin contact during outbreak or during the asymptomatic “shedding” phase, which most commonly occurs directly before or after a herpes outbreak. Carriers can spread HSV without knowing that they are doing so and if they have never had an outbreak are often unaware that they are carriers of the illness. Because HSV is viral, once it is contracted the carrier will have the illness indefinitely, in other words, there is no cure for HSV. That being said, the long-term physical effects of HSV are minimal for the persons infected. Most people living with HSV report having about 4 outbreaks per year (Herpes Clinic, 2009). Outbreaks consist of small sores near the genitals or anus and generally last for a few days. The outbreaks are not physically very painful but are reported to generate emotional distress. The first herpes outbreak is usually the most painful and elicits the most shame and emotional stress among the people dealing with the illness (Oster & Cheek, 2008; Youngkin, Henry, & Kilgore-Gracely, 1998). Because HSV is spread through skin-to-skin contact it is very

difficult to protect against. There does not have to be any fluid exchange for HSV to be transferred from partner to partner. This means that HSV can be contracted without engaging in sexual intercourse. While the use of condoms and dental dams reduce the risk of spreading HSV significantly, the best prevention is knowledge of the illness, its effects, and comfort with partner disclosure so that the risk of infection is minimized (Youngkin et al., 1998).

When a person with HSV experiences an outbreak they usually develop blister-like sores around their genitalia. These sores range from large and painful to barely noticeable. Some of the warning signs of an outbreak include lower back pain, fatigue, a slight tingling sensation in the genitalia, slight stomach cramping and occasionally vaginal discharge for women. These symptoms vary from individual to individual. Some people living with HSV may never have an outbreak or may only have one in their lifetime. Women who have frequent outbreaks often experience these directly before their menstrual cycle. The more serious effects of HSV can be seen during the birthing process. If the infant is exposed to HSV in the birthing canal it can have serious birth defects such as blindness, brain damage. If the mother is aware of her HSV positive status and willing to share this status with her doctor then the OBGYN will be able to monitor and prevent these birth defects from occurring through cesarean section or testing and viral suppressive drugs (Planned Parenthood, 2009). Another risk that comes with contracting HSV is that it doubles the infected person's vulnerability to HIV infection (CDC, 2009). The only treatments available for HSV are viral suppressive drugs. There are two types of antiviral drugs available for those living with HSV:

Famciclovir and Valaciclovir. Both reduce the rate of outbreak and therefore sexual transmission (Stanberry & Volpi, 2007).

The United States has the highest rates of STI infection in the industrialized world, up to 12 million new cases of STI's are reported in the USA per year (Marwick, 1997). According to Planned Parenthood's website, one in every four women is a carrier for both Genital Herpes (HSV) and Human Papilloma Virus (HPV). This is based on cases reported and does not account for those who have not had outbreaks or have not been tested. "More than half of the US population will get an STI at some point in their lives" (Planned Parenthood, 2009). STI reports and statistics come primarily from public health clinics and the Institute of Medicine (IOM) claims that the rates of STI infection may be twice what reported statistics show. Privately run women's health clinics and doctors in private practice are not as heavily monitored or held accountable for reporting statistical information. Minorities and people living in poverty have much higher attendance at community clinics than Caucasians and people with private health insurance. This leads to somewhat untrustworthy statistics surrounding the demographic information gathered about rates of STI infection (Bonavoglia, 2000).

It has been reported that currently in the United States the rate of HSV increases by one million per year; every 30 seconds a new person is infected with Genital Herpes and over the last decade the reported rates of infection have increased by 30% (Herpes Clinic, 2009). According to the Center for Disease Control there are currently 45 million people living with HSV over the age of 12 within the United States and more people live with Genital Herpes than any other viral STI (CDC, 2009). Rates of HSV infection are much higher among women (one in every four) than men (one in every five) (Planned

Parenthood, 2009; CDC, 2009; Herpes Clinic, 2009). Statistics regarding demographics and HSV infection is somewhat contradictory. While, according to the Center for Disease Control, approximately 46% of reported HSV cases are among African Americans compared to approximately 18% of reported cases are among Whites (CDC, 2009; Herpes Clinic, 2009), this statistic is in direct contrast with other literature claiming that the rates of HSV infection are widespread across racial groups and not disproportionately prevalent among African Americans (Bonavoglia, 2000; Herpes A to Z, 2009).

This information points to a need for education and interventions that help individuals acknowledge and address the issues surrounding sexual health, in general, and genital herpes in particular.

Stigma Theory

STI stigmatization has a major impact on the infected population's ability to access care, communicate with current/future partners and on the infected population's physical and psychological health (Newton & McCabe, 2008; Lichtenstein, 2003; Rusch et al., 2008). Because there is no vaccine or cure for HSV and it is the most prevalent viral STI in the United States the impact of the stigma on those living with HSV is even greater than with other STIs (CDC, 2009; Youngkin et al., 1998). The application of stigma theory to HSV sufferers in the context of relationships will be useful in furthering our understanding of the role of stigma in coping and disclosure behavior.

In this section I will look at a collection of articles and books that speak to the ideas behind stigma theory. Goffman is in the forefront of stigma theory. According to their discussion of Goffman's seminal work on stigma authors Newton and McCabe (2005) point to Goffman's definition of stigma as follows, "any attribute that has a

discrediting effect on an individual's character. An attribute is perceived to have a discrediting effect when a discrepancy is detected between an individual's virtual social identity and actual social identity" (as cited in Newton & McCabe, 2005, p. 52). Stigma is further explained by defining *virtual* social identity as the identity ascribed to a person by others and the *actual* social identity as the characteristics that a person truly possesses.

Goffman goes on to address the impact of stigma on those whose stigmatizing qualities are not outwardly evident. According to Goffman, in such cases individuals often encounter two separate social atmospheres: internally, as the stigmatized individual, and externally, as not possessing said stigma. This leaves the stigmatized person in a precarious situation. The individual is aware of his/her stigmatized circumstance and fears that he/she may be revealed; either by his/her own means or by those around him/her. If the stigmatized person is able to remain successfully concealed Goffman referred to it as "passing" (Goffman, 1963). In the aforementioned social atmosphere, stigma only impacts the behaviors adopted by the individual who is stigmatized. This person has to manage the concealing and revealing of his/her identity. According to Goffman, it is in the second atmosphere where the individual's stigma has been revealed that he/she is outwardly discredited, thus affecting not only the stigmatized individual's behaviors but also the behaviors of those participating in stigmatizing. Goffman goes on to explain that stigma presents itself in two different forms—the "discredited" (those who have no choice in concealing their stigmatized nature (i.e. race, gender, language, physical disability, etc.) and the "discreditable" (those who are able to conceal the stigmatized attributes to their identities (i.e. illness, STI status, ethnicity, homosexuality,

etc.). In the following excerpt Goffman (1963) is first speaking of being discredited and goes on to describe what it is to be discreditable:

The cooperation of a stigmatized person with normals is acting as if his known differentness were irrelevant and not attended to is one main possibility in the life of such a person. However, when his differentness is not immediately apparent, and is not known beforehand (or at least known by him to be known by the others), when in fact his is a discreditable, not a discredited, person, then the second main possibility in his life is to be found. The issue is not that of managing the tension generated during social contacts, but rather that of managing information about his “failings” (p. 41-42).

According to Goffman (1963) there are six dimensions that are dealt with within these two types of stigma: 1) Concealability - the extent to which others can detect the stigma; 2) Course - if the stigma becomes more or less prevalent over time; 3) Disruptiveness - the degree to which the stigma interferes with social functioning; 4) Aesthetics- the way in which other people respond to the stigma; 5) Origin- if the stigma is perceived as accidental, deliberate or present at birth; and 6) Peril- the perceived danger of the stigma being passed on to others.

More recent scholars have elaborated upon Goffman’s seminal work on stigma theory. Sociologist, Gerhard Falk (2001) describes stigma based on two categories, “Existential Stigma” and “Achieved Stigma.” According to Falk, “Existential Stigma” is defined as a “stigma deriving from a condition which the target of the stigma either did not cause or over which he has little control” (p.19). He defines “Achieved Stigma” as “stigma that is earned because of conduct and/or because they contributed heavily to attaining the stigma in question” (p. 19). Falk speaks to the idea that societies have a need to stigmatize because it creates a sense of solidarity for those who are doing the stigmatizing (Falk, 2001). Smith & Nave (2007) looked at the transmission mode and

level of negative stigma attached to sexually transmitted illness as opposed to non-sexually transmitted illness in one hundred fifty-four Caucasian college students. These authors cite the definition of stigma offered by Jones et al (1984), as “possessing an attribute or trait that makes a person deviant, flawed, limited or generally undesirable” (as cited in Smith & Nave, 2007, p. 853). Smith and Nave (2007) go on to say that those who stigmatize do so out of a desire to protect their self-image or because they feel threatened by the stigmatized party.

Writing from a feminist perspective, Nack (2002) speaks to the stigma of the tribe. She expands upon Goffman’s ideas (1963) and claims that the stigma of the tribe should not only include those who obtain stigma through lineage or group membership (interpersonal), but should also be applied to those who have to continually apply their own status against salient societal norms (intrapersonal).

Stigma and STIs

Goffman points to six different dimensions of stigmas: concealability, course, disruptiveness, aesthetic qualities, origin, and peril. According to Goffman concealability, origin and peril are the most powerful dimensions of stigma (Goffman, 1963). It can be argued that a diagnosis of STI involves all three of these dimensions.

A number of studies have looked at the impact of STI stigma on women’s health-seeking behaviors and relationship to sexuality, overall. Studies have shown that women are much less likely to seek out testing and less likely to protect themselves against STIs because of the shame and stigma attached to such an illness (Fortenberry et al., 2002 & Miller, 2000). This idea has been reinforced by another study that looked at the stigma attached to STI status among women and how the shame associated with STI status had a

direct impact on women's motivation to seek out testing and treatment. Study findings pointed to a direct correlation between participants' desire to access treatment for STIs and the amount of stigma that they attached to their STI status. Women who perceived women with STI's as "damaged goods" or thought that "women should know better" were less likely to access care than those who did not hold these ideologies (Rusch et al., 2008). In Lichtenstein's study about the stigma attached to STI status among women in the American deep-south, it was found that men and women within both urban and rural settings attach a strong negative stigma to women who seek out sexual health care. Women who accessed sexual health care were perceived by study participants as sexually active, and therefore "bad and dirty"; participants expressed that it was the woman's responsibility to keep herself "pure." Conversely it was found that "male sexual behavior was not framed in negative terms, and sexual adventuring was considered acceptable or even inevitable for young men" (Lichtenstein, 2003, p. 2439).

