Sexually Transmitted Infections and Intimate Relationships: Exploring Intimate Relationships After Diagnosis Using a Strengths-Based Approach

by

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ABSTRACT

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Very little academic literature has been published regarding the intimate relationship experiences of people living with chronic STIs/HIV. This study aimed to explore the experiences of people living with a STI in an intimate relationship using a strengths-based orientation. 28 Canadians between the ages of 21 to 56 living with a chronic STI/HIV participated in the anonymous, online survey to share their experiences of navigating a committed relationship. Using Braun and Clarke’s (2006) thematic analysis, I identified three themes from the participants’ responses: Contextualized Experiences, Individual Competencies, and Competencies in Intimate Relationship. Bivariate correlations and two multiple regressions were also performed to determine if disclosure status, relationship duration, and/or communication strategies predict Sexual Satisfaction or Relationship Satisfaction. The three communication subscales, Positive Interactions, Criticize/Defend, and Demand/Withdraw were found to significantly predict Sexual Satisfaction together. Relationship Satisfaction was significantly predicted by the Positive Interactions and Criticize/Defend model, and the Criticize/Defend subscale significantly predicted Relationship Satisfaction on its own. Directions for future research and practice are discussed.
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# Table of Contents

ABSTRACT ................................................................................................................................. ii

Acknowledgements ..................................................................................................................... iii

Chapter 1: Introduction and Layout ............................................................................................. 1

Chapter 2: Critical Literature Review ......................................................................................... 2
  Introduction ................................................................................................................................. 2
  Literature Review ....................................................................................................................... 3
    Impact of STIs on individuals .................................................................................................... 4
    STIs in relationships ................................................................................................................ 6

Limitations of Past Research ....................................................................................................... 11
  Individual focus ....................................................................................................................... 11
  Harm reduction ....................................................................................................................... 12
  Sexuality .................................................................................................................................. 13

Research Implications ................................................................................................................ 14

Chapter 3: Theorizing the Gaps ................................................................................................. 19
  Strengths-Based Approach ....................................................................................................... 19
  Research Questions .................................................................................................................. 21

Chapter 4: Qualitative Study ..................................................................................................... 22
  Introduction ............................................................................................................................... 22
  Harm Reduction: The Implicit Theoretical Underpinning to Current Literature .................... 23
  The Strengths-Based Perspective ............................................................................................ 26
  Method .................................................................................................................................... 28
    Study design ........................................................................................................................... 28
    Ethical considerations .......................................................................................................... 28
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment and sampling.</td>
<td>29</td>
</tr>
<tr>
<td>Procedure and qualitative inquiries.</td>
<td>30</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>31</td>
</tr>
<tr>
<td>Results &amp; Interpretations</td>
<td>32</td>
</tr>
<tr>
<td>Contextualized experiences: overall relationship</td>
<td>34</td>
</tr>
<tr>
<td>Contextualized experiences: Sexual</td>
<td>37</td>
</tr>
<tr>
<td>Individual Competencies.</td>
<td>41</td>
</tr>
<tr>
<td>Competencies in Intimate Relationship</td>
<td>42</td>
</tr>
<tr>
<td>Discussion</td>
<td>44</td>
</tr>
<tr>
<td>Applications</td>
<td>47</td>
</tr>
<tr>
<td>Strengths</td>
<td>49</td>
</tr>
<tr>
<td>Limitations</td>
<td>50</td>
</tr>
<tr>
<td>Future research</td>
<td>51</td>
</tr>
<tr>
<td>Conclusions</td>
<td>51</td>
</tr>
<tr>
<td>Chapter 5: Quantitative Study</td>
<td>53</td>
</tr>
<tr>
<td>Participants</td>
<td>53</td>
</tr>
<tr>
<td>Procedure</td>
<td>53</td>
</tr>
<tr>
<td>Screening Questionnaire</td>
<td>54</td>
</tr>
<tr>
<td>Demographic Questionnaire</td>
<td>54</td>
</tr>
<tr>
<td>Quantitative Measures</td>
<td>54</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>56</td>
</tr>
<tr>
<td>Results</td>
<td>57</td>
</tr>
<tr>
<td>Sample</td>
<td>57</td>
</tr>
<tr>
<td>Other correlations</td>
<td>61</td>
</tr>
<tr>
<td>Discussion</td>
<td>65</td>
</tr>
</tbody>
</table>
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Qualitative Measures</td>
<td>39</td>
</tr>
<tr>
<td>2</td>
<td>Socio-Demographics Of Sample</td>
<td>67-68</td>
</tr>
<tr>
<td>3</td>
<td>Normality Of The Predictor And Outcome Variables</td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>Bivariate Correlations Of Suggested Predictors Of Sexual And/Or Relationship Satisfaction Using Spearman Rank-Order Correlation</td>
<td>71</td>
</tr>
<tr>
<td>5</td>
<td>Linear Model Of Predictors Of Sexual Satisfaction, With 95% Confidence Intervals Reported In Parentheses</td>
<td>73</td>
</tr>
<tr>
<td>6</td>
<td>Positive Interactions And Criticize/Defend Significantly Predict Of Relationship Satisfaction, 95% Confidence Intervals Reported In Parentheses</td>
<td>74</td>
</tr>
</tbody>
</table>
List of Figure

<table>
<thead>
<tr>
<th>Figure</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Thematic Map</td>
<td>42</td>
</tr>
</tbody>
</table>
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH</td>
<td>Genital Herpes</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction and Layout

Very little academic literature has been published regarding the intimate relationship experiences of people living with chronic STIs/HIV, particularly in the Canadian context. This study aimed to contribute to filling this gap by exploring the experiences of people living with a STI in an intimate relationship using a strengths-based orientation. This paper presents this exploration in six chapters. Following the current chapter, Chapter 2 is constructed as a manuscript draft, reviewing and critiquing the current literature and building a case for the importance of exploring relationships where one or more partners is living with a chronic STI. Further, Chapter 2 outlines the importance of using a strengths-based approach in research that involves people living with marginalized identities/social traits. In Chapter 3, I follow-up on the critical literature review by outlining the strengths-based approach and identifying the three research questions this thesis addresses. Chapter 4 is also constructed as a manuscript draft, framing the qualitative results of the study I conducted using a strengths-based approach. The anonymous qualitative data was collected online, and analyzed using thematic analysis (Braun & Clarke, 2006). Following the qualitative manuscript draft, Chapter 5 expands on the data collection method, the demographics of the participants, and analyzes/discusses the quantitative results of the study. Finally, Chapter 6 concludes the paper by summing up the entire research project and the key findings that were identified.
Chapter 2: Critical Literature Review

Introduction

In 2013, the Public Health Agency of Canada released a report stating that sexually transmitted infections (STIs) are a significant public health concern across the lifespan (Butler-Jones, 2013). This concern has been echoed worldwide, with the World Health Organization estimating that more than 1 million new sexually transmitted infections occur every day (World Health Organization [WHO], 2015). In the Canadian context, there are approximately 71,300 individuals living with HIV (Public Health Agency of Canada, 2012) and approximately 10 to 30% of the adult population living in Canada are living with HPV (The Society of Obstetricians and Gynecologists of Canada, 2007). The prevalence of genital herpes is not tracked in Canada, but it is estimated that more than 500 million people are living with GH worldwide (WHO, 2015). With STIs remaining a public health concern in Canada and abroad, there is a significant need for research examining STIs and the effects they have.

