TITLE: Violated and vulnerable: Women's experiences of contracting a sexually transmitted infection from a male partner

ABSTRACT

Aims and objectives: The aim of this paper is to explore women's stories of contracting a sexually transmitted infection from a male partner and elucidate the gendered constructs and violence experienced that made the women vulnerable to these infections.

Background: Violence against women can result in both physical and psychological consequences and expose women to multiple health risks including sexual health adversity.

Design: Feminist storytelling approach.

Methods: Qualitative interviews were conducted with 10 women. All data underwent thematic analysis.

Findings: Findings from this study revealed the women were vulnerable to contracting sexually transmitted infection/s from their male sexual partners as a result of unequal gender and abusive relationship dynamics. Subsequently, contracting a sexual infection within this context potentially increased their vulnerability in both current and future relationships, through their loss of self-confidence and perceived ability to have a trusting loving heterosexual relationship as women with sexually transmitted infection/s.

Conclusion: Women in relationships in which they are subordinate to their male partner are at heightened risk of sexual health adversity, including contracting a sexually transmitted infection. Contracting a sexually transmitted infection within the

context of an abusive relationship can further increase women's vulnerability to dominant male partners, thus further exposure to sexual risk and adversity.

Relevance to practice: Nurses working in clinical settings are well placed to conduct opportunistic screening of women's sexual health, including assessment of sexually transmitted infections and the nature of the encounter in which they were contracted. Thorough assessment can potentially identify relationship and personal factors that can increase a woman's risk to both sexual adversity and forms of abuse. Also, if women do divulge that they have suffered abuse, nurses are positioned to provide support and guidance in implementing strategies to minimise risk as well as referring them to specialised services.

Keywords- Feminism, intimate partner violence, qualitative study, sexual health, women's health, storytelling

Summary Box

What does this paper contribute to the wider global clinical community?

- Unequal gender dynamics in their intimate relationships may make women vulnerable to contracting STIs
- Having an STI can increase a woman's risk of being exposed to abuse from a future sexual partner

INTRODUCTION

Violence against women is a serious global health issue affecting millions of women throughout the world. Although violence against women can include any form of violence such as physical and psychological violence, intimate partner violence (IPV) including sexual violence is reportedly the most prevalent form of violence experienced by women (WHO 2016). Further, according to global statistics, approximately 35% or 1 in 3 women worldwide have either experienced IPV or sexual violence from a non-partner (WHO, London School of Hygeine and Tropical Medicine & South African Medical Research Council 2013).

Experiencing any form of violence can have detrimental effects on a woman's health. Violence against women can cause both fatal and non-fatal physical injuries, lead to long-term health consequences such as cardiovascular disease, gynaecological issues, chronic pain, neurological disorders, disability, gastrointestinal problems, and can also result in mental health issues and subsequent drug abuse, depression and anxiety and in some cases suicidal attempts (WHO *et al.* 2013). Moreover, intimate partner and sexual violence against women predisposes and increases a woman's vulnerability to illnesses such as HIV and sexually transmitted infections (STIs) (WHO 2016). Therefore, the aim of this paper was to explore women's stories of having an STI/s from a feminist perspective and elucidate how gender and the experience of abuse, heightened the women's risk of contracting an STI.

BACKGROUND

Women of all ages may experience challenges in protecting their sexual wellbeing, however young women may find this particularly difficult (East *et al.* 2007). Young people may lack knowledge associated with HIV/STIs and safer sex, perceive themselves as invulnerable to any kind of sexual adversity associated with sexual activity, and may not have the skills to effectively negotiate condom use to engage in safer sexual practices (East *et al.* 2007). The ability for women to negotiate condom use and engage in safer sexual practices can also be hindered by unequal gender dynamics that can exist within heterosexual relations, which is exacerbated by the presence of violence (Dunkle & Decker 2013).

Both past and current literature has documented the association between unequal gender dynamics, IPV and risk of sexual adversity among women (for example see Coker 2007, Li *et al.* 2014), thus these associations are not new. Yet research suggests that violence against women is still highly prevalent and therefore many women's physical and psychological wellbeing are being affected. For example research among a sample of young women revealed that women who had experienced IPV had significantly higher rates of being coerced into sexual activities compared to women who were not in an abusive relationship (Sutherland *et al.* 2012).