A related area of study has been on the effects of stigma on those who are not carriers of the STI, but who come in contact with the affected population. In particular, several studies have looked at the impact of stigma related to venereal disease on health care professionals. In his case study of a female contact tracer Kampf (2008) looks at the impact that the stigma attached to venereal disease has on healthcare professionals within their own communities. The author acknowledges the considerable influence of STI stigma within western culture and reinforces Newton & McCabe's (2005) ideologies around stigma. Kampf's study was a single subject study with an extensive literature review. The author's review of the literature revealed the fear and stigmatization that healthcare professionals face when disclosing that they work with STI populations. The

researcher found that the stigma attached to STI status also results in a, so-called, “second degree stigma” attached to the study participant who was involved in tracing the origins of STI infection (a.k.a. “contact tracer”). The “contact tracer” maintained that her life was “a little world of your own because you can’t talk to anybody about it” (Kampf, 2008, p. 244). The study’s literature review also revealed that “contact tracers” withdrew from society voluntarily and were also excluded by their work with infected populations. Kampf’s study found that, “Tracers’ lives were compromised by secrecy, stigma, morality and the demands of public health policy. The stigma that contact tracers acquired limited their options, as well as isolating them in the non-stigmatized social world” (p.239). The study’s literature review showed that “contact tracers” were almost entirely female and often single and self-isolating and the single subject associated this isolation with the content of “contact tracers” professional work.

Several other studies have looked at gender roles and STI stigmatization (Bonavoglia, 2000; Nack, 2002; Smith, Mysak, & Michael, 2008). Study findings show that stigmatization among women who have an STI+ status has a significant impact on their emotional and social response to self and affects their desire to seek out treatment or share their STI status (Bonavoglia, 2000; Nack, 2002; Smith et al., 2008). Smith et al (2008) studied one hundred fifty-one undergraduates from the southeastern United States and their reactions to hypothetical STI diagnosis. Study findings showed participants were more likely to stigmatize women with a sexually transmitted illness than women with any other kind of illness. This study also showed that women with sexually transmitted illnesses were much more likely to be labeled undesirable, to feel ashamed and were much more likely to anticipate social rejection than men. In Bonavoglia’s

article (2000) the author addresses the long history of blame assigned to women for the spread of STIs within the United States. She refers to a poster, distributed widely during World War II, that “pictures a young woman in a crisp white shirt above the words: She may look clean—but pick ups, “good time” girls, prostitutes spread syphilis and gonorrhea” (Bonavoglia, 2000, p. 56). The facts are that women are at greater risk for contracting STIs from men than men from women (Bonavoglia, 2000). In discussing the findings of her qualitative study of women’s reactions to STI diagnosis and their perceptions of STI stigmatization, Nack (2002) expands upon the idea of the disproportionate stigmatization accorded to women who have STIs and how this stigmatization is encouraged by our cultural concepts of womanhood. She states, “In a society that ideologically structures women as a tribe divided over sexual morality, a health status of being STD infected stigmatizes a woman both morally and socially” (p. 465).

Stigma and HSV

Several studies have looked specifically at the impact of HSV diagnosis and the stigma that adheres to this diagnosis on individual sexual and psychological adjustment to this illness. Some studies have found that the impact of the diagnosis diminishes over time.

Brooks, Haywood & Green (1993) looked at the impact of an HSV diagnosis among people visiting a health clinic who had been diagnosed for over 6 years. Most studies are conducted on people who have been recently diagnosed with HSV; this was a less frequently examined sample population. The findings showed that 70% of the subjects reported that they had disclosed their STI status with current or past partners.

The study also found that the diagnosis of HSV had had a limited effect on the subject's sexual activity. According to the authors, study subjects on the whole, "enjoyed sex and functioned well in sex. There was no evidence that, for most subjects, having Herpes had influenced the way in which they saw themselves, their ability to relate to others in intimate situations or their feelings of attractiveness" (p. 385). The researchers concluded that, given time, people who have contracted HSV have experienced few long-term psychological issues, are as sexually active as previous to diagnosis and on the whole disclose their status to their partners. Of note, and a potential limitation to the study, is that half of the sample was selected from an HSV support service. This portion of the sample was provided with more support than most people who are diagnosed with HSV; it is possible that this type of support – as well as subjects' ability to make use of this support - may have had a positive affect on their ability to adjust to the diagnosis. The high rate of disclosure among this population underlines the importance of conducting further studies looking at partners' reactions, the role of supportive services, and the relationship of HSV sufferers' disclosure to maintenance of normative relationships and positive sense of self, over time.

Conversely, in Youngkin et al's (1998) study of seventy-three women with an active diagnosis of HSV and ninety-seven women with an active diagnosis of HPV from a college women's health center and a community women's health clinic, sixty percent of the women studied said that HSV did interfere with relationships. This study was not longitudinal and the majority of the participants were currently in long-term stable relationships. Further longitudinal study is warranted. This study's findings did not speak to the change in relationship concept over time. The study points to what is called the

“Herpes syndrome, which includes feelings of low self-esteem, isolation, helplessness, depression, shame, guilt denial, anger, anxiety and negative sexual attitudes (Youngkin et al., 1998).” This study also found that young adults with HSV have lower self-esteem and higher rates of psychopathology than is normative for their age group.

Another study (Inhorn, 1986) found similar psychological reactions to stigma associated with HSV. In this study, a self-help group for people with HSV infection was observed over several sessions. Findings included the expression of group participants’ feelings that stigmatization has increased since the 1980s when HSV was deemed the “new scarlet letter” and ad campaigns and scare tactics, influenced by the national response to the AIDS epidemic, were put out through the media. Because HSV was brought to the public’s attention at the same time as AIDS many of the participants felt that it gained a larger stigma than it deserves. HSV status had an effect on participants’ behaviors and relationships in three major ways: they divided their social world into two groups, those with whom they felt it was safe to disclose their status and those who weren’t; they limited sexual partners in order to “avoid disclosure to intimates”; and they joined a support group for people living with HSV. Ebel and Rosenthal (2004) further highlight the stigma attached to HSV, stating that having this illness is viewed as “a mark of shameful behavior and an infection that is restricted to marginal groups” (p. 3). They point to the barriers that this stigma places in efforts to find a vaccine and to work towards prevention of the spread of HSV. Nack’s study (2002) reports several female participants who had recently been diagnosed with HSV received responses that reinforced their feelings of stigmatization. One participant reported that her doctor “pulled back like she was contaminated merchandise” upon HSV diagnosis. Newton and

McCabe (2005) reference Lee and Craft's (2002) study in which one participant reports that her sister-in-law "took bleach and disinfectant and disinfected the bathroom" after she disclosed her HSV status (as cited in Newton & McCabe, 2005, p. 55)

The stigma attached to HSV also has a large impact on some infected individuals' feelings about their ability to be desirable sexual partner and to enjoy physical intimacy (Newton & McCabe, 2008). One 38-year-old female respondent in Newton and McCabe's (2008) study of HSV and HPV sufferers claimed, "I cannot imagine having another sexual relationship. I do not believe anyone would want me. I no longer flirt. When men try to chat me up I am very dismissive. I think to myself if they really knew what I was like they would run a mile" (p. 866). The authors reported that some of the participants had a positive interpretation of their HSV or HPV status, but that the majority reported that having HSV or HPV had in some way restricted their sexuality (Newton & McCabe, 2008).

Genital Herpes (HSV) Disclosure within Intimate Relationships

Other studies have looked at the experience of STI disclosure in intimate relationships – specifically HSV and HPV. Although these are different STIs they are similar in that they are both viral and can shed asymptotically. This means that they will always be with the infected party and the infected party may not know when they are contagious. Studies point to the influence of relationship type on HSV positive individuals' decision to share their HSV status with their non-infected intimate partner.

Newton and McCabe (2008) found that when people receive positive feedback from their intimate partners to disclosure of STI+ status their feelings of stigmatization greatly decrease. One study participant saw her Herpes status as a tool in creating more

authentic relationships and in identifying the true intentions of her partners (Newton & McCabe, 2008). The findings from Newton and McCabe's study (2008) speak to the power of stigma and point to the importance of positive partner responses to STI status disclosure in minimizing the negative psychological impact of stigma on the HSV+ partner.

Findings from studies of HSV disclosure indicate that people who are in long-term relationships are more likely to share their status than those in "casual relationships" (Newton & McCabe, 2008; Wald, Krantz, Selke, Lairson, & Morrow, 2006; Cunningham, Tschann, Gurvey, Fortenberry, & Ellen, 2002). Cunningham et al (2002) found that the stigma attached to HSV status among African American adolescent women created a major barrier in disclosure to health professionals and to getting regular testing. These authors found that a major barrier to HSV+ individuals' disclosure to intimate partners was their fear about non-infected partners' reactions and shame related to their STI status (Cunningham et al., 2002). Other studies have looked at individuals who had disclosed their STI status (Green et al., 2003; Keller et al., 2000). These studies' findings point to the role of feelings regarding the morally correct choice and guilt about placing partner at risk, in participants' decisions to disclose. In the Keller et al (2000) study, participants' level of understanding of the illness had little impact on their decision to disclose; rather, the expectation of a long-term relationship was more closely associated with disclosure. Green et al's (2003) qualitative study of males and females patients in a Herpes clinic yielded similar findings of the association of respondent consideration of HSV + status to being in a "serious relationship," with 22 out of 29 respondents reporting that they would not disclose their HSV status to casual sexual partners. In this study,

most respondents who shared their HSV status were more likely to do so in a “low key” manner; others would leave clues or spontaneously discuss HSV. Twenty-two respondents reported having a positive response from partners while 5 reported their partners as having an adverse response (Green et al., 2003).

In summary, HSV is a predominate health issue within the United States effecting over a quarter of the population. The rates of the spread of HSV are increasing by 30% each year. The stigma attached to STI's in general and HSV in particular create major barriers in preventing the spread of illness.

Partner disclosure within the context of an intimate relationship is one of the key preventative factors in the prevention of spreading HSV. Studies have pointed to the potential for partner disclosure of HSV status to positively effect prevention of the spread of HSV (Wald et al., 2006). Through breaking down the barriers of stigma and shame surrounding STI status, fear and emotional impact of partner disclosure would decrease among those living with HSV and ultimately the rates of HSV would decrease as well. While studies have looked at disclosure of HSV status in intimate relationships, intimate partners' responses to HSV disclosure have received less attention in the literature. Based on what is currently known in the area of stigma and HSV disclosure, a study of partner reactions to disclosure will add to our current understanding of the impact of disclosure on prevention in the area of sexual and reproductive health.

CHAPTER III

METHODOLOGY

This chapter will present the study purpose and design as well as specific recruitment methods implemented by the researcher to achieve the study sample. Data collection methods, areas addressed - including the types of question included in the study survey, both qualitative and quantitative - and a brief summary of the characteristics of the sample will also be provided. The chapter will conclude with a discussion of the methods of data analysis.