Current research on STIs is strongly focused on the medical implications of STIs (i.e. prevention and treatment options) and individual-level factors and outcomes, such as psychological well-being and personal decisions to disclose (e.g. Aljassem et al., 2016; Hughes et al., 2013; Moses & Tomlinson, 2013; Panel on Antiretroviral Guidelines for Adults and Adolescents, 2014). While this research is necessary given the increasing concern surrounding sexually transmitted infections, it is equally necessary to explore the intimate relationships of individuals living with STIs since the risk of transmission could influence many aspects of the relationship. By exploring STIs in the context of intimate relationships, researchers and clinicians could develop a deeper understanding of the unique circumstances surrounding a
relationship involving an STI, and offer empirically-directed care for individuals in these relationships.

The purpose of this article is to review current literature regarding the impact of sexually transmitted infections on intimate relationships, as well as how individuals living with STIs may approach and experience relationship decisions as a result of potentially unique needs and challenges. This article will specifically focus on:

1. Briefly outlining the individual-level factors associated with having an STI that are likely to impact relationships;
2. Reviewing the literature on intimate relationships in which one (or both) of the partners has an STI;
3. Critically evaluating the current literature focusing on individuals in committed relationships where one or both partners has an STI; and
4. Offering future research directions related to the study of relationships that are affected by a sexually transmitted infection.

Literature Review

For the purpose of this paper, the scope was limited to studies focused on STIs without a medical cure, including human immunodeficiency virus (HIV), persistent human papillomavirus (HPV), and genital herpes (GH). Chronic STIs were chosen as they presumably present unique life-long challenges compared to STIs that can be treated and consequently may have only short-term implications (or none at all) for present or future relationships. Due to the rapid progress of antiretroviral therapy and their effectiveness on HIV/AIDS management and survival rates (e.g. Joseph, Flores, Parsons, & Purcell, 2010), and the progress of medications intended for managing HPV and genital herpes (Healthwise Staff, 2013; Public Health Agency of Canada,
2012), the experiences of individuals living with STIs have likely changed in the recent past. For this reason, this literature review was limited to research that has been published since 2005.

Impact of STIs on individuals. A great deal of evidence suggests that individuals living with STIs are at risk for detrimental psychological and emotional burdens (e.g. Foster & Byers, 2008; Newton & McCabe, 2008). Gao et al. (2010) reported that individuals living with STIs are at a heightened risk for depression compared to those living without STIs; the depression they experience also correlates with “anxiety disorders, increased risky behaviours, substance abuse, suicide, decreased quality of life, and other negative outcomes” (p. 313). Numerous studies have supported these findings, with individuals reporting that living with a STI made them depressed (Newton & McCabe, 2008b) and/or anxious (Sadeghi-Nejad, Wasserman, Weidner, Richardson, & Goldmeier, 2010). Merin and Pachankis’s (2011) review of the psychological impact of stigma due to GH suggested that the negative thoughts and feelings related to sexually transmitted infections persist long-term only when symptoms persist. The link between depressive symptoms and relationship quality has been frequently noted in the literature (e.g. Whitton & Kuryluk, 2012) and, as such, it stands to reason that the negative psychological symptoms experienced by individuals living with STIs could be impacting their relationships.

Limited research connected the experience of living with an STI to aspects of intimate relationships, and findings have been conflicted. In Newton and McCabe’s (2008b) study of 274 participants (mean age of 31.9), people living with HPV and GH reported lower sexual satisfaction than individuals without HPV or GH (Newton & McCabe, 2008b). In contrast, a more recent study (Foster & Byers, 2016) of 188 participants living with HPV or GH found that the majority of the participants were sexually satisfied, had high sexual self-esteem, and reported engaging in regular sexual activity with little anxiety, especially when in a committed
relationship. Foster and Byers’ (2016) results are relatively consistent with past research they conducted (2013), in which sexual functioning of a sample of individuals with STIs did not significantly differ from individuals without STIs. Sexual functioning has been raised as a concern for individuals living with STIs in other research, though, as HIV and GH have been associated with sexual dysfunctions in both men and women, specifically with respect to desire and pain disorders (e.g. Sadeghi-Nejad et al., 2010). Given the mixed and somewhat contradictory findings relevant to sexual well-being in individuals living with STIs, it seems reasonable to suggest that factors beyond just STI status are influencing findings; perhaps other factors, such as relationship dynamics, may be significantly contributing to sexual outcomes.

External and internal stigma has emerged as an important predictor for sexual well-being in individuals living with STIs (including sexual functioning, sexual frequency, sexual anxiety, sexual self-esteem, and sexual satisfaction; Foster & Byers, 2016). Stigma, defined as “an attribute or label that sets a person apart from others and links the labeled person to undesirable characteristics” (Lichtenstein, 2003, p. 2437), may also cause individuals to avoid obtaining sexual health care for STIs (Foster & Byers, 2008), leading to concerns regarding treatment and transmission prevention. With this in mind, it becomes increasingly important to acknowledge that various populations have been documented as believing and expressing harmful messages associated to STIs, including university students, clinic workers, and patients with STIs (Foster & Byers, 2008; Lichtenstein, 2003). Some attempts at preventing STIs may also promote stigma, as prevention campaigns with messages such as “You know the risks, the decision is yours” (critiqued in Rhodes & Cusick, 2000, p. 2) place blame on individuals who contract STIs. Interestingly, these stigmatizing messages also emerge in the academic literature, with specific recommendations (e.g. “choose partners carefully”, Sadeghi-Nejad et al., 2010, p. 404) and
language choices (e.g. “the women in this study learned to accept a tainted sexual self”, Nack, 2000, p. 22, emphasis added) suggesting that individuals living with STIs have undesirable traits and are not ideal intimate partners. These attitudes and messages are important to note as individuals living with STIs have been reported to be less likely to disclose their STI status to their partner, or potential partners, when they feel highly stigmatized (Foster & Byers, 2008). Clearly stigma is still present.

**STIs in relationships.** Individual-level research provides support for the idea that relationships can be affected by sexually transmitted infections; the nature and extent of these effects on relationships are unclear, though. A review of the academic literature was conducted to explore the impacts STIs can have on intimate adult relationship development and maintenance. Along with the previously established criteria (chronic STIs and research published after 2005), the literature was limited to research exploring any kind of personal relationship that involved sexual experiences (e.g. romantic, intimate, sexual, etc.), as these relationships would be more likely to require long-term consideration of the STI, and research conducted with at least a portion of the sample consisting of Canadians (due to the accessibility of medications in Canada that may influence sexual practices). However, with the exception of Foster and Byers’s (2013) and Newton and McCabe’s (2008) studies (both described below), few studies specifically examining intimate/sexual relationships where one or both partner had a sexually transmitted infection were found. Given the lack of studies meeting the criteria, the literature review was expanded to include research examining specific issues that could arise in an intimate relationship context, such as disclosure and sexual risk-taking (with or without Canadian participants).
Research examining STIs in the context of intimate relationships. Only two studies were found that met the inclusion criteria for the literature review; it should be noted that neither study required participants to currently be in a relationship. Newton and McCabe (2008) conducted qualitative interviews with 60 participants (n=30 living with genital herpes, n=30 living with HPV) to expand the “little or no research in some of the areas” (p. 865) related to sexuality and relationships where one or both partners have a STI. The majority of participants in the study reported feeling like they were now restricted with respect to their sexuality, and that they felt less sexually desirable since their diagnosis. Participants also reported a decrease in sexual experiences since their diagnosis; however, this may be partially attributable to the fact that they were not currently in a relationship. Many participants reported avoiding intimate relationships due to their STI status. The last significant finding related to relationship experience was that “a very high number of respondents” (Newton & McCabe, 2008, p. 867) experienced conflicts and/or miscommunication in their relationships that they attributed to their STI status, with one participant explaining that her and her partner experienced difficulties communicating about STI symptoms and desired support related to these symptoms.

