Disrupted sense of self: young women and sexually transmitted infections

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Aim. This article is an exploration of young women’s experiences of having a sexually transmitted infection.

Background. Sexually transmitted infections are prevalent worldwide and have serious physical and psychological sequelae. Although some aspects of having sexually transmitted infections have been identified in the literature, the stigmatised nature of these infections means that relatively little is known about the experiential aspects of these conditions.

Design. This research used a qualitative feminist approach.

Methods. Data were collected in 2007 via online interviews with ten women. Thematic analysis was guided by a feminist narrative technique.

Results. Findings revealed the women had not believed themselves to be at risk of sexually transmitted infections because of perceptions they held about the sorts of women who contract these infections. Because these perceptions were incompatible with their self-perceived views, the women initially experienced a disruption in their sense of self. To facilitate the restoration of their previously held sense of self, these women engaged in wishful thinking and denial.

Conclusion. This study illuminates how perceptions of sexually transmitted infections influence the way young women perceive themselves in the context of these infections. Awareness of the detrimental impact contracting sexually transmitted infections can have on young women can help nurses to provide services that facilitate positive and effective coping strategies among this group.

Relevance to clinical practice. Nurses providing care to women with sexually transmitted infections should promote positive coping strategies that could help curb non-disclosure and denial among young women who contract these infections. Education focused on sexually transmitted infections should emphasise that all sexually active individuals are at risk of these infections, which could potentially minimise the shame felt by persons who contract these infections. Further, recognition of the gender issues that limit women’s ability to practise safer sex should be incorporated into safer sex education and campaigns.

Key words: feminism, nursing, qualitative research, sense of self, sexually transmitted infections

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Introduction and background

Sexually transmitted infections (STIs) cause immense physical, emotional and economic burdens [Chesson et al. 2004, World Health Organisation (WHO) 2001], and although they can potentially affect any sexually active individual, women (WHO 2002, NIMH Collaborative HIV/STD Prevention Trial Group 2007) and young people are disproportionately affected (Dehne & Riedner 2005). The physical consequences of contracting an STI can be severe,

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particularly for women, with these infections capable of causing infertility, pelvic inflammatory disease and ectopic pregnancy (Braverman 2003, Tao et al. 2007).

The WHO (2001) estimated that among persons aged between 15–49, the rate of chlamydia, gonorrhoea, syphilis and trichomoniasis had increased to over 340 million new cases per annum. However, estimates for STIs are grossly underestimated. This is because of inadequacy of surveillance systems, incomplete data, lack of access to healthcare services and the large proportion of STIs that remain undiagnosed and therefore not reported, because of the asymptomatic nature of some of these infections (WHO 2002, Weinstock et al. 2004). Despite the increasing incidence of STIs, the Center for Disease Control (CDC) (2006) identifies a lack of awareness of the risks and impact of these infections on both physical and psychological health (CDC National Prevention Information Network 2006).

STIs are stigmatising conditions that not only create emotional and physical burden for individuals, but can also strain and alter intimate relationships (Newton & McCabe 2005, 2008). The stigma surrounding STIs is intensified because of the mode of transmission and the societal perception that persons contracting such infections must exhibit deviant behaviours (Bunting 1996). STIs influence sexual behaviour and contraceptive choices within relationships and may create strong emotional responses such as fear of rejection (Newton & McCabe 2005), guilt associated with STI transmission and concern that others are aware of an individual’s STI status (Rosenthal et al. 2006, Oster & Cheek 2008, Scrivener et al. 2008). Nurses are fundamental in providing care for those who have contracted STIs (Tyler 2005) and are in prime positions to provide support and education to assist women to cope with and adjust to a diagnosis of an STI (Madrid & Swanson 1995). However, the scarcity of nursing literature focused on the holistic care of individuals with STIs signifies nurses may have gaps in their knowledge about the effects these infections can have on the daily lives of affected women.

Feminist approaches recognise and make apparent the oppression and social constructs that influence women’s experiences (White et al. 2001). Sexuality is socially constructed (Baker & Rosenthal 1998, Lewis 1998, Kitzinger 2000). Therefore, exploration of women’s experiences with STIs cannot be effectively achieved without taking into account the social subjugation and the stereotyping that has been imposed on women’s sexuality. Past research suggests that gendered societal stereotypes have contributed to women with STIs feeling shamed and stigmatised both personally and in the healthcare setting (for example Nack 2002), and so a feminist framework was selected to guide this study.