Study Design and Sampling

This exploratory descriptive study used mixed methods and was carried out online using SurveyMonkey.com. The purpose of this study was to explore in greater depth the effects of Sexually Transmitted Infection (STI) stigma on intimate relationships by examining the reactions of non-infected intimate partners to their female partner's disclosure of her Herpes Simplex Virus (HSV) positive status. The research question was: what are non-infected partners perceptions, reactions, feelings and attitudes to their female partner's disclosure of HSV positive status? Some sub questions to this topic are: What role does the non-infected partner's gender play in their reactions to female HSV status disclosure? How does relationship type (level of commitment, length of relationship, choices around monogamy) affect intimate partner's response to HSV disclosure? What impact does pre-sex or post-sex disclosure of HSV status have on non-infected intimate partner response? Do non-infected intimate partners' previous concepts

of STI stigma change after intimate partners' disclosure of HSV positive status? How does the female partner's disclosure of positive HSV status impact the sexual choices of the non-infected partner within their relationship? What roles do education, gender, geographic location, religious beliefs, ethnicity and age play in non-infected intimate partners' response to female partners' disclosure of HSV status? How do non-infected partners feelings about HSV positive partner change after disclosure?

During the first two weeks of the recruitment process the researcher received feedback from someone who had received the survey via the snowball sampling process. The individual informed the researcher that she had mistaken the abbreviation for Herpes Simplex Virus (HSV) for Human Immunodeficiency Virus (HIV) and was concerned that others may be confused by this terminology. Because of this, only the term "Herpes" was used for the remainder of the recruitment effort.

The researcher chose an on-line mixed methods survey design to allow full anonymity for the participants involved. Given the stigmatized nature of STI disclosure and intimate relationships, it was anticipated that people would be more willing to participate in the study if it was completely anonymous and would be more comfortable being authentic in their responses when filling out an online survey as opposed to personal interviews. It was also felt that the use of an online survey would minimize the possibility of researcher bias influencing participants' responses as might occur in in-person interviews. These advantages of the on-line survey design were felt to outweigh any potential limitations in the sample posed by the necessity of having a computer in order to access the survey. Due to the intimate nature of this study, a qualitative component was added to this predominantly quantitative study to permit participants the

opportunity to express any additional feelings, thoughts, perceptions or reactions to the partners HSV positive disclosure.

Recruitment Methods

The largest number of participants meeting the inclusion criteria for the study was recruited through snowball sampling. Inclusion criteria required that participants were over the age of 18; and had been in an intimate relationship with a female who had disclosed her HSV+ status at some point in their lives, including present relationships. For the purposes of this study, “intimate relationship” specifically referred to physical intimacy and/or the anticipation that this relationship will/would include this level of intimacy. Those who did not meet these criteria were excluded from participation in the study.

E-mails (Appendix C) were sent to a list serve consisting of one hundred sixty five family members, colleagues and friends previously known to the researcher, informing them of the study. The demographic make up of this initial rung of the snowball sampling consisted of predominantly Caucasian/White, college educated, individuals between the ages of 24 and 60, including a number of people who were involved in the field of social work. The e-mail contained an attachment to the recruitment flyer (Appendix E) which included a hyperlink to the study survey (Appendix B), the study survey included the Informed Consent (Appendix D). Individuals on the list serve receiving this e-mail were requested not to take the survey themselves but to forward the recruitment flyer and survey link to people that they knew that were not included in the list serve. The largest group of participants (35) was recruited in this manner and all responded within the initial month of recruitment efforts.

Once participants followed the link to the survey they arrived at a page introducing the researcher, explaining participant anonymity, and informing potential participants that by following the link to the survey and completing and returning the survey they were confirming their willingness to participate (see Appendix D).

In addition to the snowball method, recruitment efforts included the creation of a page on both MySpace and Facebook, featuring the survey. Individuals who indicated interest in the content of these pages were “friended” by the researcher. Once the interested individuals agreed to the researcher’s friendship they were given the option to follow the link to the survey (see Appendix E). Their decision to follow this link was not known to the researcher. The researcher requested approximately 20 “friends” through this data collection method and it is not known how many of the people “friended” qualified as participants and went on to complete the survey. The link to the survey was also posted on the researcher’s own Facebook and MySpace pages where the researcher’s “friends” were requested to forward the link to people that they know.

Given the limitations posed by these recruitment methods in terms of yielding a diverse sample, the researcher also reached out to the director of a local non-profit with a focus on access to sexual and reproductive healthcare and education in underserved and minority communities, and received approval to post a link to the survey on their website. Unfortunately, this additional recruitment effort did not yield an increase either in participation or diversity among the final sample, as had been hoped. The researcher also contacted two well-established national non-profit organizations focusing on access, education, and advocacy in the area of sexual health in order to explore the option of

posting a link to this survey on their websites, but did not receive responses to these requests.

Following the first month of recruitment, the survey link continued to be posted on Facebook and MySpace and e-mails to the first rung of the snowball were re-sent, asking for their continued help with recruitment. Additionally, a flyer and survey link was posted on three different online Herpes bulletin boards and two Men's Health Websites. These postings also did not yield increased participation. Finally, two months into the recruitment process, 45 flyers with pull tabs providing the survey link were posted at campus centers, coffee shops, and bulletin boards on or near three local university campuses and one local community college campus. In addition the researcher obtained the names and e-mail addresses of the administrators of the LGBTQ, Volunteer and Women's Health Centers at two of the local universities and contacted these individuals, requesting that the survey flyer and link be posted to organizational list serves, as appropriate. The campus outreach recruitment methods yielded an additional 8 participants.

The researcher also contacted the director of a local non-profit youth health outreach and education organization, requesting that youth that attended the drop in hours and were over the age of 18 be provided a link to the survey. The director informed the researcher that she would want the researcher to give a presentation to the youth at the organization before they looked to see if they fit the criteria. The researcher felt that this would compromise the anonymity of the participants. The director agreed and sent the flyer and survey link on to her staff and network. This method also did not yield any additional participants.

Data Collection

Since this study utilized online survey methods, the participants completed the survey from their home, school or work computer at their convenience. The survey was taken online via a link provided to the instrument located at SurveyMonkey.com and it consisted of a mix between close-ended multiple-choice questions, a series of close-ended Likert scale questions and open-ended qualitative questions. Estimated time needed to complete the survey varied with each participant but it could have been completed between 15 to 30 minutes.

Upon beginning the survey, participants were asked to provide some basic demographic information including their level of education, age, geographic location, ethnicity, religion, and gender. The study also included close-ended quantitative multiple choice questions addressing relationship status, tools for seeking out information about HSV, relationship type, relationship length, age at time of disclosure, timing of disclosure and whether or not the participant chose to continue the physical relationship with his/her partner after HSV + disclosure. There were also a series of Likert scale questions that addressed the participants' responses, reactions, feelings and perceptions of their intimate partners' disclosure of HSV + status. There were three qualitative questions included; one that asked the participant to elaborate on his/her emotional response to his/her partner's HSV + disclosure, one that asked the participant to share any other thoughts, perceptions, feelings or attitudes that they had to his/her partner's HSV + disclosure and one that asked whether or not the participant sought out help from a mental health professional and, if so, what type of mental health professional.

Protection and Risks

A potential risk of participation was that participants may have felt exposed given the sensitive and personal subject matter of this study. That being said, the survey was designed in a sensitive and thoughtful manner as to limit the level of exposure that participants experienced. The researcher offered a list of referrals to those participants who may have felt exposed or in need of additional support or information surrounding Sexually Transmitted Infection.

Conducting this survey over the Internet guaranteed anonymity of respondents and also eliminated any stress a participant might have had about being identified as a respondent. This study was conducted strictly online via SurveyMonkey.com. The website used encrypted software designed to protect the identity of the participants and each participant remained completely anonymous with no answers able to be traced back to the individual respondent. SurveyMonkey.com disposed of the contact information of the participants and they were be protected by SurveyMonkey.com's encrypted software.

This was a two-step process. Participants were first offered a consent opportunity at the beginning of the survey (see Appendix D), and were asked to acknowledge consent or refusal to participate in the survey by answering "yes" to the question at the bottom of the letter requesting willingness to participate in the study. If they chose to participate, they then went on to the first question of the survey. If they declined to participate, they were automatically taken to the end of the survey, where they were thanked for their interest in the survey.

The researcher and thesis advisor had access to the data collected, however, the identities of the participants are not known.

Sample Characteristics

Over 300 people viewed the survey but only 43 completed the majority of the survey. Upon review, three of the participants either did not meet the study eligibility criteria, or did not complete the survey, leaving a final N of 40.

The sample was predominantly male (N=30 or 75%). One of the participants who identified as female also identified as transgendered, and one participant identified as “non-conforming.” The sample (N=40) ranged in age from 23-60 with a mean age of 31. The ethnic make up of the participants was predominantly Caucasian/White (N=35 or 87.5%); Two participants were Latino(a) (5%), one participant was Asian/Pacific Islander (2.5%), and one participants was African American/Black (2.5%). Two participants who chose the “other” option self-identified as “human” and “Italian/Redneck.” Sample characteristics will be described in greater detail in the following chapter.

Data Analysis

The data collected was downloaded from SurveyMonkey.com and emailed as a spreadsheet to a statistical analyst at Smith School for Social Work who imported the data into an SPSS program to run statistical analyses. The analyst reviewed the participants’ responses to the quantitative portion of the survey, created a set of frequencies describing the participants’ responses, ran T-Tests, Cross Tabulations, Chi-Square Tests, and created a “Disclosure Response Scale” from the five Likert scale questions chosen by the researcher that specifically measured participant response to Herpes disclosure.

Descriptive analysis defined by Anastas (1999) as “a means for summarizing, and therefore condensing and simplifying, the information provided by a set of numbers,” (p.

433) was used in analyzing the following demographic information: age, race/ethnicity, gender, level of education, religious preference, geographic location. In addition, frequencies were also provided for relationship type, point of HSV + disclosure in physical intimacy, length of relationship at time of HSV + disclosure, age at time of disclosure and the scores on a series of Likert scale questions that addressed participants' perceptions, reactions, feelings and thoughts about their female partners' disclosure of her HSV + status.

Cross tabulation analysis was carried out to look for possible association between the following variables: demographic variable (gender) and relationship (relationship type and timing of disclosure in physical relationship) with participant response to the question: "Did you continue your physical relationship with female partner after HSV + disclosure?." Cross Tabulations were run to determine what relationship existed between demographic variables (race/ethnicity, religion, level of education, geographic location, age at time of disclosure) and response to the question: "Did you continue a physical relationship with your female intimate partner after HSV + disclosure?." Chi square analysis revealed insufficient cell frequencies for statistical analysis. A T-Test was run to test the differences between those who answered yes, from those who answered, no to the question: "Did you continue a physical relationship with your female intimate partner after HSV + disclosure?" by mean age. A T-test is "a statistical test to determine if two groups are significantly different from one another" (Simon, 2005). It was hypothesized that those who chose to stop physical intimacy would be older than those who chose to continue. No significant difference was found.