In a study that examined the association between IPV and condom negotiation among women (N=478), researchers found that recent experiences of IPV (previous 3 months) were associated with greater fear of subsequent violence associated with condom negotiation compared with women who had not recently experienced IPV (Mittal *et al.* 2013). Study authors also found recent experiences of IPV were

positively associated with greater incidences of unprotected sex, suggesting that these women were unable to practice safer sex due to fear of abuse from a partner, which subsequently predisposed these women to STIs (Mittal *et al.* 2013). Similarly, Seth *et al.* (2015) found that IPV hindered condom use among a sample of young African American women, and research focused on examining the association between IPV and STI prevalence confirmed that young women who had experienced IPV had a higher STI prevalence compared to women in non-violent partnerships (Hess *et al.* 2012).

All of these studies confirm the risk of sexual adversity women face, particularly within the context of IPV. Moreover, although literature has acknowledged and confirmed the association between unequal gender dynamics, IPV and women being vulnerable to sexual adversity, there is paucity of literature that focuses on the experiences of women who have contracted an STI under these circumstances. To extend this knowledge, the aim of this paper is to elucidate women's stories of contracting an STI/s within the context of unequal gender dynamics, IPV and or sexual violence from a feminist perspective. The findings presented here are from a larger study focused on women's experiences of having an STI/s. Furthermore, for the purposes of this study the term male partner is used to refer to the male sexual partner from whom a participant contracted an STI/s. The term is inclusive of an intimate partner, a casual partner and/or a non-intimate partner and is used to explicate the unequal gender dynamics that underpinned the sexual circumstances in which the women contracted an STI/s.

METHODS

Design

This study was conducted using a feminist storytelling approach. Feminist and storytelling approaches to research both value subjectivity and place participants and their stories at the forefront of the research (Chase 2005, Elliot 2005, Joyappa & Self 1996), making these approaches ideologically compatible. Additionally, feminist research acknowledges that personal experiences are influenced by, and derived from societal constructs, such as gender, culture, and race (Campbell & Bunting 1991, Cowman & Jackson 2003, White *et al.* 2001). Considering traditional gender norms and societal constructs which have positioned women's sexuality as inferior to the dominant male and the stigma and stereotypes assigned to women based on their sexual behaviour (Nelson 2005), a feminist approach was deemed appropriate to underpin the conduct of this study.

Feminist research also aims to empower participants, and aims for non-hierarchy within the researcher/participant relationship. Further, feminist research supports the voices of marginalised individuals and resists contributing to oppression among groups and individual participants (Hall & Stevens 1991, Harding & Norberg 2005, Joyappa & Self 1996). Following these principle aims of feminist research and due to the nature and focus of this study, it was deemed appropriate to use a storytelling approach to gain insights into the women's experiences of having a STI.

By listening to personal stories, insight into experiences and individual's perceptions of these experiences can be gained (Thomas 2003). Asking women to tell their personal stories of having an STI also minimises the hierarchal researcher and participant relationship (Elliot 2005, Thomas 2003). This occurs through the women being asked to tell their story freely, which lessens the researcher's power and direction of the research encounter, and emphasises the collaborative nature of the encounter between the researcher and the participant (Thomas 2003). By asking participants to elucidate their own stories in the way they choose, the power of the researcher that often accompanies research encounters is transferred to the participants, through the focus being on the participants stories, and what they choose to disclose, rather than the researcher's questions (Chase 2003). The research encounter that focuses on participant stories changes the research relationship from being characterised as an interviewer/interviewee relationship to a storyteller/active listener relationship that is characterised as the researcher as listener and the participant as storyteller (Chase 2005). Moreover, by inviting the women to disclose their personal stories, they could disclose the story they wish to be heard in their own words (Atkinson 2002), which also can promote the development of resilience (East *et al.* 2010).

Data collection

The local Australian University Human Research Ethics Committee granted ethical approval for this study. The study sought to recruit young women who could converse in English and who had been diagnosed with an STI that was contracted through heterosexual intercourse between the ages of 17 and 30 years. Women who had HIV and hepatitis were excluded from this study as these infections could be contracted via

other means. Women could participate regardless of relationship status and the circumstances associated with heterosexual STI acquisition.