Aim

This article is a report of a study of young women’s experiences of having an STI/s.

Study design and methods

Participants

To participate in this study, the women needed to be able to communicate fluently in English and have a past or present history of a diagnosed infection that was contracted through sexual intercourse between 18–30 years of age. For the purpose of this study, sexual intercourse was defined as heterosexual vaginal or anal intercourse. The study excluded women who contracted a viral condition such as HIV/AIDS and hepatitis, because these viruses can be contracted through other avenues such as intravenous drug use and medical procedures. For the purpose of this study, oral sexual contact was also excluded from the definition of sexual intercourse, because, although STIs can be transmitted orally, there is a lower STI risk compared with vaginal and anal intercourse (Edwards & Carne 1998). In addition, past literature has suggested that oral sexual contact is not necessarily viewed as an act of sexual intercourse and is not perceived by young people to be as intimate as penetrative intercourse (Chambers 2007).

Data were collected in 2007 from 10 participants. Participation in this research was voluntary, and recruitment was via media release and poster advertisements placed around sexual health clinics, university campuses and on Internet STI-support websites. All advertisements invited potential participants to contact the first author for further information. After this initial consultation, all potential participants were forwarded an information pack providing details of the study, requirements for participation, a consent form and contact details for further enquiries.

Data collection

Because of the sensitivity and stigma surrounding STIs, a data collection method that promoted anonymity was sought. Therefore, similar to other studies (for example Kralik et al. 2000, Beck 2005), data were collected via online unstructured interviews using electronic mail (email) and instant messenger software. Instant messenger software is a synchronous online service that offers instant online messaging in a private domain, with only invited contacts having the ability to join the typed conversation. These modes of data collection provided the opportunity to discuss a sensitive topic with women who may not have been willing to participate in face-to-face interviews because of the stigmatising and sensitive nature of STIs (Peris et al. 2002). Data
collection ceased after the tenth interview because no new data was being presented; therefore, data saturation was achieved. Each interview began with the broad question ‘can you tell me your story of having a sexually transmitted infection?’ that was followed up by prompts and probing questions determined by participants responses. The interviews lasted between 40–120 minutes, generated between 6–16 pages of text and were conversational in nature.

Ethics issues
Ethics approval was received from the relevant institutional ethics committee, and all participants either provided or were provided with pseudonyms to maintain confidentiality. Their concern with complete confidentiality meant that some women chose not to return consent forms. In these cases and to respect the women’s desire for true anonymity, informed consent procedures were upheld during the online or email interviews. Because of the sensitive nature of this research, all participants were provided with a list of professional services providing free, confidential counselling on matters relevant to STIs and reproductive and sexual health.

Data analysis
The analysis of the data was informed by feminist narrative techniques proposed by Anderson and Jack (1991). These techniques were originally developed for narrative arising from oral interviews; however, in this study, they were applied to written narratives. Anderson and Jack (1991) propose that researchers be attentive to participant’s ‘moral language’, ‘meta-statements’ and the ‘logic of the narrative’ (19–22). Being attentive to participants’ ‘moral language’ in their written text involves being aware of language that reflects the relationship between the participant’s values and societal values and norms (Anderson & Jack 1991). ‘Moral language’ reflects how societal values, norms and expectations influence an individual’s self-perception. ‘Meta-statements’ in the text are statements and thoughts that reveal participant’s reflective processes (Anderson & Jack 1991). ‘Logic of the narrative’ refers to being attentive to the consistencies and contradictions in an individual’s statements and story and how these are related to gain understanding into the individual’s experience (Anderson & Jack 1991).

Ten women aged between 21–39 participated in this study. They had contracted a range of STIs including genital herpes, human papilloma virus (HPV) and chlamydia, with some having had multiple diagnoses. The women were from various backgrounds and described themselves as being mothers, students and/or having a professional career and participated in this research from various locations in Australia and overseas.