Five Likert scale questions, created by the researcher, were found to have strong internal reliability (Cronbach's Alpha - .712). The participants' scores on the five question scale represented the individual participant response to their female partner's HSV + disclosure. These were divided into two groups those whose responses were "more negative" and those who were "more positive." Because each of the five questions were scored on a 1-5 scale; the responses were measured by a means and that also fell on a 1 to 5 scale. "More negative" was then defined as those with a mean score of <3, and "more positive" was defined as between 3 and 5. Cross tabulations were carried out to determine possible associations between participant scores, and gender, geographic location, level of education, age at time of disclosure, relationship type and timing of disclosure in physical relationship. Chi square analysis revealed insufficient cell frequencies for statistical analysis of the variables geographic location, level of education and age at time of disclosure. Gender, relationship type, and disclosure timing and their relationship to disclosure response are the focal points of the findings and discussion chapters.

Finally, qualitative analysis of responses to two open-ended questions was carried out to uncover potential themes in participant reports of emotional responses to their partners' disclosure, and any additional information that the participants' chose to share. Qualitative data was then organized into categories based on the themes and patterns presented.

CHAPTER IV

FINDINGS

The purpose of this study is to explore in greater depth the effects of STI stigma on intimate relationships by examining the reactions of non-infected intimate partners to their female partner's disclosure of her HSV positive status. This mixed methods study was carried out via an anonymous online survey. This was a predominantly quantitative study with some qualitative components.

This chapter begins with a description of the demographic characteristics of the sample and moves on to describe the sample in terms of: relationship type, disclosure timing in physical relationship, age at time of disclosure, and length of relationship at time of disclosure. The participants' responses to a series of Likert scale questions that address participants' perceptions, reactions, feelings and attitudes of participants to their female partners disclosure of Herpes + status will be presented descriptively. The researcher will then present findings from the qualitative analysis of responses to open-ended questions, including the salient themes that emerged from this analysis.

The questions examined in this study include; what are non-infected partners perceptions, reactions, feelings and attitudes to their female partner's disclosure of HSV positive status? What role does the non-infected partner's gender play in their reactions to female HSV status disclosure? How does relationship type (level of commitment, length of relationship, choices around monogamy) affect intimate partner's response to HSV disclosure? What impact does pre-sex or post-sex disclosure of HSV status have on non-

infected intimate partner response? Do non-infected intimate partners' previous concepts of STI stigma change after intimate partners' disclosure of HSV positive status? How does the female partner's disclosure of positive HSV status impact the sexual choices of the non-infected partner within their relationship? What roles do education, gender, geographic location, religious beliefs, ethnicity and age play in non-infected intimate partners' response to female partners' disclosure of HSV status? How do non-infected partners feelings about HSV positive partner change after disclosure?

While a total of 43 individuals responded to the survey, three of these completed the six demographic questions only, including: age, gender, race/ethnicity, religious preference, geographic location, and education. The remaining questions were answered by a smaller portion of the sample, ranging from 37 to 42 participants for the close-ended survey questions, and 19 to 33 for the open-ended questions. Since the researcher was unable to learn which of the 43 respondents answered all or most of the questions, tables illustrating demographic characteristics reflect a total N of 43, while remaining table totals reflect the fewer number of participants who answered a majority of the questions. In some tables, a response of "Other" to multiple-choice questions has been removed from the analysis.

Demographics of Participants

Of the 43 participants who met the inclusion criteria there was a range in age from 23-60 with a mean age of 30.7. The ethnic make up of the sample was predominantly Caucasian/White (N=37, or 86%), but also included two Latino(a) (4.7%), one Asian/Pacific Islander (2.3%), one African American/Black (2.3%) and two participants

(4.7%) who chose the “other” option and self-identified as “human” and “Italian/Redneck.”

Participants’ race/ethnicity is represented in Table 1 below. Those who chose the “other” option were not included in Table 1.

Table 1

Race/Ethnicity

Race/Ethnicity	Frequency	Valid %
African American/Black	1	2.3%
Caucasian/White	37	86.0%
Latino(a)	2	4.7%
Asian/Pacific Islander	1	2.3%
“Other”	2	4.7
Total	43	100.0%

Thirty (69.8%), of the participants were male followed by 11 (25.6%) female, one (2.3%) participant who identified as transgender, and one participant (2.3%) who chose the “other” option and self-identified as “gender non-conforming.”

Gender of participants is represented in Table 2 below.

Table 2

Gender

Gender	Frequency	Valid %
Female	11	25.6%
Male	30	69.8%
Transgender	1	2.3%
“Other”	1	2.3%
Total	43	100.0%

In response to the multiple choice question: “Which of the following best describes your racial or ethnic background?” the majority, 23, of the participants (53.5%)

identified as “having personal spiritual beliefs that are independent of organized religion,” followed by nine participants (20.9%) “Having no religion or religious preference,” five participants (11.6%) identified as Jewish, four participants (9.3%) as Protestant and two participants (4.7%) as Catholic.

Religious preferences of the participants are represented in Table 3 below.

Table 3

Religious Preference

Religious Preference	Frequency	Valid %
Protestant	4	9.3%
Catholic	2	4.7%
Jewish	5	11.6%
No Religion	9	20.9%
Independent Spiritual Belief	23	53.3%
Total	43	100.0%

As illustrated in Table 4, below, twenty-seven (62.8%) of the participants currently live in urban settings, eleven (25.6%) are currently living in a suburban environment, and 5 (11.6%) are currently living in a rural environment.

Table 4

Geographic Location

Geographic Location	Frequency	Valid %
Urban	27	62.8%
Suburban	11	25.6%
Rural	5	11.6%
Total	43	100.0%

The majority of the participants (N=28, or 65.1%), had graduated from a four year college, nine of the participants (20.9%) had their Masters degrees, four (9.3%) had attended “some college,” one participant (2.3%) had completed a two-year college program and one participant (2.3%) had received a Doctoral level education.

Level of education of the participants is represented on the following page in

Table 5.

Table 5

Level of Education

Level of Education	Frequency	Valid %
Some college	4	9.3%
2 year college	1	2.3%
4 year degree	28	65.1%
Masters degree	9	20.9%
Doctoral degree	1	2.3%
Total	43	100.0%

Relationship Type

Participants provided the following multiple-choice responses to a question asking them to define the type of relationship in which they were involved: “Casually dating,” “Open relationship,” “Monogamous relationship,” “Seriously dating,” “Engaged,” or “Married.” The majority (N=17 or 40.7%), responded that they were “casually dating,” followed by nine participants (21.3%) who defined their relationship as “monogamous,” six (14.3%) referred to their relationships as “open,” five (11.9%) as “seriously dating” and one (2.3%) as “married.” Three of the four participants (9.5%) who chose the “other” option defined their relationship as: “friends with benefits,” “friends,”; the fourth participant explained that his partner lived “on the west coast with a boyfriend, I live in the Midwest, we do love each other, but are not currently with each other.”

Relationship type of the participants is represented in Table 6 on the following page.

Table 6

Relationship type

Relationship type	Frequency	Valid %
Casually dating	17	40.7%
Open relationship	6	14.3%
Monogamous	9	21.3%
Seriously dating	5	11.9%
Married	1	2.3%
“Other”	4	9.5%
Total	42	100.0%

Timing of Disclosure in Physical Relationship and Relationship Length at Time of Disclosure

The researcher was interested in learning about the timing of disclosure. The researcher postulated that the timing of disclosure in the physical relationship would have an impact on partner response and worked under the assumption that partners’ responses being “more positive” or “more negative” would be contingent upon the timing of disclosure in physical relationship. The researcher hoped to show that by disclosing her HSV + status prior to sexual intercourse the non-infected intimate partner would receive a more positive reaction and that her HSV+ status would not necessarily end physical intimacy. The multiple choice question presented was “At what point in your physical relationship did your female partner disclose her Herpes + status?” The possible responses included: “Before physical intimacy,” “Before intercourse but after physical intimacy,” “During physical intimacy/intercourse,” and “After intercourse.”

The majority of participants reported that their partners had disclosed their Herpes positive status prior to intercourse. The total number of participants whose partners disclosed their HSV + status prior to intercourse was 28 (70%). This group included

those whose HSV+ partners disclosed their HSV + status before physical intimacy (N=15 or 36.6%) and those whose HSV+ partners disclosed after physical intimacy but prior to intercourse (N=13 or 31.7%). Two (4.9%) of the participants’ partners disclosed their Herpes status “during physical intimacy/ intercourse” while ten (24.4%) of the participants’ partners disclosed after intercourse. One of the participants (2.4%) chose the “other” option for this question. This participant reported, “she was infected after the last time that we were intimate.”

Disclosure timing of female partners HSV+ status in the physical relationship is illustrated in Table 7 below.

Table 7

Disclosure timing in physical relationship

Disclosure timing in physical relationship	Frequency	Valid %
Before physical intimacy	15	36.6%
Before intercourse but after physical intimacy	13	31.7%
During phys intimacy/intercourse	2	4.9%
After intercourse	10	24.4%
“Other”	1	2.4%
Total	41	100.0%

Length of relationship at time of disclosure

Participants were asked to provide an answer in the form of number of weeks, months, or years to the question: “How long had you been with your female partner before she disclosed her Herpes + status?” The length of the individual participants’ relationships with his/her HSV + partners at time of disclosure ranged from “a few hours” (a response that had been added by a participant to the choices provided) to two years, with the majority of the participants (26) reporting that their partner had disclosed their

HSV+ status within the first six weeks of their relationships. Eight of the participants reported that they had been with their partners from 2 to 8 months at the time of disclosure and six of the participants reported having been with their partners from 1 to 2 years at the time of HSV + disclosure.

Age at Time of Disclosure

The majority of the participants (N=26 or 65%) were between the ages of 23-29 at the time of their partner’s disclosure of her HSV + status. Nine participants (22.5%) were between age 16 and 22 at the time of their partner’s disclosure. Two (5%) of the participants were between age 30 and 35, one participant (2.5%) was between age 36 and 40 and, finally, two participants (5%) were between age 46 and 50.

Table 8 represents the age of the participants at time of female partners’ HSV+ disclosure.