The second study, conducted by Foster and Byers (2013), explored relationships where one or both partners had a STI. A quantitative design was used. The sample consisted of participants living with herpes only (n=79), HPV only (n=24), herpes and/or HPV with an additional STI (n=80), or no STI diagnosis (n=299). The study aimed to explore the sexual well-being of individuals living with HPV or herpes by comparing their results on psychometric measures to those of individuals living without a STI diagnosis. Although the focus of the study was on individual sexual well-being, participants living with a STI were more likely to have experienced a distressing sexual situation and to report low sexual satisfaction than the
participants living without a STI, despite reporting higher sexual frequency. Overall, Newton and McCabe’s (2008) and Foster and Byers’s studies offered an important contribution to the literature by exploring relationships where one or both partner(s) was living with an STI. Both Newton and McCabe’s and Foster and Byers’s studies acknowledged the struggles and strengths that people living with STIs were experiencing in their current relationships, suggesting that there is a need to further investigate relationships where one (or more) individual(s) in the relationship has a STI, specifically with respect to sexuality and communication.

**Disclosure.** Disclosure was one factor explored thoroughly in the literature focusing on individuals living with STIs. Researchers have extensively examined reasons for disclosing or not disclosing STI status (Newton & McCabe, 2008), effects of disclosing to partners (Newton & McCabe, 2008b), and specific strategies that are employed by individuals living with STIs regarding STI disclosure (Frye et al., 2009). In these studies, decisions regarding whether or not to disclose to partners were influenced by a variety of circumstances, including whether or not the individual was asymptomatic (Frye et al., 2009), and how the individual imagined their partner would respond. For example, in one study, a participant explained that they chose not to disclose after witnessing their partner’s negative reaction to learning about someone else’s STI diagnosis (Frye et al., 2009). Additionally, some findings have suggested that individuals with genital herpes who have experienced negative reactions upon STI disclosure have had significant negative effects related to this experience and have, in some cases, chosen to avoid future disclosures either by not disclosing to new partners or not pursuing new partners (Frye et al., 2009). Individuals who do not disclose to intimate partners may experience more sexual anxiety and depression and lower sexual esteem and satisfaction than individuals who choose to disclose.
(Newton & McCabe, 2008b). Ultimately, issues around disclosure have a clear impact on intimate relationships and individuals who have sexually transmitted infections.

The focus on disclosure seems to suggest that the main concern of the research is ensuring that the risk of future transmissions is minimized, which is consistent with a harm reduction approach. Harm reduction is a guiding framework intended to reduce possible harm that could arise due to specific behaviours, such as sexual behaviours (Brocato & Wagner, 2003). The various studies focusing on disclosure patterns demonstrates harm reduction inquiries regarding an individual’s experience in an intimate relationship in which one or more partners have a STI. Disclosure was thoroughly examined in the research, with participants being asked about the timing of their disclosure to new partners (Frye et al., 2009; Nack, 2000), their experiences regarding these disclosures (Frye et al., 2009; Nack, 2000), and factors that contributed to their decisions of whether or not to disclose (Newton & McCabe; Newton & McCabe, 2008b; Sadeghi-Nejad et al., 2010).

While disclosure patterns have an obvious impact on individuals with STIs, the focus on disclosure seems to suggest that the main concern of the research is ensuring that individuals disclose their STI status and thus minimize the risk of future transmissions - a clear harm reduction inquiry despite never being explicitly labelled as such. While harm reduction research can lead to successful health outcomes in practice (Brocato & Wagner, 2003), it appears that this focus has restricted the questions that have been asked and the suggestions made regarding the management of STIs in relationships. Despite the fact that the majority of participants in the literature reviewed had STIs, the research that has been conducted has offered very little to our understanding of positive intimate relationships involving individuals with STIs. With STIs being a significant, growing health concern (Butler-Jones, 2013), these experiences need to be
examined from a new perspective to explore the lived experiences of people who are currently navigating relationships where one or both partners have a STI and inform future approaches to care.

**Risk behaviours.** Risk behaviours were also a recurring theme in the majority of research that examines relationships where one or both partners has a STI. For example, Rhodes and Cusick (2000) conducted a qualitative study of individuals with HIV in intimate relationships. Individuals living with HIV were interviewed, with the focus of the interview mainly on the behaviours of participants that could put others at risk of contracting HIV. The predominant finding of the study was that as relationships shift towards more intimate and permanent states, they also tended to shift towards using less protection (e.g. condoms). The authors concluded that risk reduction strategies need to re-conceptualize condom use to promote use within relationships involving STIs (Rhodes & Cusick, 2000). While this re-conceptualization could be important for individuals with STIs (as they are more at risk of contracting new infections due to their weakened immune state; Butler-Jones, 2013) as well as their partners, it seems to be targeted largely at the health and well-being of partners without a STI. By expanding the scope of research, more knowledge can be generated regarding people living with STIs.

**Summary of the themes.** While there is clearly interest in exploring STIs in the context of relationships, the depth of exploration is minimal and does not seem to specifically investigate the impact of STIs on relationships beyond a consideration of disclosure and reduction of sexual risk with a focus on protecting the partners without a chronic STI from the one with a diagnosis. Researchers have acknowledged the gap in academic literature regarding sexually transmitted infections in the context of intimate relationships on several occasions (Foster & Byers, 2013; Guthrie et al., 2009; Newton & McCabe, 2008a; Newton & McCabe, 2008b; Rhodes & Cusick,
2000) and have called for an exploration of the ways that relationship quality/dynamics (including relationship satisfaction and communication) might impact relationships where a partner has a STI (Foster & Byers, 2016).

Some findings have suggested that individuals living with STIs may struggle with conflict and miscommunication (Newton & McCabe, 2008), and poor communication with a sexual partner has been noted as contributing to negative reactions to one’s STI status (Melville et al., 2003), but experiences related to communication and communication patterns and their effects on intimate relationships where one or more partners is living with a STI have not been adequately examined. Melville et al. (2003), an older but still relevant qualitative study of psychosocial impacts of GH diagnosis among a sample of 24 individuals diagnosed within 10 months of data collection, hinted at the importance of communication within intimate relationships involving STIs with the incidental finding that participants felt open and honest relationships helped with personal acceptance of STIs. The author of the current paper was unable to find any further research exploring the implications of these findings; the current research examining STIs in relationships continues to focus almost exclusively on risk behaviours and the sexual outcomes related to having a STI. Potentially, open communication between partners might mitigate the negative outcomes of STIs on aspects of the couple relationship. Research to date has not thoroughly or systematically examined this.

Limitations of Past Research

Individual focus. The literature revealed a strong focus on individual level analyses, such as psychological and emotional burdens (e.g. Merin & Pachankis’s 2011), and independent decisions and experiences regarding disclosure (e.g. Frye et al., 2009; Moses & Tomlinson, 2013; Newton & McCabe 2008a; Newton & McCabe 2008b). Understanding an individuals’
personal thoughts, feelings, and experiences related to sexually transmitted infections has demonstrated merit, and should be examined further. Conducting research with this individual level focus has allowed for a deeper understanding and testing of psychological theories and it allows clinicians to pull from a wealth of knowledge to guide individuals struggling with their identity maintenance or redevelopment post-diagnosis, as well as to offer education around disclosure if an individual requests aid. However, focusing solely on individual-level analyses contributes to the gap that exists regarding the relational aspects that may be expected, given the circumstances.