To recruit participants, advertisements were placed in sexual health clinics willing to advertise the study, throughout an Australian university setting and on social media sites focused on STIs. Interested participants were invited to contact the primary researcher for further information and were provided with a participant information sheet and consent form. The participant information sheet detailed the aims of the study, inclusion criteria (being diagnosed with an STI contracted through heterosexual intercourse), and what was required of participants (participating in an open-ended interview with the primary researcher, which could be conducted face-to-face, via telephone or computer-mediated communication). Additionally, the information sheet addressed the voluntary nature of participation with specific reference to participants having the right to withdraw from the study at anytime without obligation, how confidentiality would be maintained, and how the results of the study would be disseminated.

Ten women participated in this study (please refer to table 1 for participant characteristics). Data were collected throughout 2007 and at the time of the interviews the women were aged between 21 and 39 years of age and had contracted an STI/s between the ages of 17 and 30 years. The women's diagnoses included chlamydia, human papilloma virus (HPV), genital herpes, and pubic lice. To maintain the women's confidentiality, pseudonyms were selected by the primary researcher. All women chose to participate in the interviews via computer-mediated communication inclusive of electronic mail and instant messenger software. As this study used a

storytelling approach, all interviews were unstructured and conversational in nature, and were commenced with the general question 'can you tell me your experiences of having an STI?'. Follow up, clarifying and prompt questions were asked according to participants' responses. The interviews lasted between 40 to 120 minutes.

Insert table 1 here

Analysis

Once data saturation was achieved, data underwent thematic analysis. Data saturation was confirmed after the tenth interview in which no new data had emerged. For the purpose of this study and to illuminate any gender constructs within the women's transcripts, analysis was guided by feminist techniques suggested by Anderson and Jack (1991). Initially, all transcripts were read and re-read by the research team to identify commonalities, which were categorised in order to identify potential themes (Green & Thorogood 2004, Jackson & Borbasi 2008, Morse & Field 1996). Once completed, the women's stories were explored for personal reflections, social and gender constructs, and consistencies and contradictions (Anderson & Jack 1991) within the context of having an STI/s. Through exploration of reflections, constructs and contradictions and consistencies, how the women perceived and constructed their experiences of having an STI/s within a social and gendered society could be illuminated. For a more detailed account of data analysis, please see XXXX (2010a).

Rigour

According to Hall and Stevens (1991) rigour in feminist research is dependent on research adequacy. Adequacy refers to the congruency of the research study and encompasses the research reflecting meaning and relevance (Hall & Stevens 1991).

The adequacy of this study used the principles of believability, naming and honesty and mutuality. Believability was achieved through all members of the research team confirming the findings both independently and collaboratively, and naming was confirmed through the use of excerpts from the women's stories to represent findings. In the current study, honesty was upheld through the comprehensive information provided to the women regarding details of the study, which ensured the women's participation was both voluntary and informed. Within this study, mutuality was enhanced through the non-hierarchal approach within the qualitative interviews. This, according to Hall and Stevens (1991) facilitates the preservation and validity of the participants' stories, through allowing participants to express their thoughts and stories freely.

FINDINGS

As previously stated, findings presented in this paper arose from a larger study focused on women's experiences of having an STI/s. Elsewhere we have published findings associated with how the women perceived themselves within the context of having an STI/s (XXXX, 2010) and the women's experiences of condom negotiation (XXXX, 2011). Here we report aspects of the women's stories of contracting an STI/s from heterosexual relations characterised by unequal gender dynamics and/or abuse. Additionally, how the women were vulnerable to STI acquisition and how contracting an STI/s increased these women's vulnerability to possible future abuse is elucidated.

Theme: Violated and vulnerable

Data analysis revealed an overall theme 'Violated and vulnerable' which comprises of two sub-themes (Please see table 2). The first sub-theme, Violation and betrayal: *How could someone think I'm so worthless* reveals how the women were vulnerable to STI/s through maintenance of traditional gender norms, male dominant relationships,

and abuse. The second sub-theme, Wary of men: *I feel I am too vulnerable* illuminates how the women were cautious of engaging in intimate relationships due to their experiences and how through contracting STI/s some of these women had become even more vulnerable to male domination within their heterosexual relationships.