Table 8

Age at time of disclosure

Age at time of disclosure	Frequency	Valid %
16-22	9	22.5%
23-29	26	65.0%
30-35	2	5.0%
36-40	1	2.5%
46-50	2	5.0%
Total	40	100.0%

Choice to Continue Physical Relationship with HSV+ Partner

When asked if the participant chose to continue a physical relationship with his/her partner after partner’s HSV + disclosure, 35 (87.5%) of the respondents replied “yes” while the remaining five participants (12.5%) chose the “no” option. Because the majority of the participants answered “yes” to this question the researcher was interested

to learn more about the characteristics of the group who answered “no” and whether any trends would emerge from an analysis of the differences between these groups. A T-Test was run to look for trends in age. The results were unremarkable, showing a mean age of 30 for participants who responded “yes” and a mean age of 32 for those who responded “no.” Further analysis was carried out to look for possible associations between responses to this question and other variables such as gender, relationship type, and timing of disclosure. Statistical analysis was limited by the size of the cells; however, crosstabulations revealed differences by gender and relationship type between those who answered “yes” and those who answered “no” to the question regarding continuing a physical relationship after disclosure.

Table 9 illustrates the gender of the participants who answered “yes” or “no” to the question “Did you continue your physical relationship with female intimate partner after her disclosure of Herpes+ status?” It is noteworthy that none of the female participants chose to cease physical intimacy; this finding is discussed in greater detail in the following chapter. This analysis did not include the two participants who listed gender as “transgender” and “other.” Table 9 is presented on the following page.

Table 9

Gender by Decision to continue physical relationship

		Decision to continue physical relationship		
Gender		Yes	No	Total
Male		N= 24	N=5	N=29
	% within gender	82.8%	17.25%	100.0%
	% within choice to continue phys relationship	72.2%	100.0%	76.3%
Female		N=9	0	9
	% within gender	100.0%	.0%	100.0%
	% within choice to continue phys relationship	27.3%	.0%	23.7%
Total		33	5	38
	% within gender	86.8%	13.2%	100.0%
	% within choice to continue phys relationship	100.0%	100.0%	100.0%

The researcher hypothesized that “relationship type” would be related in some way to the choice to continue a physical relationship; of interest in relation to this hypothesis is the finding, as illustrated in Table 10, below, that the “monogamous/married” sub-group was the only relationship type in which none of its members chose to end physical intimacy. These findings will be discussed in greater detail in the following chapter. Analysis revealed that two of the participants who answered “no” to this question referred to their relationship as “casually dating,” one as an “open relationship” and the other as “seriously dating.” The remaining participant did not answer this question. This analysis did not include the three participants who listed their relationship type as “other.”

Table 10 shows a cross tabulation of relationship type to participant response to the question “Did you continue your physical relationship with your female intimate

partner after she disclosed her Herpes + status?” One individual did not indicate relationship type.

Table 10

Relationship type by Decision to continue physical relationship

Relationship type Count		Decision to continue physical relationship		Total
		Yes	No	
Casually dating		N= 15	N=2	N=17
	% within relationship type	88.2%	11.8%	100.0%
	% within choice to continue phys relationship	45.5%	50.0%	45.9%
Open relationship		N=5	N=1	N=6
	% within relationship type	83.3%	16.7%	100.0%
	% within choice to continue phys relationship	15.2%	25.0%	16.2%
Monogamous/Married		N=9	N=0	N=9
	% within relationship type	100.0%	0.0%	100.0%
	% within choice to continue phys relationship	27.3%	0.0%	24.3%
Seriously dating		N=4	N=1	N=5
	% within relationship type	80.0%	20.0%	100.0%
	% within choice to continue phys relationship	12.1%	25.0%	13.5%
Total		N=33	N=4	N=37
	% within relationship type	89.2%	10.8%	100.0%
	% within choice to continue phys relationship	100.0%	100.0%	100.0%

Two of the four participants who answered “no,” had been informed of their HSV + partner’s status “before intercourse, but after physical intimacy” and three had been disclosed to “after intercourse.”

Table 11 illustrates the relationship between disclosure timing within physical relationship and the participant's decision to continue with physical relationship.

Table 11

Disclosure timing in physical relationship by Decision to continue physical relationship

		Decision to continue physical relationship		Total
		Yes	No	
Disclosure timing in physical relationship				
Before physical intimacy		N= 15	N=0	N=15
	% within disclosure timing	100.0%	0.0%	100.0%
	% within choice to continue phys relationship	49.2%	0.0%	37.5%
After physical intimacy, but before intercourse		N=11	N=2	N=13
	% within disclosure timing	84.6%	15.4%	100.0%
	% within choice to continue phys relationship	31.4%	40.0%	32.5%
During physical intimacy/intercourse		N=2	N=0	N=2
	% within disclosure timing	100.0%	0.0%	100.0%
	% within choice to continue phys relationship	5.7%	0.0%	5.0%
After Intercourse		N=7	N=3	N=10
	% within disclosure timing	70.0%	30.0%	100.0%
	% within choice to continue phys relationship	20.0%	60.0%	25.0%
Total		N=35	N=5	N=40
	% within disclosure timing	87.5%	12.5%	100.0%
	% within choice to continue phys relationship	100.0%	100.0%	100.0%

Responses to Likert Scale Questions Addressing Perceptions, Reactions, Feelings and Attitudes of Participants to their HSV + Partners

Participants were asked to respond to five Likert form, 5-point, strongly disagree to strongly agree statements addressing the following possible responses to partner disclosure: absence of negative effects on attraction to partner; admiration of partner for sharing; having an image of partner as trustworthy; absence of negative emotional response; and increased closeness.

These five questions were found to have strong internal reliability (Cronbach's $\alpha=.712$) and a 5-item scale was created to yield a composite score indicating positive attitudes or negative attitudes. Responses were placed into "more positive" or "more negative" groupings based on participant score on the "Disclosure Response Scale". "More negative" was defined as a mean score of <3 , and "more positive" was defined as a mean score of 3 to 5. The participants were then divided into categories "those who responded more positively to disclosure" and "those who responded more negatively to disclosure" based on their score. The responses to each of the items on the scale will first be described individually, followed by an analysis of associations between responses to the 5-item scale and selected variables of interest.

The first item posed the statement, "Upon learning that my partner had Herpes I found her less attractive and appealing." The majority of the participants (N=16 or 39%) responded "strongly disagree" to this statement. This was followed by nine participants (22%) who "disagreed," Seven (17.1%) who had "no reaction" and nine (22%) who responded with "agree." None of the participants chose the "strongly agree" option. In analyzing this data "strongly disagree," "disagree" and "no reaction" were grouped as

more “positive” responses while “agree” and “strongly agree” were seen as more “negative” responses. That created a total of 32 (78.1%) of participants responding to this statement in a “positive” manner compared with nine (22%) who responded more “negatively.”

The majority of the participants (N=20 or 50%) chose the “strongly agree” option when responding to the second Likert form question which posed the statement, “I admired my partner for sharing her Herpes status.” This was followed by 16 participants (40%) who responded with “agree,” two (5%) who had “no reaction” and two (5%) who “disagree.” The responses to this statement were grouped so that “strongly agree,” “agree,” and “no reaction” were seen as more “positive” while “disagree” and “strongly disagree” were seen as more “negative.” This left a total of 95% (N=38) of the participants who responded “positively” to this statement while 5% (N=2) responded “negatively.”

The third Likert form question posed the statement, “After my partner shared her Herpes positive status my perception of her as a trustworthy person decreased.” The majority of the participants (N=19 or 47.5%) responded to this statement with “strongly disagree,” followed by nine participants (22.5%) responded with “disagree,” three participants (7.5%) responded with “no reaction.” Six participants (15%) responded with “agree” and three participants (7.5%) responded with “strongly agree.” “Strongly disagree,” “disagree,” and “no reaction” were grouped as “positive” responses to this statement while “agree” and “strongly agree” were seen as “negative.” This left a total of 31 participants (77.5%) having a more “positive” response while nine participants (22.5%) had a more “negative” response.

The statement, “After my partner shared her Herpes + status I had a strong negative emotional response” was posed in the fourth Likert form question. The majority of participants (N=20 or 50%) responded to the above statement with “disagree;” followed by six participants (15%) who chose the “strongly disagree” option, six (15%) who responded with “no reaction.” Five (12.5%) of the participants responded with the “agree” option and three (7.5%) with “strongly agree.” According to the grouping of “strongly disagree,” “disagree” and “no response” as “positive” responses and “agree” and “strongly agree” as “negative” responses, 80% (32 participants) responded “positively” while 20% (N=8) responded “negatively.”

The fifth Likert form question posed the statement, “After my partner shared her Herpes + status with me we became closer.” The majority of the participants (N=15 or 37.5%) chose the “no reaction” option, followed by 14 participants (35%) who chose the “agree” option. Six participants (15%) chose “disagree,” three (7.5%) who chose “strongly disagree” and two (5%) who chose the “strongly agree” option. The limitation of this statement is that it does not specify that the relationship becoming closer was directly related to the intimate partners Herpes + disclosure. The grouping for this statement placed “strongly agree,” “agree” and “no reaction” as “positive” while “disagree” and “strongly disagree” were grouped as “negative,” leaving 31 participants (77.5%) having a more “positive” response and nine participants (22.5%) having a more “negative” response.

Once the individual participants responses to the above 5 statements were measured as “more positive” (mean=3-5) or “more negative” (mean=<3) they were then

analyzed to in order to look at the trends in relationship type, gender and timing of disclosure.

Analysis of differences between those with higher and lower scores on the “Disclosure response scale” based on age at time of disclosure, geographic location, race/ethnicity, level of education and religious beliefs could not be carried out due to the restricted variance in response. However, crosstabulations of participant score ratings by relationship type, gender, and timing of disclosure revealed that those in “more committed” relationships (Monogamous/Married or Seriously dating) were more likely to have a “more negative” response to their partner’s HSV+ disclosure than those who were in “less committed” relationships (Casually dating or Open relationship). The findings also revealed that gender does not play a major role in emotional response to partner HSV+ disclosure. Furthermore, findings indicate that timing of disclosure within physical relationship plays a part in non-infected partners’ emotional response to HSV+ disclosure; those who are disclosed to after intercourse are more likely to have a negative emotional response than those disclosed to prior to intercourse.

Table 12 illustrates a cross tabulation of “Relationship type” by “Disclosure response scale score.” The table on the following page does not include the four participants who listed their relationship type as “Other.”

Table 12

Relationship type by Emotional response to intimate partner HSV + disclosure

		Emotional response to intimate partner HSV+ disclosure		
Relationship type		More negative (mean=<3)	More Positive (mean=3-5)	Total
Count				
Casually dating		N= 2	N=15	N=17
	% within relationship type	11.8%	88.2%	100.0%
	% within emotional response to disclosure	28.6%	48.4%	44.7%
Open relationship		N=0	N=6	N=6
	% within relationship type	0.0%	100.0% %	100.0%
	% within emotional response to disclosure	0.0%	19.4%	15.8%
Monogamous/Married		N=3	N=7	N=10
	% within relationship type	30.0%	70.0%	100.0%
	% within emotional response to disclosure	42.9%	22.6%	26.3%
Seriously dating		N=2	N=3	N=5
	% within relationship type	40.0%	60.0%	100.0%
	% within emotional response to disclosure	28.6%	9.7%	13.2%
Total		N=7	N=31	N=38
	% within relationship type	18.4%	81.6%	100.0%
	% within emotional response to disclosure	100.0%	100.0%	100.0%

Table 13 illustrates a crosstabulation of “Relationship type” by gender. The table on the following page does not include the two participants who identified gender as “transgender” and “gender non-conforming.”