Sexually transmitted infections are primarily transmitted through sexual contact, which suggests individuals who have contracted them have likely had sexual experiences. Due to unfortunate circumstances, these infections may not have always been contracted through consensual relations (e.g. transmission can occur during childbirth or forced relations); yet, it is reasonable to assume that a significant proportion are the result of consensual sex, whether the STI was known about or not. For this reason, it is logical to examine the experiences of individuals living with STIs considering relational factors; this conclusion is echoed in the call from researchers for more in-depth exploration of couple relationships involving STIs (e.g. Foster & Byers, 2013, 2016; Guthrie et al., 2009; Newton & McCabe, 2008; Newton & McCabe, 2008b; Rhodes & Cusick, 2000).

**Harm reduction.** A concern arising from the current implementation of harm reduction approaches is revealed by researchers’ choices of language as well as their recommendations. The premise of a harm reduction approach is that certain circumstances are to be avoided - in this case, that circumstance is contracting a sexually transmitted infection. Although it may not be intended, implicit thoughts and values attributed to individuals with sexually transmitted
infections are revealed through the researchers’ choice of words. Nack (2000), for example, uses words like “deceitful” (p. 106) to identify an individual who chooses not to disclose their status and Newton and McCabe (2005) use phrases such as “the infected individual” (p. 12), which can be interpreted negatively.

Perhaps a stronger example of value-laden judgements found within the research can be demonstrated by the recommendations that are offered following the research analysis; as noted previously, one researcher states that individuals should “choose partners carefully” (Sadeghi-Nejad et al., 2010, p. 404), and another suggests that “women [with STIs] could always decide [on]... temporary or permanent celibacy” (Nack, 2000, p. 117). While some would argue that these recommendations are fair and perhaps even necessary to assist with STI prevention efforts, these recommendations can be stigmatizing to people living with STIs.

**Sexuality.** Lastly, several researchers have acknowledged the importance of exploring the experiences of individuals living with STIs for more than prevention purposes, and have opted to focus on the sexual experiences of individuals with STIs instead (e.g. Foster & Byers, 2013; Newton & McCabe, 2008a, 2008b). Essentially, the strength of this focus is the realistic acknowledgement that an individual who has an STI conceivably has a sexual history, and will likely continue to have one post-diagnosis.

Another strength of these studies is that sexual satisfaction and well-being were not measured using a sole item or measure. Foster and Byers (2013) and Newton and McCabe (2008, 2008b) examined a number of dimensions of sexuality, including sexual functioning, sexual self-esteem, sexual satisfaction, and sexual anxiety. The examination of different dimensions allows for a more holistic understanding of the sexual experiences of individuals with STIs. Considering the clear benefits of examining multiple dimensions of sexuality, the literature is limited due to
the focus on individual-level sexual experiences (e.g. sexual self-concept, functioning). The literature still fails to consider sexual experiences within a relationship and the sexual communication used within. Despite incidental findings in past research suggesting communication within relationships where one (or more) partner(s) has a STI may be cause for concern (e.g. Newton & McCabe, 2008a, research examining the sexual experiences of individuals living with STIs continues to ignore the role of communication in sexual satisfaction.

Further, relationship satisfaction is largely not considered in the research exploring the experiences of individuals living with STIs. Research consistently demonstrates that relational and sexual communication influences sexual satisfaction (MacNeil & Byers, 2005; Widman, Welsh, McNulty, & Little, 2006), and this should be explored in studies regarding specific intimate relationships where one or more partners is living with a STI. The next step appears to be looking at sexual outcomes in a relationship context more closely. Does sexual communication negate some of the negative effects, such as low sexual satisfaction (Foster & Byers, 2013) and high reports of conflict (Newton & McCabe, 2008), that have been observed by the presence of a STI in a relationship?

**Research Implications**

This literature review and critical analysis highlights specific strengths and weaknesses of the current research regarding individuals living with STIs within a relationship context. There is strong support for broadening the current harm reduction approach to the research to ensure that the needs of individuals living with STIs are being examined and met, and that the current knowledge regarding transmission is being considered in the approach. It is the responsibility of the researcher to create a methodological approach that minimizes stigmatization or judgment of the participants involved, and it is critical for the work produced to, in some way, provide
knowledge and potential benefits for the population being explored. As research continues, a balance needs to be sought between analyzing the experiences of individuals living with STIs in a way that respects them and honours their contribution to the research process, and in a way that helps reduce transmission. Both approaches to research are valuable, and the former is currently being neglected in the literature. By broadening the current approach to research and encouraging new perspectives on ongoing research topics, the outcomes of the research will continue to produce necessary change.

A sex-positive lens may help with reinterpretations of harm reduction models and outcomes. A sex-positive perspective emphasizes acceptance and openness to sexual diversity and experiences; it highlights the positive aspects of sexuality and the importance of relaying sexual information in a nonjudgmental manner (Williams, Prior, & Wegner, 2013). As Williams et al. (2013) indicate, approaches that conflict with sex-positivity can contribute to the marginalization of individuals with diverse “sexual identities, orientations, and behaviours; gender presentation; and multiple important dimensions of human diversity” (p. 273).

Considering this further, a sex-positive approach would conceptualize the experiences of people living with STIs as one of many sexual diverse experiences, and would aim to reduce fears and judgements against people living with STIs. A sex-positive reinterpretation would avoid any terms or phrases that depict individuals living with STIs negatively. The focus could still implement harm reduction frameworks (taking into account how diverse harm reduction can be), but it could go much further; for example, exploration of the successful experiences of individuals living with STIs could be considered. Future research may recruit individuals living with or affected by STIs and ask about the main concerns in their relationships, rather than specifically targeting concerns related to STIs. By asking about concerns in this manner, it may
come to light that sexually transmitted infections do not always lead to major concerns in committed relationships.

Future research should also aim to discover more about individuals living with STIs, in relation to their experiences in relationships specifically. Although more complex studies could require more resources, in-depth questions, and/or theoretical frameworks, relationships involving STIs need to be examined further. Doing so may help to develop a stronger understanding of the unique processes and communication patterns that take place, as well as to redistribute the levels of accountability and responsibility within relational contexts. Relationships involving members with STIs seem subject to the regular challenges of an intimate relationship but may also involve unique processes regarding communication, negotiation, and sexual considerations; this cannot be confirmed, though, as there is no current research that examines experiences of people living with STIs in a relationship. Individual-level factors should still be considered in relational research, though, as they could contribute to the results. For example, an individual who is currently taking medication for their STI (an individual-level action) would likely face different challenges in a relationship than an individual who is not taking medication, or who does not need medications due to being asymptomatic.

Considering the current gaps in the literature, the next step for research investigating relationship dynamics where one or more partners have a STI is to adopt a qualitative approach to explore if relationships are really impacted by the STI and, if so, how. Researchers exploring this area should be mindful of implicit assumptions that may arise; questions that only leave space for participants to discuss negative aspects of their STI should be avoided. Since “what is perceived to be occurring in an interaction is of more importance often than what actually occurs” (Shepard, Giles, & LePoire, 2001, p. 41), the first step for moving forward should be to
investigate how a person living with a STI experiences their current relationship, giving space for both neutral and positive responses to be reported. A sex-positive approach to research investigating relationships where one or more partner(s) has a STI would be one way to accomplish this.