Results
Findings from this study indicated that the participants had previously perceived themselves invulnerable to STIs and did not believe they engaged in risk behaviours that could possibly do them harm. They experienced conflict between their previously held beliefs about women who contracted STIs and their own status as women with STIs, and this caused a disruption in the women’s sense of self. Subsequently, in attempting to restore their disrupted sense of self, the women used coping mechanisms of denial and wishful thinking. The findings are presented in three themes that capture the women’s disrupted sense of self and include Self-perceived invulnerability: ‘This can’t happen to me’; Self-blame and shame: ‘I feel so ridiculously foolish’; and Self-preservation: ‘Living in denial’.

Self-perceived invulnerability: this can’t happen to me
Prior to being diagnosed with STI/s, the women did not believe they were at risk of STI/s. This belief was attributed to age, naivete´ and the perception that their behaviours, such as practising unsafe sex within perceived monogamous relationships, did not carry risk: ‘before I got herpes simplex virus I don’t think I would have thought very much about it (STI risk). But now I look back and realise how naive I was’ (Cathy). Although the women were aware of the risks of engaging in unsafe sex, they did not associate their own behaviour with risk behaviour.

Despite some of the women having a history of STI/s, their continued sense of invulnerability outweighed the risks associated with unsafe sexual practices. Bree had chlamydia prior to being diagnosed with genital herpes; however, she continued to have a sense of invulnerability: ‘…it is always in the back of your mind, but it’s one of those situations where you think ‘it doesn’t happen to me’ but it did’. This is also clear in Charlotte’s perception of herself as being invulnerable to these infections, which overshadowed her risk perception:

I think if someone had asked me, back then, if I thought I could get any sexually transmitted disease (STD) I would have said yes, but everyone likes to think that ‘it won’t happen to me’.

Some of the women in this study felt protected from STI/s because of the perception they were in loving and committed relationships. This is evident in Sam’s comment ‘after the initial shock of ‘this can’t happen to me’ coz I had a loving boyfriend…’ Because of the positive emotions that characterised Sam’s relationship, she believed she would not be at risk of contracting an STI from her partner. Similarly, Ruby
could not conceive that within the safety of a marriage she could contract STIs. Ruby felt deceived, dominated and taken advantage of by her older husband. When reflecting on her perception of her own risk Ruby commented:

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

Similarly, Charlotte attributed her young age and naïveté to her sense of invulnerability. Although she had been aware of STIs and felt that she took adequate precautions to prevent contracting an infection, her own experience of having an STI made her aware of her vulnerability. Charlotte asserted:

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

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

As a consequence of contracting STIs, the women felt spoiled and shamed. They felt they had let themselves down and feared being perceived as irresponsible. These women felt others would be disappointed in them and believed contracting an STI revealed their careless behaviour and participation in unsafe sexual practices. Furthermore, despite some of the women contracting STIs through forced or coerced sex and deception, all of them took responsibility for the infection. Some women not only blamed themselves for their own actions but the actions of their male partners. They felt they could have prevented contracting an STI if they had been more careful. On reflection, the women viewed themselves as naive – contrary to the mature women they had previously perceived themselves as. Ruby’s narrative revealed her shame and distress:

I felt ashamed. Looking back I know I did not do wrong but I felt dirty and used and I felt like I was just disgusting. ...I was filled with shame and it turned into self-hatred in a way. I still can’t believe I was treated so badly.

The women felt they would be perceived as careless and foolish as they had contracted preventable infections. Lilly’s remorse was amplified by the fact that she contracted an STI from a casual sexual encounter. Traditional views of femininity do not endorse casual sexual relations for women, and Lilly felt shamed and repentant for her actions:

...The disappointment I felt was due to my careless actions of engaging in unprotected sex with a male who I was not in a relationship with at the time and having contracted herpes via this means. ...In hindsight I feel so ridiculously foolish and regretful.