Table 13

Gender by Emotional response to HSV+ disclosure

		Emotional response to HSV+ disclosure		
Gender		More negative (mean=<3)	More positive (mean=1-5)	Total
Male		N= 6	N=24	N=29
	% within gender	20.0%	80.0%	100.0%
	% within emotional response to disclosure	75.0%	77.4%	76.9%
Female		N=2	N=7	N=9
	% within gender	22.2%	77.8%	100.0%
	% within emotional response to disclosure	25.0%	22.6%	23.1%
Total		N=8	N=31	N=39
	% within gender	20.5%	79.5%	100.0%
	% within emotional response to disclosure	100.0%	100.0%	100.0%

Findings for timing of HSV + disclosure within physical relationships and its relationship to participants' response to the "Disclosure response scale" are shown in Table 14 on the following page.

Table 14

Timing of disclosure in physical relationship by Emotional response to HSV+ disclosure

		Decision to continue physical relationship		
Disclosure timing in physical relationship		More negative (mean=<3)	More positive (mean=1-5)	Total
Before physical intimacy		N= 2	N=13	N=15
	% within disclosure timing	13.3%	86.7% %	100.0%
	% within emotional response to disclosure	225.0%	40.6% %	37.5%
After physical intimacy, but before intercourse		N=1	N=12	N=13
	% within disclosure timing	7.7%	92.3%	100.0%
	% within emotional response to disclosure	12.5%	37.5%	32.5%
During physical intimacy/intercourse		N=0	N=2	N=2
	% within disclosure timing	0.0%	100.0%	100.0%
	% within emotional response to disclosure	0.0%	6.3%	5.0%
After Intercourse		N=5	N=5	N=10
	% within disclosure timing	50.0%	50.0%	100.0%
	% within emotional response to disclosure	62.5%	15.6%	25.0%
Total		N=8	N=32	N=40
	% within disclosure timing	20.0%	80.0%	100.0%
	% within emotional response to disclosure	100.0%	100.0%	100.0%

Participants' Desire and Methods for Seeking out Information after Partner's HSV + Disclosure

Three additional Likert form 5-point strongly disagree to strongly agree questions asked participants to indicate their level of agreement with statements characterizing participant information-seeking behavior, safe sex practices, and attitudes about sexual

intimacy with individuals with STI's. Two of these questions provided follow-up multiple choice and open-ended options for individuals to expand on their response. A total of 41 participants responded to all of these questions.

The majority (N=37, or 90.3%) of participants indicated some level of agreement to the statement "After my partner shared her Herpes status I was driven to seek out information about the illness." Twenty participants (48.8%) indicated that they "strongly agreed," followed by 17 participants (41.5%) who "agreed," two participants (4.9%) had "no response" and two participants (4.9%) "disagreed." Only four participants (9.7%) were not driven to seek out information about the illness.

In response to the follow-up multiple-choice question asking where information was sought, 35 participants indicated that they found this information online, 14 participants gathered information from physicians, 15 gathered information from friends, seven from family members and only one from a mental health professional. Five of the participants chose the "other" options. Two of these participants reported that they gathered information from their HSV + partner, two from some form of literature and one from Planned Parenthood.

The majority of participants (34, or 82.9%) indicated some level of agreement with the statement, "After my partner shared her Herpes status I became more aware of practicing safe sex in current and future relationships." Ten participants (24.4%) indicated that they "strongly agreed," 24 participants (58.5%) reported that they "agreed," three participants (7.3%) had "no reaction" while four (9.8%) "disagreed."

When presented with the statement "My partner sharing her Herpes status changed my attitudes about having sex with a person who has a Sexually Transmitted

Illness;" five of the participants (12.2%) indicated that they "strongly agreed," 21 (51.2%) of the participants chose the "agree" option, followed by eight (19.5%) who had "no reaction," seven (17.1%) who "disagreed" and five (12.2%) who "strongly agreed." While this statement lacked clarity in that it did not identify *how*, or *in what direction* the participant's attitudes changed, the findings nevertheless represent a trend similar to that shown in the majority of participants' responses regarding interest in and methods of seeking out information, as well as attitudes to their female partners' HSV+ disclosure.

When asked if the participants spoke to a mental health professional about their partner's disclosure only three participants responded that they spoke to a counselor about this issue and one reported that he/she would like to speak to a mental health professional about this issue in the future. The remainder of the participants (N=36) either did not respond to this question or indicated that they did not seek out the support of a mental health professional.

Qualitative Data Analysis

There were two qualitative questions posed in the study. One addressed the emotional responses of the participants to their female partners' disclosure of her HSV + status. The other allowed the participants to share any additional information about their perceptions, reaction, feelings or attitudes towards their intimate female partner's HSV + status. Thirty-three (82.5%) of the participants responded to the first question and 19 (47.5%) responded to the final question.

Emotional Response

There were two overarching themes that emerged from the responses of the 33 participants who replied to the statement: "In your own words please describe your

emotional response below.” These two themes were fear of the illness and trust and sympathy for the partner who disclosed her HSV+ status. The majority of the responses were combined (i.e., demonstrating both fear and support) although some indicated mainly or exclusively one or the other. Responses fell into several categories, including: fear of illness (N=10); increased trust of partner (N=5) ; feelings of betrayal/anger (N=6); feeling that their partner was “worth it” (N=5); love/respect (N=5); sympathy/support(N=7); feeling worried/cautious both for themselves and their partners (N=7); appreciative of partner (N=6); and being driven to seek out information (N=5). Many of the participants experienced a number of these feelings at once for example one participant reported, “I was a bit afraid, but I trusted her and felt it was worth the risk. And it was.”

One participant reported, “I felt cautious. I also felt there was more trust between us than I had originally thought, that made me feel more at ease,” while another reported “I was upset at first but then grew to respect her.” Some of the participants responded with total support of their partner, for example “I was glad she felt comfortable sharing it with me and I was trying to focus on listening and providing support.” A number of the participants spoke about how their love for their partner overshadowed their fear of the illness “we practiced safe sex for a while...emotionally I loved her and it did not bother me.”

Several responses indicated participants’ feelings of anger or betrayal by their partners. These examples were generally coupled with a post-sex disclosure or partner going outside of the relationship. One participant wrote, “In addition to finding out her Herpes status, I realized she went outside the relationship. I was reacting to both the

betrayal and the fear of Herpes.” While another participant responded with “I was devastated and felt extremely betrayed.”

Additional perceptions, reaction, feelings or attitudes

The following themes emerged as salient among the 19 responses to the final question asking if there was any additional information that the participants would like to share on their perceptions, reactions, feelings or attitudes about their female partners’ Herpes + disclosure: gratitude/admiration (N=7), the importance of choice (N=5), information about the illness (N=7), increase awareness of safe sex practices (N=9), HSV+ status did not affect non-infected partner or the relationship (N=6) and STI stigma (N=5).

Many participants expressed gratitude for and respect of their partners for disclosing:

I have now learned how common the virus is, and I think that it takes great self-confidence and courage to speak up about being a carrier of the virus. Being able to accept Herpes as a reality in our lives has brought us closer.

Another example of this emotional expression was: “I was impressed by the courage that my partner showed in sharing this information with me. It did not change my feelings or attitudes towards her whatsoever.” Others spoke to the importance that the choice that was afforded the non-disclosing partner by the HSV+ partner’s decision to disclose played in HSV disclosure “be honest before sex, consider what you might be doing to your partner without given them a choice,” and “It was my right to choose if I continued a physical relationship with her-because it was up to me I found my own comfort level with it.” Some provided information about the illness, “This prompted me to go to the CDC website to read more about the STD” others spoke to the importance of

pre-intercourse disclosure “I was glad she told me, but felt like she should have done it before we touched privates.” Some spoke to an increased awareness of safe sex practices, “We are now married and she manages her outbreaks with medication. We are both very conscious to not put me at risk for contracting the virus.” Some spoke to the lack of impact that their partner’s HSV+ status has had on their relationship, “we dated for nine months after (HSV+ disclosure) with it never creating a problem in our relationship,” and a few addressed the negative impact of STI stigma directly “we have had something going for years now and I still have not contracted it...people need to realize that you are not a “dirty” person for having Herpes” while another participant spoke to the negative stigma attached by stating “I love loose chicks” when referring to his HSV+ partner.

CHAPTER V

DISCUSSION

This chapter will first review the study purpose and research questions. The researcher will then describe the sample characteristics and present the key findings, under the following three headings: emotional response (both quantitative and qualitative findings); gender roles; and information seeking and safe sex practices. This will be followed by a discussion of the study limitations and the implications of this study for the field of social work. The chapter will end with a concluding statement.

Purpose of Study

The purpose of this study was to explore in greater depth the effects of STI stigma on intimate relationships by examining the reactions of non-infected intimate partners to their female partner's disclosure of her HSV positive status. The research question was: what are non-infected partners perceptions, reactions, feelings and attitudes to their female partner's disclosure of HSV positive status? Some sub questions to this topic were: What role does the non-infected partner's gender play in their reactions to female HSV status disclosure? How does non-infected partner's sexual history impact their response to their intimate partners HSV positive status disclosure? How does relationship type (level of commitment, length of relationship, choices around monogamy) affect intimate partner's response to HSV disclosure? What impact does pre-sex or post-sex disclosure of HSV status have on non-infected intimate partner response? Do non-infected intimate partners' previous concepts of STI stigma change after intimate

partners' disclosure of HSV positive status? How does the female partner's disclosure of positive HSV status impact the sexual choices of the non-infected partner within their relationship? What roles do education, gender, geographic location, religious beliefs, ethnicity and age play in non-infected intimate partners' response to female partners' disclosure of HSV status? How do non-infected partners feelings about HSV positive partner change after disclosure?

Sample Characteristics

The sample characteristics for this study were fairly homogeneous. The majority of the participants were Caucasian/White (90.2%), urban (62.8%), college educated or above (88.4%), and did not affiliate with organized religion (74.2%) (Identifying as both "having independent spiritual beliefs" (53.3%) and "having no religious beliefs"(20.9%)). The fact that the majority of the participants were not affiliated with an organized religion may be reflective of this specific demographic, but it also could indicate that people who are less affiliated with organized religion are more inclined to be open about issues surrounding sex and may be less affected by the stigma attached to women's sexual choices. This assumption is based on the idea that religion has had an impact on the moral responsibility that is disproportionately placed on women when it comes to their sexual choices (Bonavoglia, 2000; Smith et al., 2008).