As communication has been noted as problematic in past research exploring relationships where an individual has a STI (Newton & McCabe, 2008), this should be a priority for future research. Once these perceived relational inquiries have been addressed, research can then shift to a quantitative and/or qualitative dyadic approach based on the findings. A dyadic approach could involve recruiting people living with a STI and their partner(s) in order to unpack their relationship in a holistic way. Lastly, since the focus of past research has been limited to exploring sexual functioning and sexual satisfaction of people living with STIs without taking more nuanced factors into account, it would be useful to explore this topic with a more balanced approach. It has been well-established in research that relationship factors and sexual communication with a partner impact sexual experiences with one’s partner (MacNeil & Byers, 2005; Widman, Welsh, McNulty, & Little, 2006), and thus these factors should also be considered when exploring sexual experiences of people living with an STI.

In summary, research regarding sexually transmitted infections in the context of relationships would be strengthened by becoming more broad and encompassing of a wider range of factors. Researchers should begin exploring beyond the obvious and/or established implications of STIs and start to examine the deeper concerns that individuals living with STIs may have. For example, what do the communication and negotiation patterns involve within an intimate relationship where one or both partners has a STI? Or, perhaps most importantly, what
are the unique needs and challenges faced by individuals living with an invisible and stigmatized chronic illness, and how can researchers and practitioners address these concerns?
Chapter 3: Theorizing the Gaps

It is clear from the literature that factors of a relationship need to be explored further in the context of relationships where one or more participants live with a STI. The implicit assumptions previously underlying the research have limited the diversity and depth of exploration of this topic. To begin addressing this significant gap, a strengths-based approach (Maton, Schellenbach, Leadbeater, & Solarz, 2004) was utilized for the current study. A Strengths-Based Approach to research provides a framework to explore relationships where one or more partners are living with a STI in a way that challenges the deficits-based (and, at times, stigmatizing) models that are currently found in the literature.

Strengths-Based Approach

Strengths-based approaches to research aim to empower populations of interest by resisting research questions, methodologies, and outcomes which result in “diagnosing, fixing, punishing, or simply ignoring those affected” (Maton, Dodgen, Leadbeater, Sandler, Schellenbach, & Solarz, 2004). As the literature review (see Literature Review – Manuscript Style) demonstrated, people living with STIs are often presented in the literature through deficits-based models; for example, they are often diagnosed (e.g. with sexual dysfunctions; Sadeghi-Nejad et al., 2010) or ignored in terms of research implications (e.g. the gap that exists in the literature regarding people living with STIs and their relationships; described in Literature Review – Manuscript Style). In comparison, strengths-based approaches to research actively focus on the “positive potential of individuals, families, and communities” (Maton et al., 2004, p. 5).

Four goals have been identified as fitting for strengths-based inquiries, including: recognizing and building on existing strengths; building new strengths; strengthening relevant
social contexts; and involving populations of interest through the process of initiating and managing interventions (Maton et al., 2004). Since a strengths-based approach has not yet been utilized in the context of relationships where one or more partner(s) is living with a STI, the current study focused on the first goal: recognizing and building on existing strengths of the participants. Strengths are conceptualized broadly, including, but not limited to, individual, relational, societal, and cultural aspects (Maton et al., 2004). By approaching research from this multifaceted perspective, concerns about establishing ‘ideals’ through the identification of individual strengths (and thus attributing stigma to those who do not model these ideals) are largely absolved as strengths at the individual and broader levels are addressed, and the responsibility for overcoming any concerns are similarly situated in broader contexts (Leadbeater, Schellenbach, Maton, & Dodgen, 2004).

Competencies, a key construct to strengths-based inquiries, can be described as successes achieved in a particular context (Leadbeater et al., 2004). For the purpose of the current study, competencies of people living with STIs within their relationships were identified, as well as competencies that were developed within the relationship of the participant (as reported by the participant). Protective processes, including “experiences, events, and relationships” (Leadbeater et al., 2004, p. 18), are also important to consider in strengths-based inquiries as they work to mitigate negative reactions and outcomes either in general (known as “general protective processes”; Leadbeater et al., 2004, p. 18), or in response to adversities (known as “risk-specific processes”; Leadbeater et al., 2004, p. 18).

A strengths-based approach to research provides a solid framework for exploring the relationship context of individuals living with a STI. Given the stigma associated with STIs and the current deficits-based approaches to research in the field, it was important to begin
exploration from a strengths-based approach to challenge current perceptions of people living with STIs within the context of their relationships. Since disclosing to a partner (Newton & McCabe, 2008b) and maintaining a relationship long-term (Rhodes & Cusick, 2000) have been noted as significant factors in reducing negative effects on sexual well-being, these two constructs needed to be included in the current study. Additionally, communication strategies utilized by people living with STIs were necessary to explore due to the previous implications that (mis)communication has impacted relationships where one or more partner(s) has a STI. Lastly, general perceptions of the relationship and specific strengths/challenges within relationships had to be considered in order to fully incorporate a strengths-based analysis.

**Research Questions**

Based on the literature reviewed and a strengths-based approach, three research questions were constructed to inform the methodological choices made for this study:

1. How do Canadians living with a STI perceive their STI status in their intimate relationships?
2. What strengths and/or challenges do Canadians living with STIs experience in their committed relationships?
3. Does the length of the relationship, disclosure of the STI, and communication strategies predict sexual and/or relationship satisfaction?
Chapter 4: Qualitative Study

Introduction

In 2007, the World Health Organization estimated that more than 340 million new sexually transmitted infections (STIs) occur every year. 5 years later, the Public Health Agency of Canada echoed the concern of STIs in the Canadian context. Although most STIs are medically curable, the prevalence of chronic STIs in Canada is significant. Approximately 71,300 individuals are living with HIV (Public Health Agency of Canada, 2012); conservative estimates suggest 10-30% of people are living with HPV (The Society of Obstetricians and Gynaecologists of Canada, 2007). Incidence rates of genital herpes are not tracked in Canada, it is estimated that approximately 1.6 million people contract the infection every year in the United States of America (Public Health Agency of Canada, 2013). That STIs are prevalent (and, one could argue, common) is undeniable.

Despite the high rates of STIs, current research on STIs generally focuses on the medical aspects of STIs (i.e. prevention and treatment options; e.g. Panel on Antiretroviral Guidelines for Adults and Adolescents, 2014), individual-level factors and outcomes (such as psychological well-being and personal decisions to disclose; e.g. Frye et al., 2009; Gao, MacDonald, Collins, & Alaghehbandam, 2010), and sexual health (e.g. Foster & Byers, 2016). Given increasing concerns about STIs around the world, it is clear that the current research is necessary as it can offer important contributions to fill the gaps in current literature and practice. To date, though, very limited research has been published that explores intimate relationships where one (or more) partners has a chronic STI.
Harm Reduction: The Implicit Theoretical Underpinning to Current Literature

Very few recent (i.e. 2005 and later) articles were found that explore the experiences of people living with chronic STIs in intimate relationships, and fewer were found that involved Canadians (an important influencing factor due to the varying accessibility of medications in Canada and the criminalization of HIV, both factors that may influence sexual behaviours; Canadian HIV/AIDS Legal Network, 2009). Only three studies to date (i.e. Fernet et al., 2011; Foster & Byers, 2013; Newton & McCabe, 2008) explicitly consider the relational-level context for people living with STIs in Canada.