Insert table 2 here

Betrayal and violation: *How could someone think I'm so worthless*

The women were subordinate within their relationships as a result of various gender dynamics, which made them vulnerable to contracting STI/s. The women were vulnerable due to either being with older partners, wanting and believing in love, and/or experiencing emotional and physical abuse. Four of the women spoke of their experiences of abuse and coerced sex through which they had contracted STI/s (please refer to table 1). Through this violation, the women's ability to protect their sexual wellbeing was hindered. Contracting an STI/s through abusive or coerced sex amplified the emotional pain felt by the women associated with these infections. For example Cindy's story revealed how vulnerable young women are to sexually predatory men. Cindy believed that she was drugged, which allowed men to exert their sexual dominance whilst oppressing her and forcing her to be sexually submissive. These men not only emotionally injured Cindy, but left her with an incurable infection that she must endure for the rest of her life. Cindy commented:

Well I have genital herpes … which I was diagnosed with in my late teens I think 18 due to from what I can remember a sexual assault while under the influence of something. I did not know [what] *I was given- some sort of drug I assume. I am 28*

now. ... It was more like 5 [men] *all who were involved but there was one specifically I found out later was said to have an infection...*

Similar to Cindy, Rita felt violated by her partner from whom she contracted an STI. Although Rita wanted to preserve her sexual wellbeing, she felt she was unable to do so due to her partner exerting dominance over her. Within their relationship it was her partner's sexual pleasure that was the dominant concern and as a result of the abusive nature of her relationship and contracting an STI, Rita felt that her partner had taken her innocence. Rita stated:

When I originally found the warts I felt ... violated amongst an array of strange feelings. … I guess because the person I blamed for giving me the virus was also physically abusive. I felt that something so sacred was taken from me, not only did he emotionally scar me but he left me now with physical scars, which each day I had to deal with the consequences.

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

I was a romantic in that I thought if a man was interested in me it was genuine & not just sex for him. Being an open & honest person myself I presumed that others would

be open & honest also. Since then I have had my eyes opened in regard to how deceitful/sly men or women can be, especially about issues that involve any possible feelings of shame.

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

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

Ruby was extremely young when she began a relationship with an older man. Her age alone made her vulnerable to this man and STI/s. At such a tender age Ruby looked up to her husband and thought that he would always care for her. Ruby's story highlighted how gender scripts and gender norms can cause unequal power dynamics between a husband and wife:

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

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

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

Both Ruby's and Melinda's STI experiences have contributed to their mistrust in men. They were both extremely vulnerable to men before contracting STI/s due to past experiences, which potentially increased their risk to sexual adversity. Reflecting on their experiences; both women felt the men they were involved with took advantage of their vulnerability. Melinda commented: *I've always had issues with trust in*

men. I was sexually abused as a child. This herpes experience just adds to the 'all men are arseholes' list. Ruby simply wanted love and protection and wanted to escape her past, which subsequently heightened her vulnerability to sexual adversity. Ruby asserted:

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

The women's experiences of violation and their desire for romantic love made these women vulnerable to sexual risk and subsequently STI/s. Due to their experiences of betrayal, vulnerability and abuse, many of the women shared how their experiences of having an STI made them wary of, and increased their vulnerability to men and subsequently unequal gender dynamics, abuse and potentially further sexual risk and adversity.

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

Contracting an STI from male partners had made these women more vulnerable in their future relationships with men. As a consequence of contracting an STI/s, some of the women disclosed feeling the need to 'settle' for any man willing to be involved with someone who has an STI, highlighting the potential for increasing their sexual risk. Other women had become wary of engaging in emotional and sexual relationships with potential male partners for fear of rejection and further abuse. As stated by Sam: [I] *have found myself backing away from guys I really like that I think*

wouldn't take it well [STI disclosure]*, hence not having a serious boyfriend for over 2 years now.* It was the women's fear of loneliness, thoughts of being tainted and their loss of confidence that increased their vulnerability to sexual risk and subsequent sexual adversity following STI diagnoses. Ruby believed that her abusive past and STIs would provide a man with the opening to abuse her, and that men would perceive her as a woman not worthy of respect:

Um, I feel I am too vulnerable to get into an intimate situation … and feel I could get hurt again or catch more diseases, and I also feel that if I told anyone the truth they would think I am a slut so that would give them the opening to treat me badly.