The women’s stories reflected the common societal view that women are responsible for men’s sexual behaviour. Cindy concluded that although she did not have control over being sexually assaulted, she blamed herself. She negated the behaviour of the men that were involved and criticised herself for her actions at the time: ‘I was a sly drunk 18 yo (year old) who got in the car with a group of guys and thought I was old enough to take care of myself’. Similarly, Bree blamed herself for engaging in unprotected sex and contracting herpes. She felt her actions were careless and irresponsible, and although she expressed anger towards the male partner, she ultimately took responsibility and excused his behaviour by considering that he may have been unaware of his status:

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

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

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

**Self-preservation: living in denial**

Despite the anguish and burden the infections caused these women, they minimised the impact of the infection in other contexts. This was revealed through ambivalence and the contradictions in the women’s stories. Although the women generally perceived themselves as responsible, some did not disclose their infection status and on occasions continued to engage in unsafe sexual practices after their STI diagnoses. The women denied and minimised the extent of their
infections to preserve their integrity and image to others. They used wishful thinking and denial to diminish the burden of having an STI, to repair their disrupted sense of self and return to their previous state of well-being. This is clear in Bree’s comments:

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

Likewise, although Ruby was diagnosed with herpes via clinical pathology, she stated she has never been symptomatic and contemplated whether the diagnosis was a mistake:

With the herpes it was diagnosed with a blood test but I don’t ever remember having it so I suppose I have been in a bit of denial about that. With herpes I have read that it is painful so I think I would know if I had it.

When discussing why people deny their infections, Charlotte explained that it was her shame that led to denial:

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

Some of the women had chosen not to disclose to their sexual partners post diagnosis. Ruby’s justification for non-disclosure was that she was not engaging in heterosexual intercourse: ‘…I got a female partner. She was great and I didn’t feel I had to tell her anything about the diseases as there was no penetrative sex’. Both Ruby and Sam felt men posed as much risk to them as they did to men, as they were just as likely to contract further STIs from other male partners. Sam had not disclosed her infection to any of her sexual partners since being diagnosed with genital herpes, she felt she had taken adequate precautions to minimise transmission:

Well truthfully I haven’t told any guys like guys I’ve just been ‘seeing’ only two guys since. …The two guys I have been with in the past two years since finding out I haven’t told them but have used condoms and taken Valtrex® as a suppressive. Also, I’m at as much risk of catching something from them as they are from me.

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

I did not contact previous partners that may have been at risk to warn them because I didn’t want them or the whole town to find out I had it and I had no idea how long I may have had it anyway.

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

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

Discussion

The following discussion illuminates the ways that social constructs influenced how these women felt about themselves following diagnoses of STIs and the determinants that led to these women experiencing a disruption in their perceived sense of self.

The self

The term ‘self’ is nebulous and has been used ambiguously throughout the literature (Baumeister 1998). However, for the purpose of this study, the term ‘sense of self’ is used to represent the social construction of the self and encompasses the woman’s self-perceived individual character. A person’s ‘self’ cannot be disaggregated from their social environment, interactions and the influences these constructs have on their sense of self and individual life (Sanford & Donovan 1984, Miller 1991, Baumeister 1998, Stets & Burke 2000, Ellemers et al. 2002). Due to the self being fundamentally interconnected with the social environment, societal views and social
interactions influence and shape self-perceptions and the perceptions individuals hold of others (Sanford & Donovan 1984, Belenky et al. 1997, Cederstrom 2002). For example, in a social context, a female child is socialised and becomes aware that she is a woman; a woman who should possess the attributes ascribed to the female gender, such as being attractive, gentle and providing nurture to others, and therefore should behave accordingly (Sanford & Donovan 1984). Hence, people are socialised to behave, to conform and to become the individuals that they are expected to represent in a given social context (Cederstrom 2002).

Failure to fulfil social expectations and self-perceptions can create emotional pain and fear that one’s self has been, or will be, revealed as flawed (Cederstrom 2002). When women feel they have failed to fulfil expectations, they may begin to question their capabilities and experience self-doubt (Fisher 2008). The questioning of one’s self and perceived failure caused by not fulfilling an individual’s expected, perceived and desired self can create a disruption in a person’s sense of self, as the women in the current study revealed in their stories.

The physical body is a fundamental component of a woman’s sense of self (Ussher 2006). How the feminine body is experienced and perceived, in addition to the social meaning that the body carries, profoundly affect one’s sense of self (Jack 1991, Ussher 2006). The feminine body is expected to be attractive, pure and chaste (Nelson 2005). Perceiving their body as diseased and unclean disrupted the sense these women held of themselves. Women who experience a disruption in their sense of self may begin to perceive themselves through their flaws rather than their individual characters (Estés 1992). Due to the body being indivisible from the sense of self, these women felt that the STIs characterised who they were. The finding that these women experienced a disrupted sense of self resonates with work by Doyal and Anderson (2005) who found that women’s internalisation of stereotypes caused them to feel that by having an STI their identity and character had become tarnished (Doyal & Anderson 2005). However, the current study extends on this and sheds light on how shame and the social construction of the self influence the perception of being tarnished in women with STIs.