Newton and McCabe (2008) aimed to explore the sexual and relational experiences of participants living with a STI as “little or no research [has been conducted] in some of the areas” (p. 865). 60 participants were interviewed for the study, 30 of whom were living with genital herpes and 30 of whom were living with HPV. Participants generally experienced negative effects related to their sexuality, with participants reporting that they felt restricted in their sexual relationships and less desirable as a sexual partner. As well, “a very high number of respondents” (p. 867) attributed conflicts and/or miscommunication in their relationships to their STI status (the nature of these conflicts/miscommunications were not explored in the paper). Additionally, participants were not required to be in a relationship and thus responses were, in many cases, based on past relationships, making recall bias a concern. Further investigation of sexual and general relational experiences specific to communication is warranted given these findings and limitations.

Foster and Byers (2013) examined the sexual well-being of individuals living with STIs (regardless of relationship status) and the effects of relationship status on sexual well-being for people living with herpes and/or HPV. People living with herpes and/or HPV who were not in a
relationship experienced lower sexual self-esteem than single participants who were not living with a STI. Contrarily, participants who were in a relationship reported similar levels of sexual self-esteem as the participants in a relationship who were not living with a STI. This analysis suggests that relationship status, and likely relationship components, may have more of an effect on sexual outcomes than simply STI status, and further, that being in a romantic relationship may have a protective effect on well-being for people living with STIs.

Lastly, Fernet et al. (2011) explored relationships and sexual activities in the Canadian context with a younger (13-22 year-old) sample unique in that they had contracted HIV perinatally (i.e. in utero/childhood). The study aimed to explore the relationships and sexual behaviours of youth, though participants were not required to be in a relationship to participate. Of the 18 participants, girls reported an average of three regular and four casual sex partners and boys reported an average of 12 and eight, respectively. Participants reported taking sexual risks with partners, such as not using condoms, and attributed these behaviours to mixed messages about risk levels and persuasion from partner(s). For example, some participants reported that the risk of transmission was unclear as they had engaged in condomless sexual activity in the past and had never transmitted the virus. In terms of disclosure, five young women had disclosed their positive HIV status to at least one partner. Of those who did not disclose, some explained they were afraid of losing someone they loved and others reported they felt it was unnecessary since they were taking precautions in the relationship (e.g. they were using condoms and were undetectable). Fernet et al.’s (2011) study offered important information about a population that is largely overlooked in terms of sexuality (i.e. youth who acquired HIV perinatally). As the researchers point out, this study was a first step in exploring intimate relationships that involve
one or more partners living with a STI and future studies need to examine relational features and qualities that could impact experiences of living with a STI and being in a relationship.

The empirical literature beyond the recent, Canadian context consistently highlights disclosure as a common area of research when exploring the experiences of people living with a STI. The motivators for disclosing one’s STI status (Newton & McCabe, 2008a; Newton & McCabe, 2008b; Sadeghi-Nejad et al., 2010), the reactions to one’s disclosure (Frye et al., 2009; Nack, 2000), and identified patterns of disclosure (Moses & Tomlinson, 2012) have been investigated thoroughly in the literature. Disclosure has been considered to be a facilitator in promoting sexual well-being and satisfaction (Newton & McCabe, 2008), and is generally presented as a necessity in the relationship context; those who do not disclose are generally perceived and/or presented negatively (e.g. Nack, 2000).

The focus on disclosure in the literature seems to suggest that an underlying theoretical framework is informing the research: harm reduction. Harm reduction is a guiding framework developed in response to situations where the risk of harm is unlikely to be completely eliminated (Brocato & Wagner, 2003). In the context of sexually transmitted infections, a harm reduction approach would aim to reduce the risk of future transmissions (e.g. through limiting sexual activity or using safer sex practices), and/or reduce the possible repercussions if transmission were to occur (i.e., perhaps by ensuring disclosure to intimate partners occurs to allow informed sexual decision-making). The perspective taken in the literature to date suggests a primary concern is ensuring individuals disclose their STI status to minimize the risks involved in potential transmissions – a clear harm reduction inquiry. While harm reduction research can lead to successful health outcomes in practice (Brocato & Wagner, 2003), it also appears to have limited the scope of research inquiries and the consideration of implications in the literature.
regarding STIs. Despite the fact that much of the published research recruited and collected data from individuals living with STIs, very little has been offered regarding the experiences of people living with STIs after they disclose to their partner(s), and even less has been offered regarding positive intimate relationships involving individuals with STIs. With the recognition that STIs are an ongoing health concern (Butler-Jones, 2013), the experiences of people living with STIs who are currently navigating relationships need to be examined from a new perspective.

The Strengths-Based Perspective

Recognizing that people living with STIs are likely to experience more in their relationships than the complex disclosure process and factors impacting their sexual health and experiences, I sought to explore the relationships of people living with STIs using a strengths-based perspective. The strengths-based perspective aims to fill the gaps created by traditional deficits-based research, as deficits-based orientations tend to disempower or simply ignore the persons of interest (Maton et al., 2004). The existing gap in research that overlooks results, implications, or discussions that may apply to people living with STIs in their relational experiences, beyond those related to potential transmission risks. This indicates a major need for a strengths-based orientation in the field.

Strengths-based research can typically be surmised under four goals: recognizing/building on strengths in the people or groups of interest; helping to build new strengths; strengthening the social environments; and/or engaging the persons or groups of interest in co-creating, engaging in, and evaluating interventions (Maton et al., 2004). For the purpose of this study, the first goal is most appropriate as the strengths of people living with STIs who are in relationships have yet to be established in the academic literature. By inquiring about
the strengths people living with STIs have in a relationship context, either individually or with the support of their partner and/or broader community, and identifying opportunities for establishing new or building on existing strengths, I will work towards fulfilling the first goal of a strengths-based orientation.

One construct vital to the strengths-based perspective, competencies, can be described as adaptive processes that relate to positive outcomes given the sociocultural context (Leadbeater, Schellenbach, Maton, & Dodgen, 2004). Competencies develop depending on the person and the situation, the development and expression of a particular competency varying given one’s development, experiences, and tangible and intangible resources. Competencies develop and grow, and operate as ‘protective processes’ to help individuals, groups, and/or communities thrive (Leadbeater et al., 2004, p. 18). Protective processes can be general, occurring naturally over time and development, or risk-specific as a reaction to a particular situation (Leadbeater et al., 2004). Competencies and protective processes should both be considered when a strengths-based perspective is adopted.

As Leadbeater et al. (2004) contend, “Investing in … families, and communities requires a prevention, wellness, competency, and future-oriented approach to building strengths” (p. 28). Following this contention, the current analysis focuses on the individual and relational competencies of people in romantic relationships where one or both partners is living with a STI. When a stigmatized group (in this case, people living with STIs) is compared to another group (e.g. people not living with STIs), there is a risk that social norms may influence the analytic outcomes and that any differences between the groups will actually be perceived and/or presented as deficits in the group that is stigmatized. By limiting the exploration to people living
with STIs, as opposed to comparing people living with STIs to people living without STIs, I aim to restrict the problematic ‘othering’ that can occur in analyses.