Ruby's experience caused her to lack faith and trust in men. Her experience of contracting the STIs made Ruby fear intimacy: *As I said I don't trust men, and have become afraid of intimate relationships and don't feel I can tell anyone about it …* Likewise, having an STI had also made Cathy fear intimacy. This fear was exacerbated by her thoughts and feelings of being tainted, in addition to her experience of being rejected by men. Cathy expressed that it is easier for her to keep her distance rather than to form a romantic attachment to a man:

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

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

... Like at the moment I like one of my brother's friends. He has asked me out and I said I'll let him know coz [because] *I couldn't imagine my family finding out ... so that's why I'd wait soooo long before telling someone like that, otherwise everyone would find out and it's not something you can ever take back.*

Some of the women experienced a loss in confidence and damaged self-esteem after contracting an STI. Bree had lost confidence in herself and feared that if she was unable to satisfy a man he would leave her. This has increased Bree's emotional, physical and sexual vulnerability to men:

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

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

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

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

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

Despite their own affections and desires, both Sam and Bree felt that they may have to settle for, and be involved with any man that is willing to accept them having an STI, which can position these women in a subordinate position within heterosexual relations. As simply put by Sam *… and thinking that I'd have to settle with whatever guy accepts that I have it* [herpes]. In discussing how she felt about disclosing having an STI to a male partner, Bree felt vulnerable. She felt that by disclosing having an

STI, her partner held the dominant stance in the relationship as he was risking his sexual wellbeing through the possibility of contracting herpes; ultimately if the relationship was to continue it was her partner's choice. Bree felt that due to her STI status she could not choose a man to be with her, rather a man needed to choose her:

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

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

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

Findings presented in this sub-theme have highlighted how the women's experiences of contracting an STI either through a perceived trusted partner or in some instances forced sex, had cast a shadow on the women's present or future relationships. For

some women, they revealed how they felt that they may have to settle for any male partner who would accept them as a partner with an STI, which in turn amplified their vulnerability to potential abuse and further sexual adversity.

DISCUSSION

Findings from this study revealed that the women were vulnerable to STIs due to either traditional gender norms and/or exposure to various forms of violence perpetrated by their male sexual partners. Violence and abuse perpetrated by men within heterosexual relations exists to disempower, oppress and control a woman's behaviour (Danis & Bhandari 2010, Travis & Compton 2001). Within a patriarchal society men are perceived to be the dominant and superior gender (Gamache 1998, Hanmer 2000). Forms of abuse and domination, as experienced by the women in this study, occurs as a result of societal constructs, based on power that exists to maintain the dominant stance the male holds within patriarchal society (Gamache 1998, Yodanis 2004). Although not all men inflict violence and domination on women, the male gender benefits from domination arising from abuse by the knowledge, vulnerability and fear this can provoke in women (Bograd 1988, Yodanis 2004), which resonates with the findings of this study.

Findings from this study revealed that the women were both vulnerable to unequal gender dynamics that existed within their heterosexual relations prior to contracting an STI. These findings highlight that the experience of abuse within heterosexual relations can continue to exist in terms of supressing women's ability to protect their wellbeing particularly within the context of sexual risk and having an STI. The vulnerability experienced and felt by the women in this study, resonates with past

research that has acknowledged all sexual encounters carry risk behaviours dependent on both parties, however, IPV significantly increases women's vulnerability and sexual risk behaviour, including heightening the risk of STI acquisition (Fontenot *et al.* 2014). This vulnerability can be further heightened particularly within cultures, communities and indeed at the societal level, which endorse traditional patriarchal norms that acknowledge women as subordinate to men. Within these cultures and communities it may be near impossible for women to protect themselves from sexual risk and therefore exposure to sexual adversity inclusive of contracting STIs.