Prior to their own diagnoses, the women in the current study had themselves previously perceived women with STIs as deviant and promiscuous. Because they did not identify themselves as promiscuous, they had not believed they were at risk of contracting an STI. This belief aligns with earlier literature that asserts many young women do not readily identify with the characteristics that they believe are associated with these infections (Holland et al. 1990). The views held by women in the current study created feelings of shame when they themselves contracted an STI, which has also been found in previous research on women with STDs (for example Nack 2002).

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

Women are blamed for the transmission of STIs, partly because they are capable of transmitting infections to their offspring; a factor that strengthens the perception that women are responsible for the spread of these infections (Sandelowski et al. 2004, Lekas et al. 2006). This perception is consistent with the views of the women who participated in this research as they blamed themselves for contracting an STI. Women blaming themselves for their behaviours after contracting an STI has also been noted in qualitative studies focused on women with HPV (Perrin et al. 2006, Kahn et al. 2007) and chlamydia (Darroch et al. 2003).

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

The findings of denial in the current study concur with previous literature focused on women and STIs. For example, Nack (2000) found women participants had denied their STD to themselves and others, which facilitated them in maintaining a healthy social sexual status, rather than being.
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labelled ‘dirty’ or promiscuous. Other research has indicated that denial may occur particularly among those who lack symptoms (Melville et al. 2003) as found to be the case with Ruby in this study, and Kahn et al. (2005) found women choosing not to disclose a HPV positive result to partners was associated with shame, stigma and the fear of rejection.

Strengths and limitations

The use of computer-mediated communication (CMC) was considered a strength of this research. By using CMC, recruitment of participants that otherwise may not have participated was achieved. CMC promoted freedom of expression by ensuring anonymity. Further, the use of a feminist approach enabled the exposure of how social constructs and the positioning of women’s sexuality in society influenced and impacted on these women’s experiences of having STIs. However, use of a feminist approach may also be a limitation in that it limits other stand points and approaches.

The small sample size of this study is a limitation, as it is the inclusion criterion requiring women to communicate fluently in English. Future research is needed to explore the influence of culture and ethnicity on the experiences of having STIs in both men and women. Further, although these women had been living with their diagnosis for a period of 1–10 years, future studies need to address the lasting impact these effects have on the psychosocial development and well-being of young women.

Conclusion

The findings reported in this article indicate a detrimental impact on the sense of self and sexual well-being of these young women. Awareness of the negative effects and impact these infections can have on young women can assist nurses in the provision of appropriate healthcare, education and support that can facilitate positive coping strategies and self-protective behaviours among this group, which could also help curb non-disclosure and denial among young women who contract STIs.

Relevance to clinical practice

Findings from this study revealed that the perceived invulnerability of STIs among young women can continue into early adulthood, with this perception leading to risk behaviour. Findings also highlight that contracting an STI can cause a personal crisis that can foster a sense of denial and this too can result in continuing risk behaviour. Nurses providing care to women with STI should promote positive coping strategies that could help curb non-disclosure and denial among young women. Education focused on STI should emphasise that all sexually active individuals are at risk of these infections, which could potentially minimise the shame felt by persons who contract these infections. Further, public health campaigns that endeavour to promote safer sex through condom use must recognise and acknowledge the power imbalances and social forces that hinder women’s ability to practise safer sex. Further, the development of and referral to women’s healthcare centres providing small group work and interpersonal skill development may prove beneficial to young women with an STI and help with strategies to promote women’s autonomy in the context of condom use (East et al. 2007). These groups could provide a safe and supportive environment for young women to explore and develop personal strategies to minimise STI risks and gendered issues associated with heterosexual relationships, whilst fostering a positive sense of self among young women.

Contributions

Study design: LE, DJ, KP, LO; data collection and analysis: LE, DJ, KP, LO and manuscript preparation: LE, DJ, KP, LO.

Conflict of interest

Not applicable.

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