The purpose of the current study is to explore the experiences of people living with a STI in an intimate relationship using a strengths-based orientation to analyze participants’ written responses. Given the need for more in-depth research examining relationships that involve one or more partner(s) living with a STI (Foster & Byers, 2013, 2016; Newton & McCabe, 2008; Rhode & Cusick, 2000), this analysis first considers the general experiences of the relationship overall (which is currently missing from the literature) and the sexual experiences within the relationship, as navigating sexual relationships has been noted as challenging (Fernet et al., 2011; Foster & Byers, 2013; Newton & McCabe, 2008). This analysis also aims to explicitly acknowledge and discuss the strengths described by participants and offer implications for future strengths-building at the individual, relational, and broader societal levels.

Method

**Study design.** Data for this analysis were collected for the purpose of a larger, online study conducted between December 2015 and May 2016, which included quantitative and qualitative measures. For the purpose of this analysis, the demographic data and the qualitative responses from the larger study’s dataset were considered. Strengths-based and empirical literature regarding STIs informed the creation of the qualitative questions (see Procedure and Measures).

**Ethical considerations.** Ethics approval was obtained from the University of Guelph’s Research Ethics Board before the study was initiated (see Appendix A). I decided that complete anonymity would be the best option for data collection given the stigmatized nature of STI status in general, and the added barrier of the criminalization of HIV in Canada (Canadian HIV/AIDS
Legal Network, 2009). To provide anonymity, recruitment and data collection occurred online and no identifying information (including IP addresses) were collected. This led to another major ethical consideration regarding ongoing consent. I created a clause in the consent form explaining that the last page of the study needed to be submitted by the participant (regardless of whether or not all of the questions were answered) in order for the consent to be considered valid (see Appendix B). If the last page was not submitted the responses were discarded as this could signal that the participant became uncomfortable or decided they no longer wished to have their responses considered. No incentives were used.

Recruitment and sampling. To participate in this study, eligibility criteria was: 1) living with a chronic STI (i.e. HIV, HPV, genital herpes, or hepatitis B, hepatitis C, or hepatitis D), 2) currently being in a romantic/intimate relationship that had lasted for a minimum of four weeks, 3) being 18 years of age or older, 4) being a resident of Canada, and 5) being able to read/write in English. To recruit participants, the University of Guelph’s Study Recruitment website, social media (i.e. Facebook and Twitter posts), and email listservs (intended for clinics, support groups, and research networks involving people living with STIs) were utilized. The online recruitment poster invited Canadians 18 years of age or older who were currently in a committed relationship and living with a chronic STI and/or HIV to click on a link to access a Qualtrics survey (see Appendix C for Recruitment Material). In total, the call for participants was answered by 85 individuals; 31 of these individuals were determined to be eligible as per the screening questionnaire (see Appendix D). Of the 31 eligible participants, 28 submitted the final page of the survey (a requirement for inclusion; see Ethical Considerations) and thus their responses were included in this analysis (response rate = 90%).
**Procedure and qualitative inquiries.** The data were collected via an online survey hosted by Qualtrics that was designed to screen participants for eligibility before they had access to the letter of information, consent form and survey. Eligible individuals who consented to participate were then presented with the survey, which included the 5 open-ended questions analyzed for this analysis (see Table 1). Participants were also given the opportunity to add any additional information that they felt was important for the researchers to know at the very end of the survey. The length of time to complete the study ranged between five minutes 53 seconds and 75 hours 19 minutes (likely not spent entirely on the study).

Table 1

<table>
<thead>
<tr>
<th>Order</th>
<th>Qualitative Question</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>What (if any) are the concerns and/or struggles in your current relationship?</td>
<td>Created by the researcher</td>
</tr>
<tr>
<td>2.</td>
<td>Thinking about the main concern/struggle in your current relationship, please describe how you and your partner have discussed/managed this concern.</td>
<td>Created by the researcher</td>
</tr>
<tr>
<td>3.</td>
<td>Have you developed any strengths, insights, or skills through overcoming the challenges in your relationship? If so, please describe them.</td>
<td>This is a variation of a strengths-based inquiry (Saleebey, 2004).</td>
</tr>
<tr>
<td>4.</td>
<td>What effect (if any) has having an STI had on your current relationship? Please think about any impact the STI has had on intimacy, emotional support, your perception of your partner, partner’s perception of you, etc.</td>
<td>This question is a variation of a qualitative question asked by Newton and McCabe (2008). The question was altered to ensure the participant was considering their current relationship, and it was intended to elicit rich data regarding the emotional aspects of their relationship.</td>
</tr>
<tr>
<td>5.</td>
<td>In what ways, if any, has having an STI affected your sex life with your current partner? Please consider how it may or may not impact what you do, say, feel, how you talk together, and more.</td>
<td>This is also a variation of a qualitative question asked by Newton &amp; McCabe (2008). The question was altered to ensure the participant was considering their current relationship, and to elicit rich data regarding sexuality.</td>
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Data Analysis

To analyze the data, I used an inductive approach to Braun and Clarke’s (2006) six-phase thematic analysis. Although I tried to avoid coding the data in a pre-existing framework in order to allow a fresh perspective on relationships where one or more partners has a chronic STI, I recognize that my social constructionist perspective likely influenced my analysis (inevitably, as it is impossible to free myself of the epistemological standpoint I hold and the knowledge I am privileged to have; see Braun & Clarke, 2006). To familiarize myself with the data, my first and second reading of the data corpus (i.e. reviewing the collected data as a whole rather than by question; Braun & Clarke, 2006) involved reading and recording my initial thoughts and reactions. In this stage, it became apparent that the second question (Thinking about the main concern/struggle in your current relationship, please describe how you and your partner have discussed/managed this concern) generated the longest responses, possibly due to participants often describing the strengths and strategies related to the primary challenge in this response. On average, most responses in the dataset were 54 words long. Through this process, I began to note common and/or competing ideas that I felt linked participants. On my third reading of the data corpus, I began to code (Phase 2). Recognizing that the participants would be responding to the study questions based on their holistic relationship with their partner, of which I was only given a glimpse, a semantic-level approach (Braun & Clarke, 2006) was optimal in the initial coding process as this would best honour the participants’ understanding of their relational experience. In this phase, I identified 395 codes (see Appendix E for a list).

In phase three of the Braun and Clarke model, I organized the initial codes into potential themes by reviewing the data corpus and comparing each code. At this point, I aimed to be inclusive so as not to overlook potentially important themes; I settled on 85 potential themes
such as “Differing Needs” and “Finances”. I then refined the names of the themes and looked for overarching similarities; for example, I determined that themes such as “Role Negotiation” and “Financial Stability” demonstrated contextual information about the overall relationship. I sorted the themes, defined each, and then used the definitions to condense the groups further. At each stage, I confirmed that the data extracts still fit into the theme and removed or reorganized data extracts that no longer fit the overarching theme and definition. Lastly, I reviewed the entire data corpus to ensure the data was being represented accurately and considered the themes using a strengths-based lens. After the six-phase analysis, I felt comfortable organizing the data into three themes (with eight level two subthemes): Contextualized Experiences, Individual Competencies, and Competencies in Intimate Relationship (see Figure 1). My interpretation of the themes is presented below with consideration to implications for research and application presented along with the analysis.