Though findings from this study cannot assert a direct association between unequal gender dynamics and violence against women and the contraction of an STI/s, findings have revealed the vulnerability of these women in terms of STI risk. These findings resonate with previous work that postulates having limited power within a relationship and having a fear of abuse from a partner, hinders a woman's ability to practice safer sex, which can increase her risk of STI acquisition (McGrane Minton *et al.* 2016). Furthermore, these findings support earlier work which concluded that adolescent girls exposed to physical and sexual dating violence are more likely to be diagnosed with an STI than adolescents who are not exposed to such abuse (Decker *et al.* 2005) and experiences of IPV increases women's risk of STIs (for example Callands *et al.* 2013, Kishor 2012, Spiwak *et al.* 2013).

Contracting an STI, the unequal gender dynamics within their relationships, and these women's experience of abuse, caused varying degrees of disempowerment for the women in this study. Disempowerment encompasses feelings of vulnerability, lack of power, and lack of self-efficacy (Reid & Finchilescu 1995, Young *et al.* 2003).

Feelings of disempowerment can cause fear and withdrawal among individuals, and arises from interpersonal, social, and political power structures (Reid & Finchilescu 1995, Young *et al.* 2003). These women expressed vulnerability arising from unequal gender dynamics and male domination within their intimate relationships. Their vulnerability and the effects of having an STI further intensified these women's vulnerability, which was revealed through loss of self-confidence, perceived worth and ability to have a trusting relationship with a man.

The vulnerability felt by the women in this study and the associated psychosocial effects concurs with research focused on women's experiences of having an STI and undergoing STI testing. Similar to this study's findings, Newton and McCabe (2008) explored individuals relationships experiences within the context of having genital herpes or HPV and found participants felt 'less attractive' and undesirable due to having an STI. The authors also found that some participants chose to stay in 'unhappy relationships' as a result of having an STI (Newton & McCabe 2008). Likewise, research investigating the psychosocial impact of testing for HPV and associated HPV diagnosis, revealed that women with a HPV related diagnosis (through pap smear screening) had greater concerns associated with 'self image' and 'sexual impact' compared to women who had normal pap smear results (Pirotta *et al.* 2009). Our findings highlight that these feelings and concerns have the potential to promote disempowerment and oppression, and expose women with STIs to further abuse and domination by current and future male partners.

Limitations

Though the study offers insights into women's experiences of contracting an STI particularly within the context of heterosexual power imbalances and abuse, the study has several limitations. The findings from this study are limited by the small sample size who self selected to participate and thus are not generalizable. The women in this study were also all residing in Australia and although they did not disclose any cultural or religious background, the findings are not representative of women from differing cultural backgrounds nor women from non-English speaking backgrounds. Further, the aim of this study was to explore women's stories of contracting an STI/s, rather than focusing on women's experiences of contracting an STI through abuse, therefore further research is needed to contribute to this specific body of knowledge.

CONCLUSION

All the women in this study were vulnerable to contracting STI/s. Some of the women were positioned subordinately within their relationships, and it was due to these gender dynamics that they were vulnerable. Several of the women were particularly vulnerable due to experiencing violation through coerced sex and abuse; their sexual health was in the hands of their male partners. In addition to the abuse experienced by some of these women, contracting an STI made them even more vulnerable to future intimate heterosexual relations. This occurred through the women experiencing a loss of self-confidence and feeling that they had to settle for any man that would accept them.

RELEVANCE TO CLINICAL PRACTICE

Many of the women contracted STI/s in the context of emotional and/or physical and sexual domination and abuse. Awareness of the differing situational circumstances

that can lead to the transmission of these infections and creating an environment where women can disclose and discuss these events can promote the provision of therapeutic care and support for these women. In light of findings from this study and others, nurses working in areas of domestic violence and abuse should acknowledge the heightened sexual risk among affected women and facilitate sexual health education and services to reduce risk and maximise these women's health and wellbeing.

Acknowledgement of the possible vulnerability and oppression that can arise among young women who have contracted an STI is vital in the provision of support and in facilitating their wellbeing. Findings from this study indicated that through their experience of having an STI, some of the women lost confidence in themselves. They perceived that if they wanted to engage in intimate relations they would have to accept any man that would be willing to be sexually involved with them. This places them in a submissive position, which puts them at risk of abuse in future relationships. Therefore, providing these women with the opportunity to discuss relationship issues, including fear of abuse and oppression, can provide a supportive environment in which healthcare professionals can offer and promote individualised strategies to overcome these issues and promote a positive sense of wellbeing.