Of interest from the point of view of diversity was the gender representation within this small sample. There were 30 (71.4%) males, 11 females (26.2%), one transgendered person (2.4%) and one person who chose the "other" option and identified as "gender non-conforming." Relationships falling outside of the heterosexual norms

have not been studied in prior research surrounding STI stigma and disclosure. This will be examined further later in this chapter.

Emotional Response: Quantitative Findings

A positive emotional response to female HSV+ disclosure in intimate relationships was far more likely to have occurred among study participants than was a negative response. Participants' responses to a range of questions about the impact of their partner's disclosure were mainly positive, as follows:

- Absence of negative effects on attraction to partner: (78.1%),
- Admiration of partner for sharing (95%)
- Having an image of partner as trustworthy (77.5%)
- Absence of negative emotional response (80%)
- Increased closeness (77.5%).

These positive trends in emotional response to female HSV+ disclosure indicate that STI stigma and stigmatization of women who carry HSV in particular may not be expressed explicitly in partner responses to disclosure within interpersonal relationships. Furthermore, the findings show that the majority of the “more negative” responses come from the participants who were disclosed to after intercourse. This finding is aligned with some of the literature about disclosure according to Green et al (2003) 22 out of 27 respondents reported having a positive response from partners while 5 reported their partners as having an adverse response.

Although not reaching statistical significance, the association of selected variables – specifically, “relationship type” and “timing of disclosure” – with emotional response

to partner disclosure is of interest. The implications of these findings will be discussed in greater detail below.

Relationship Type

When asked to define relationship type at time of HSV+ partner's disclosure the participants were given the following options; "casually dating," "open relationship," "monogamous relationship," "seriously dating," or "married." Of the seven participants who indicated having had a "more negative" response to their partner's disclosure, 71.5% (N=5) were in the three relationship types ("married," "monogamous relationship" and "seriously dating") that reflected a higher level of commitment and/or were more likely to have been on-going for some time at the point of partner disclosure. Those who identified as "casually dating" at time of disclosure made up the remaining 28.5% (N=2) of those having a "more negative" emotional response to their partner's HSV+ disclosure. None of the participants who defined their relationship as "open" were found to have had a "negative" response.

These findings indicate that those who are informed of their partners HSV+ status after already forming a long term relationship may be more likely to have a negative response than those who are in the beginning phases or who are less committed to their partners. These findings also point to the possibility that the disclosure of HSV+ status early in the intimate relationship may be more likely to be well received by the partner than a disclosure that comes later on in the relationship. Finally, the findings suggest that individuals in open relationships may not be as negatively affected by the disclosure of HSV+ status, compared to individuals in other relationship types.

Although those in open relationships were less likely to indicate a negative emotional response to partner disclosure, they were more likely than those in committed relationships to cease physical intimacy with the partner following disclosure. These findings suggest that while a negative emotional impact of HSV+ disclosure may be more likely to occur among those who are in more committed relationships at the time of HSV+ disclosure, this negative response does not generally lead to a termination of physical relationship. Conversely, those who are in more “casual” relationships may be likely to stop physical intimacy regardless of a more “positive” emotional response. These results raise interesting questions about the complexity of the emotional response to STI disclosure in the context of varying relationship types, and the relationship of this combination of factors to a partner’s decision to continue a physical relationship.

The fact that the majority of the participants in this study were disclosed to while in casual/open relationships is in direct opposition to the findings in Green et al’s (2003) qualitative study of males and females patients in a Herpes clinic where he found that 22 out of 29 respondents reported that they would not disclose their HSV status to casual sexual partners (Green et al., 2003). The current study’s finding is hopeful for the reduction in the spread of HSV and the possible decrease in stigmatization. It may be indicative of a greater degree of willingness on the part of HSV + sufferers to disclose to casual partners than previously thought.

Timing of Disclosure

The majority of the participants in this study were disclosed to by their HSV+ partner prior to intercourse. Two of the five participants who chose to cease physical intimacy after their partners’ HSV+ disclosure were disclosed to “before intercourse, but

after physical intimacy” and the remaining three were disclosed to “after intercourse.” None of the respondents who were disclosed to “before physical intimacy” or “during physical intimacy/ intercourse” ended their physical relationships with their HSV+ partners. Those few who were disclosed to “before physical intimacy” who had a negative response to their partner’s disclosure, nevertheless chose to continue a physical relationship. These findings imply that the HSV+ party is more likely to receive a negative response to HSV+ disclosure if she discloses after intercourse, and that a negative response to post-intercourse disclosure is more likely to be accompanied by the intimate partner’s choice to stop physical relationship.

Emotional Response: Qualitative Findings

Those who elected to write responses to the open-ended questions, “What was your emotional response to your female partner’s Herpes+ disclosure?” and “Is there any additional information that you would like to share about your perceptions, reactions, feelings or attitudes to female partners’ Herpes+ disclosure?,” indicated having a mix of reactions; that is, while they were generally supportive and/or understanding toward their partner, they were also fearful or confused by the possible exposure to the illness. The majority of the participants who responded to this question expressed feelings of fear about getting the disease, but admiration and/or appreciation that their partner shared the illness. These findings indicate that, for partners, fears elicited by the stigma associated with STI may be more likely to be applied to the potential health effects of the STI itself rather than to a view of their female partner as a stigmatized person. In other words, based on this study’s findings, it appears that STI stigmatization may elicit fear of the illness but respect and appreciation of the partner for disclosing her HSV+ status.

Findings further indicate that the participants who chose to continue a relationship with their partners and who had more positive responses viewed the illness as a part of life and often felt that the disclosure of the HSV+ status served as a foundation upon which honesty and closeness in the relationship could be built. It seems that those who are disclosed to experience a range of emotional responses to their intimate partner's disclosure and that there is a period of "surprise" and "fear" prior to an understanding and acceptance followed by a level of comfort with the illness.

Study findings point to the possibility of a stronger negative emotional response among those who are disclosed to after their partner has already exposed them to HSV or due to their partner obtaining the illness by engaging in a physical relationship, than among those whose partner gave them the "choice" to continue a physical relationship. A majority of the participants (N=35 or 87.5%) chose to continue a physical relationship with their HSV+ partner after disclosure and of the five who did not, three of them were disclosed to after sexual intercourse. This finding, coupled with the quantitative findings discussed above suggests that, when given the "choice" (i.e., the partner was informed of their partners' Herpes+ status before being exposed to the illness and was therefore able to decide for themselves if they wanted to take the risk of being exposed), intimate partners are likely to choose to continue the relationship regardless of HSV+ status.

Information seeking and safe-sex practices

Partner disclosure within the context of an intimate relationship is one of the key preventative factors in the prevention of spreading HSV. Studies have pointed to the potential for partner disclosure of HSV status to positively effect prevention of the spread of HSV (Wald et al, 2006). The results of this study reinforce the positive impact of

disclosure as a preventative factor in the spread of HSV. The vast majority of study participants (90.3%) were driven to seek out information about HSV after their partner's disclosure and 82.9% of the participants indicated that they became more aware of practicing safe sex in current and future relationships. The majority of the participants indicated that they sought out information on the internet (N=35), followed by 15 who gathered information from friends, 14 from physicians, seven from family members and only one from a mental health professional. Qualitative findings echo the same theme of information-seeking and increased safe-sex practices among participants in this sample. Twelve of the 33 participants who chose to respond to these questions expressed a drive to seek out information or provided insight into their increased awareness around safe sex practices. These findings point to the importance of disclosure in promoting safe sex practices. They also indicate that when individuals seek information about STIs the majority do so via the internet. Given that stigma is seen as the main barrier to STI disclosure and that disclosure plays a major role in a decrease in the spread of STIs, the findings are useful in pointing to the importance of including information about STI stigmatization and tools for partners' to cope with their own fears around STIs on major sexual health websites.

Role of Gender

There have been very few studies that included same-sex relationships in their understanding of STI disclosure in intimate relationships. This study has yielded interesting findings in relation to gender. This study's sample was comprised of 30 (69.6%) males, 11 females (25.8%), one transgendered person (2.3%), and one (2.3%) who identified as "gender nonconforming." While 30% (N=13) of the respondents

identified as other than male, all five of the respondents who chose to end their physical relationship were male. This is an important finding, particularly since the range of negative and positive responses to the “Disclosure Response Scale” was similar for both male and female participants. This finding implies that, while male and female emotional responses to their female partners’ disclosure may be similar in range, females are more likely to continue their physical relationship regardless of emotional response. Potential explanations for this finding, requiring further study, include the possibility that men’s negative emotional response to STI disclosure is more likely to be exhibited through decision-making around physical intimacy; additionally, or alternatively, it may be that women are more driven by physical desire and therefore less likely to cease physical intimacy despite their negative responses to HSV+ disclosure.

Limitations

The main limitation to this study was the small sample size and the limited diversity of this sample in terms of socioeconomic class, age, and race/ethnicity. These limitations may have been due to the researcher’s recruitment methods coupled with the sensitive nature of the topic and the limited period of time in which to gather a diverse sample in a sensitive area of study. The majority of the participants were recruited using a snow-ball sampling method which included mostly friends of the researcher’s family, friends and colleagues. Because of this, the demographic information provided in this study is not representative of the large and diverse population of Herpes sufferers, nationwide. The lack of diversity in the sample (the majority was White/Caucasian, not affiliated with an organized religion, College educated, under the age of thirty at the time

of disclosure and urban), therefore limits the generalizeability of the findings to a wider population.

The lack of diversity in the sample also limited the extent to which the study could shed light on the role of race/ethnicity, religion, age at time of disclosure, level of education and geographic location in intimate partner responses, as originally proposed.

Additionally, in considering the limitations of the study, the researcher's own bias in the creation of the survey should be accounted for, as should the ways in which these biases may have affected both the survey language used as well as the analysis of the qualitative data.

Implications

Several implications for professional work can be drawn from these findings. The tendency for couples in committed relationships to remain together despite negative emotional reactions to disclosure of HSV+ status of one of the partners raises the question as to what types of supports are needed for people in committed relationships who are coping with the presence of a stigmatized STI within the context of their relationship. Further study is needed to learn about the types of interventions that would be most supportive for couples who choose to work through the issues of anger and sense of betrayal that often accompanies post-intercourse STI disclosure in committed relationships.

Because this is one of the only studies that addresses people who are in same sex relationships it may be useful to carry out further research looking at differences and similarities in same-sex and heterosexual couples' interactions with STI stigma and intimate relationship. This could be useful for clinicians working within the LGBTQ

community specifically and could help inform the field of the different approaches that could be taken when working within these communities.