It is important to note that although all sexual encounters can carry forms of sexual risk inclusive of contracting an STI, not all women will contract an STI within the context of abuse. Despite this, nurses working in both clinical and primary health care settings have the opportunity to conduct a thorough sexual health history, inclusive of exploring the nature of the encounter in which the infection was contracted. Doing so

can identify relationship and personal factors that can increase a woman's risk to both sexual adversity and forms of abuse. Additionally, when working with women who have experienced or are experiencing abuse, nurses can guide and assist women in implementing strategies such as safety planning, in order to facilitate reducing and preventing women's risk for contracting an STI and forms potential abuse.

REFERENCES

Anderson K & Jack DC (1991) Learning to listen: Interview techniques and analyses. In *Women's words: The feminist practice of oral history* (Gluck SB & Patai D eds.). Routledge, New York, pp. 11-26.

Atkinson R (2002) The life story interview. In *Handbook of interview research: Context and method* (Gubrium JF & Holstein JA eds.). Sage, Thousand Oaks, California, pp. 121-140.

Bograd M (1988) Feminist perspectives on wife abuse: An introduction. In *Feminist perspectives on wife abuse* (Yllö K & Bograd M eds.). Sage, California, pp. 11-26.

Callands TA, Sipsma HL, Betancourt TS & Hansen NB (2013): Expereinces and acceptance of intimate partner violence: Associations with sexaully transmitted infection symptoms and ability to negoitate sexual safety among young Liberian women. *Culture, Health & Sexuality* **15**, 680-694.

Campbell JC & Bunting SM (1991): Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science* **13**, 1-15.

Chase SE (2003) Taking narrative seriously: Consequences for method and theory in interview studies. In *Turning points in qualitative research: Tying knots in a handkerchief* (Lincoln YS & Denzin NK eds.). AltaMira Press, California, pp. 273-298.

Chase SE (2005) Narrative inquiry: Multiple lenses, approaches, voices. In *The Sage handbook of qualitative research* 3edn (Denzin NK & Lincoln YS eds.). Sage, California, pp. 651-680.

Coker AL (2007): Does physical intimate partner violence affect sexual health: A systematic review. *Trauma, Violence, & Abuse* **8**, 149-177.

Cowman K & Jackson LA (2003) Time. In *A concise companion to feminist theory* (Eagleton M ed.). Blackwell, Massachusetts, pp. 32-52.

Danis FS & Bhandari S (2010) Understanding domestic violence. In *Domestic violence: Intersectionality and culturally competent practice* (Lockhart LL & Danis FS eds.). Columbia University Press, New York, pp. 53-87.

Decker MR, Silverman JG & Raj A (2005): Dating violence and sexually transmitted disease/HIV testing and diagnosis among adolescent females [Electronic version]. *Pediatrics* **116**, e272-e276.

Dunkle KL & Decker MR (2013): Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-risk Groups. *American Journal of Reproductive Immunology* **69**, 20-26.

East L, Jackson D, O'Brien L & Peters K (2007): Use of the male condom by heterosexual adolescents and young people: Literature review. *Journal of Advanced Nursing* **59**, 103-110.

East L, Jackson D, O'Brien L & Peters K (2010): Storytelling: An approach that can help develop resilience. *Nurse Researcher* **17**, 17-25.

Elliot J (2005) *Using narrative in social research: Qualitative and quantitative approaches*. Sage, London.

Fontenot HB, Fantasia HC, Lee-St John TJ & Sutherland MA (2014): The effects of intimate partner violence duration on individual and partner-related sexual risk factors among women. *Journal of Midwifery & Women's Health* **59**, 67-73.

Gamache D (1998) Domination and control: The social context of dating violence. In *Dating violence: Young women in danger* (Levy B ed.). Seal Press, Seattle, pp. 69-83.

Green G & Thorogood N (2004) Analysing qualitative data In *Qualitative methods for health research*. Sage, London, pp. 173-200.

Hall JM & Stevens PE (1991): Rigor in feminist research. *Advances in Nursing Science* **13**, 16-29.

Hanmer J (2000) Domestic violence and gender relations: Contexts and connections. In *Home truths about domestic violence: Feminist influences on policy and practice: A reader* (Hanmer J, Itzin C, with Quaid S & Wigglesworth D eds.). Routledge, London, pp. 9-23.