The majority of the participants in this study, when not seeking information from friends and family, looked for information about HSV on the Internet and with physicians. This implies that those who are in the medical field or who are creating websites with information about the illness need to be well informed about the issues surrounding stigma and STIs. As this study's findings indicate that those who are impacted by the illness are not as likely to seek out support from the mental health profession, it may be helpful for mental health professionals to collaborate with physicians and online resources in order to increase support around this sensitive topic.

The findings indicating a trend towards positive response to HSV+ disclosure within intimate relationships implies the need for individualized approaches to supportive intervention with STI+ clients. The aim of such approaches could be to encourage client communication with partners about their STI status prior to engaging in intercourse, with the ultimate goal of increasing client and partner information-seeking and safe-sex practices, leading to a decrease in the spread of HSV.

Conclusion

Newton and McCabe (2008) found that when people receive positive feedback from their intimate partners to disclosure of STI+ status their feelings of stigmatization greatly decrease. These findings speak to the power of stigma and point to the importance of positive partner responses to STI status disclosure in minimizing the negative psychological impact of stigma on the HSV+ partner.

The findings of the current study are hopeful for those living with an STI. They serve to highlight the possibility that, although a diagnosis of STI carries a major stigma in our culture, when shared within the context of an intimate relationship most people will respond with compassion and appreciation. The findings illuminate a more positive prospect that STI stigma, although present and painful, does not necessarily have to impair the interactions between intimate partners; rather, findings indicate that when people are given the option through the disclosure of a partner, they will often choose to work through their fears about the impact of having an STI and engage in relationship with their female partner. As one of a few studies examining partners' response to STI disclosure as opposed to the effects of disclosure on the STI+ party, the findings are indicative of the effect of STI stigmatization on both people in an intimate relationship. Clinicians should understand the importance of partner response in working with women who are living with an STI and the ways in which intimate partners' understanding of STI stigma may influence the health of the relationship.

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Appendix A

Human Subjects Committee Approval Letter

February 1, 2009

Heath Williams

Dear Heath,

Your revised materials have been reviewed and all is now in order. We are glad to give final approval to your study. Please send the permission letters should you get them to Laurie Wyman and she will keep them in your permanent file.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Beth Lewis, Research Advisor

Appendix B

Student Survey

*Note: In order to maintain your anonymity and the anonymity of the HSV+ party, please refrain from the use of names or identifying information in the short answer segments of this survey. Thank you.

Age: _____

Which of the following best represents your racial or ethnic background?

- African American or Black
- Caucasian or White
- Hispanic or Latino(a)
- American Indian or Alaskan Native
- Asian or Pacific Islander
- Other _____

Which of the following best describes your Religious/Spiritual preference?

- Protestant
- Catholic
- Jewish
- Muslim
- Other _____
- No religion, or do not have religious preference
- I have personal spiritual beliefs that are independent of organized religion.

Which of the following best describes your gender?

- Male
- Female
- Transgender
- Other _____

Which of the following best describes your geographic location?

- Urban
- Suburban
- Rural

Which of the following best describes the level of education that you have completed?

- Less than High School
- High School/ G.E.D.
- Some College
- 2-year College Degree
- 4-year College Degree (B.A., B.S.)
- Masters Degree
- Doctoral Degree (Ph.D., M.D., J.D., etc.)
- No formal education

1) Of the following options please check the ones that best describe your relationship at the time when your partner shared her Herpes+ status:

- Casually dating
- Open relationship
- Monogamous relationship

- Seriously dating
- Engaged
- Married
- Other_____

2) At what point in your physical relationship did your female partner disclose her Herpes+ status?

- Before physical intimacy
- Before intercourse but after physical intimacy
- During physical intimacy/intercourse
- After intercourse
- Other_____

3) How long had you been with your female partner before she disclosed her Herpes+ status? (Please fill in the blank below)

- _____Week/s
- _____Month/s
- _____Year/s

4) How old were you at the time of your female intimate partner's disclosure of Herpes+ status?

- 18-22
- 23-29
- 30-35
- 36-40
- 41-45
- 46-50
- 50+

5) Did you continue your physical relationship with female intimate partner after her disclosure of Herpes+ status?

- yes
- no

1) Upon learning that my partner had Herpes I found her less attractive and appealing.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

2) I admired my partner for sharing her Herpes status.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

3) After my partner shared her Herpes+ status my perception of her as a trustworthy person decreased.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

4) After my partner shared her Herpes+ status I had a strong negative emotional response.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

In your own words please describe your emotional response below:

5) After my partner shared her Herpes+ status I was driven to seek out information about the illness.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

If so, where did you look for this information? (please select any that apply from the following options)

- The Internet
- Physicians
- Friends
- Family
- Mental Health Professional
- Other _____

6) After my partner shared her Herpes+ status I became more aware of practicing safe sex in current and future relationships.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

7) My partner sharing her Herpes status changed my attitudes about having sex with a person who has a Sexually Transmitted Illness.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

8) After my partner shared her Herpes status with me we became closer.

Strongly Disagree, Disagree, No Reaction, Agree, Strongly Agree

9) Did you speak to a mental health professional after your partner shared her Herpes + status? If so, which type of professionals?

10) If there is any other information that you would like to share about your perceptions, reactions, feelings or attitudes towards your intimate female partner sharing her Herpes + status with you please do so below:

Appendix C

Initial Recruitment Email

Hello,

I am currently doing a study through my MSW program at Smith School for Social Work about on disclosure, or sharing, of Herpes Simplex Virus (HSV) positive status in the context of an intimate relationship. The purpose of this study is to learn more about the impact of HSV disclosure on partners of affected individuals.

I am seeking participants through a “snowball” sampling method. If you all could please send the attached survey link and recruitment flyer on to people that you know who are not included on the list serve above it would be greatly appreciated. If you are included on the list serve above please do NOT participate in this survey. Please do NOT forward this email, but only the attachment.

By sending this survey on you will be contributing to greater understanding of the stigma attached to female HSV+ disclosure within intimate relationships, which will inform prevention and supportive intervention with the affected population and non-infected population alike.

Thank you very much for your time and effort! Please email me if you have any questions or concerns at the email address listed below.

Best Wishes,

Heath Williams
Swillia3@smith.edu

Appendix D

Informed Consent

Dear Research Participant:

My name is Heath Williams and I am a current Master's of Social Work Student at Smith College School for Social Work in Northampton, Massachusetts. I am conducting a research study on disclosure, or sharing, of Herpes Simplex Virus (HSV) positive status in the context of an intimate relationship. The purpose of this study is to learn more about the impact of HSV disclosure on partners of affected individuals. Such knowledge will contribute to the social work profession's understanding of the types of interventions that will be most helpful to those affected. Obtained data will be used to formulate a thesis, which will be presented at Smith College as part of a dissemination process and for possible publication and presentation.

Participation in this study will involve completing an on-line fifteen-question survey covering the areas of relationship modality, demographics and partner responses, feelings, perceptions and attitudes toward their female partner's sharing of HSV+ status. In order to qualify for participation in this study you must be over the age of 18, and have had or currently be in an intimate relationship with a female who has disclosed her HSV+ status at some point in your relationship. For the purposes of this study the word intimate specifically refers to physical intimacy and/or the anticipation that this relationship will/would include this level of intimacy. Participants need to have been non-infected at the time of their partner's disclosure. If you choose to participate, the survey itself should take approximately between 15 to 30 minutes to complete. You will be asked fill out a brief section with demographic information, a multiple-choice section with a few short

answer questions, and a section where you will have to identify if you strongly disagree, disagree, have no response, agree or strongly agree to a given statement. You will then be given an opportunity to share any additional information that you feel is relevant to the study. I will be transcribing the anonymous information that you chose to provide.

The risks of participating in this survey are minimal, but, given the sensitive nature of HSV status it is possible that reflections upon some responses may be emotionally difficult for some people. If this is the case, I have attached a list of websites, which offer additional support.

A possible benefit of participating in this study is the opportunity for participants to give voice to their own experiences around the impact that HSV stigma has had on their intimate relationships. By participating in the study, you will also be contributing to knowledge that will further inform supportive services to those who are living with HSV. There is no monetary compensation for participating in this study.

As this survey is being conducted completely online, your participation is completely anonymous and no specific answer can be traced back to any particular respondent. The link to the survey does not retain email addresses or ask that you give your name. The software program collects and initially compiles the data for further research and the researcher is given these compiled data in aggregate form with no names, addresses, locations, or other identifying information about the participants except the data included in the demographic questions. Only my research advisor, the Smith College School of Social Work statistical analyst and this researcher will have access to these materials. In publications or presentations, all data will be presented as a whole and any brief vignettes of illustrative quotes that are used will be carefully disguised. All

research data will be kept secure in a locked location for three years, as mandated by federal law. After three years, I will continue to keep the materials secure or destroy them if they are no longer needed.

Your participation is completely voluntary. You may withdraw from the study at any point during the data collection process and/or may refuse to answer any question in the survey without penalty. You must read and electronically sign this informed consent form by clicking on the “yes” option below before being able to proceed with the survey. If you choose to consent, please print off this page and keep it in your records. If you click on the “no” option below, you will immediately be exited from the survey. During the survey, you may decline to answer any questions you do not feel comfortable answering. You have the right to exit this study at anytime prior to pressing the “DONE” option at the end of the survey. Once you have submitted your completed questionnaire, you will not be able to withdraw from this study since there is no identifying information on the surveys that would connect a particular survey to your responses and permit the information to be selectively deleted. Please complete the survey as soon as possible or by March 15, 2009.

I welcome your questions and comments. I can be reached by email at swillia3@smith.edu. If you have any concerns about your rights or any aspect of this study, please contact me at the above email or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR CLICKING THE “YES” BUTTON INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE

HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

HSV Resource List:

Find a psychotherapist/counselor near you:

<http://www.therapistlocator.net>

<http://www.helpstartshere.org/search/default.asp>

The Center for Disease Control and Prevention: STD Facts-Genital Herpes

<http://www.cdc.gov/std/herpes/STDFact-herpes.htm>

Herpes Select: Statistical information and information about testing.

<http://www.herpeselect.com/>

American Social Health Association: Herpes Resource Center (support groups, emotional supports, general information)

http://www.ashstd.org/herpes/herpes_comm_support.cfm

The Complete Herpes Information Center:

General address:

<http://www.globalherbalsupplies.com/herpes>

Address with information for men:

<http://www.globalherbalsupplies.com/herpes/men.html>

Appendix E

Recruitment Flyer

**Student Study. Participants needed for this
ANONYMOUS study!!!**

Are you interested in sexual health issues?

Are you over 18?

**Have you been in an intimate relationship
with a woman who told you about her Genital
Herpes + status?**

**If you answered the above questions “yes”
and you would like to participate in this
survey please follow the link below:**

www.survey.com

Thank you for your time!!!!