Harding S & Norberg K (2005): New feminist approaches to social sciences methodologies: An introduction. *Signs: Journal of Women in Culture and Society* **30**, 2009-2015.

Hess KL, Javanbakht M, Brown JM, Weiss RE, Hsu P & Gorbach PM (2012): Intimate partner violence and sexually transmitted infections among young adult women. *Sexaully Transmitted Diseases* **39**, 366-371.

Jackson D & Borbasi S (2008) Qualitative research: The whole picture. In *Navigating the maze of nursing research 2e: An interactive learning adventure*, 2nd edn (Borbasi S, Jackson D & Langford RW eds.). Elsevier, Marrickville, pp. 153-178.

Joyappa V & Self LS (1996): Feminist research methodologies as a collective self-education and political praxis. *Convergence* **29**, 16-23.

Kishor S (2012): Married women's risk of STIs in devloping countries: The role of intimate partner violence and partner's infection status. *Violence Against Women* **18**, 829-853.

Li Y, Marshall CM, Rees HC, Nunez A, Ezeanolue EE & Ehiri JE (2014): Intimate partner violence and HIV infection among women: a systematic review and meta-analysis. *Journal of the International AIDS Society* **17**.

McGrane Minton HA, Mittal M, Elder H & Carey MP (2016): Relationship factors and condom use among women with a history of intimate partner violence. *AIDS and Behavior* **20**, 225-234.

Mittal M, Senn TE & Carey MP (2013): Fear of violent consequences and condom use among women attending an STD clinic. *Women & Health* **55**, 795-807.

Morse JM & Field PA (1996) Principles of data analysis. In *Nursing research: The application of qualitative approaches*, 2nd edn. Chapman & Hall, London, pp. 103-123.

Newton DC & McCabe MP (2008): Sexually transmitted infections: Impact on individuals and their relationships. *Journal of Health Psychology* **13**, 864-869.

Pirotta M, Ung L, Stein A, Conway EL, Mast TC, Fairley CK & Garland S (2009): The psychosocial burden of human paillomavirus related disease and screening interventions. *Sexually Transmitted Infections* **85**, 508-513.

Reid P & Finchilescu G (1995): The disempowering effects of media violence against women on college women. *Psychology of Women Quarterly* **19**, 397-411.

Seth P, Wingwood GM, Robinson LS, Ralford JL & DiClemente RJ (2015): Abuse impedes prevention: The intersection of intimate partner violence and HIV/STI risk among young African American women. *AIDS and Behavior* **19**, 1438-1445.

Spiwak R, Afifi TO, Halli S, Garcia-Moreno C & Sareen J (2013): The relationship between physical intimate partner violence and sexually transmitted infection among women in India and the Unit States. *Journal of Interpersonal Violence* **28**, 2770-2791.

Sutherland MA, Collins Fantasia H, Fontenot H & Harris AL (2012): Safer sex and partner violence in a sample of women. *The Journal of Nurse Practitioners* **8**, 717-724.

Thomas RM (2003) Present-status perspectives - qualitative. In *Blending qualitative & quantitative research methods in theses and dissertations* Corwin Press, California, pp. 33-40.

Travis CB & Compton JD (2001): Feminism and health in the decade of behaviour. *Psychology of Women Quarterly* **25**, 312-323.

White JW, Russo NF & Travis CB (2001): Feminism in the decade of behavior. *Psychology of Women Quarterly* **25**, 267-279.

World Health Organisation (2016) Violence against women: Intimate partner and sexual violence against women, Fact sheet N239. World Health Organisation. Available at: http://www.who.int/mediacentre/factsheets/fs239/en/ (accessed 10th of February 2016).

World Health Organisation, London School of Hygeine & Tropical Medicine & South African Medical Research Council (2013) Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, Geneva.

Yodanis CL (2004): Gender inequality, violence against women, and fear. *Journal of Interpersonal Violence* **19**, 655-675.

Young AM, Vance CM & Ensher EA (2003): Individual differences in sensitivity to disempowering acts: A comparison of gender and identity-based explanations for perceived offensiveness. *Sex Roles* **49**, 163-171.