**Results & Interpretations**

The final sample consisted of 28 participants, 19 of which identified as women, eight as men, and one as a trans man. Participants ranged in age from 21 to 56, with a mean age of 34. Participants reported living with genital herpes ($n = 13$), HPV ($n = 12$), HIV ($n = 6$), and/or hepatitis B ($n = 1$). All participants were in a committed relationship with at least one person at the time of data collection, with the length of relationships ranging from 4 months to 18 years ($M = 4.6$ years). 27 of the participants had disclosed their STI status to their partner(s), and 23 of the participants were living with their partner(s).

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1 Some participants reported living with more than one chronic STI, and thus the total number of diagnoses exceeds the total number of participants. To ensure confidentiality, I have not identified the specific co-infections.
Figure 1. Thematic Map
Contextualized experiences: overall relationship. The experience of living with an STI and being in a relationship varied between participants, paralleling the diversity of general relational experiences. In contrast to what may be suggested by the deficits-based focus of the current literature, none of the participants expressed that their positive STI status negatively impacted their overall relationship in response to any of the posed questions. Some participants offered explicit statements confirming that their STI diagnosis was not a concern, and others simply did not mention any concerns related to their STI in response to the questions asking about relational challenges. For example, one participant explained, “Overall, my STI hasn’t affected my relationship in any significant way” (Participant 22), and another stated: “[my partner] is not concerned at all with it. Never has been.” (Participant 23).

Although the challenges presented by participants were quite unique, five subthemes were identified as most common to the overall relationship experiences (see Figure 1). Out of the subthemes, only two presented challenges that were directly tied to the relationship itself: Role Negotiation and Desire for Exploration. In terms of roles, some participants discussed recent transitions that required behavioural change (“The main struggle has been adjusting to living together – as this is a new situation for both of us.” (Participant 12), and others acknowledged that ongoing negotiation of household responsibilities and/or childcare could be challenging (“we argue over division of labour, particularly childcare” (Participant 10)). The subtheme Desire for Exploration appeared to be linked to Role Negotiation, as participants identified particular desires that would lead to inevitable change in responsibilities and/or boundaries within the relationship. One participant commented, “I wonder when we will discuss moving in together” (Participant 18), and another expressed a change in their relationship that had occurred due to pursuing a desire (“Trying to have a baby. Sex can be scheduled and therefore not fun.”
(Participant 23). These experiences of role navigation within the relationship and seeking to explore the boundaries of the relationship are common, with research suggesting that change, or pursuit of self- or dyadic-expansion, is a basic human motivator (Aron, Lewandowski, Mashek, & Aron, 2013). As relationships stabilize and the new information about one’s partner(s) lessens, pursuing new challenges that can lead to individual and relational growth builds efficacy and, in some studies, leads to greater relationship satisfaction (Aron et al., 2013).

The three other subthemes of the Overall Relationship theme presented as stressors that were largely external to the relationship. Work-Life Balance and, perhaps relatedly, Financial Instability (one study found that poor employment predicted economic strain; Kinnunen & Pulkkinen, 1998) were commonly raised as concerns. Participants explained that busy work schedules impeded on their time with their partner(s) and/or contributed to stress that negatively impacted the relationship,

This year we are really strained from the amount that I’m not around but I’m trying to put in the time at the present moment to see him more and am making plans to take on less tasks so that we can have more time together and so that I’m experiencing less stress. (Participant 3).

Several participants also noted that a major burden they experienced was related to financial stability,

Our main concern is finances. We’ve worked together to try to find solutions, adjusted our expenses and tried to stick together when things get though. (Participant 21)

Although work demands and financial means were impacting the relationship, these were experiences that could not necessarily be resolved or changed through efforts on behalf of the partners in the relationship context. Employment and economic strain have been similarly linked
to relationships in past research as well. For example, in Kinnunen and Pulkkinen’s (1998) survey of 250 married or cohabiting participants (117 women, 133 men; age = 36), career instability was linked to negative relationship outcomes, such as hostility within the relationship or simply poor marital quality. More recently, employment experiences and intimate relationships were linked such that negative employment experiences (e.g. large workloads and/or low job security) were associated with low levels of support from partners in a longitudinal analysis of 2054 participants in mid-life (Leach & Butterworth, 2012).

The last subtheme, Recovering from Difficult Experiences, also highlighted the negative impact that external stressors can have on intimate relationships. Whether participants were coping with grief, or healing from past experiences, situations external to the relationship influenced interactions within,

The vast majority of our struggles relate to major changes going on in our lives. I was the victim of a workplace bully and ended up leaving my job. The struggle to recover has been long and difficult. (Participant 19).

The impact of external stressors on relationships has been well-documented in the literature, and is commonly referred to as “negative spillover” (e.g. Leach & Butterworth, 2012). Although “negative spillover” is typically conceptualized as the transference of workplace stress into the relationship (or vice versa), the construct seems to apply between other contexts as well. When negative outcomes are occurring simultaneously in various parts of a person’s life, as some participants indicated, “negative spillover” is occurring.

A really big insight that I have had in overcoming challenges in my relationship is the huge impact that stress and anxiety have on my actions and my thoughts. I have noted that I am much more defensive when I am stressed or anxious, and tend to be more
combative. Recognizing these feelings, and letting my partner know when I am feeling that way, has really helped us to manage any conflict in a much more productive way. (Participant 12).

**Contextualized experiences: Sexual.** As participants were prompted to consider their sexual experiences with special consideration to the potential impacts they perceived that their STI status had on such experiences, the discussion around sexuality was expected. However, similar to the discussions around overall relationship perceptions, responses related to sexuality illustrated a complex picture of the lived experiences of participants’ sexual relationships. The context provided by participants suggested that factors other than STI status were equally or more disruptive to sexual experiences than STI-specific factors. These contextual factors represent the five subthemes I identified: *Stress, Medical Assistance, Effects of Time, Transmission,* and *Safer Sex Practices.* As one participant stated,

[STI] certainly [affected our sex life] at first but now our sex life is more affected by the fact that we have been together nearly 15 years. The typical evolution over time that brings challenges to sexual chemistry. (Participant 8).

*Stress, Medical Assistance,* and *Effects of Time* (either the natural aging process or relationship duration) were all identified as subthemes, as they were raised as factors in the past or present that hindered sexual activity. In terms of stress, one participant explained, “I don’t have as much time for sex as he would like and when we do have sex, I am stressed out or rushed and may not be completely focused” (Participant 3). Medication side effects were also addressed in both positive and negative ways corresponding to the perceived intent and effectiveness of medical interventions. In terms of ineffectiveness, several participants expressed concerns with medications. One person described their experience using a hormonal contraceptive method as
particularly counterintuitive, given that the device is primarily used for pregnancy prevention and that it appeared to reduce their interest in sex:

While I was on the Mirena we discussed what had happened to my sex drive and why I was so anxious… We got it removed at that point – by then I had deteriorated to the level where I didn’t want to be touched and would frequently sit on a chair alone. (Participant 3).

When given the opportunity to contextualize their sexual experiences, it was clear that participants’ sexual experiences were impacted by a diverse range of factors – not simply STI-related symptoms and effects. Participants identified common factors that people generally report as challenging in regards to sexual activity and sexual satisfaction, such as stress (Bodenmann, Atkins, Schär & Poffet, 2010), suggesting that researchers should consider how external factors may be influencing the sexual experiences and functioning of people living with STIs. Confounding factors beyond STI status need to be considered in all studies investigating the experiences people living with STIs with respect to their sexual and general relationships in order to avoid supporting stigmatized perceptions.

Perceptions of transmission risk and/or actual transmission were also discussed by participants (classified under the Transmission subtheme in Figure 1), with ranging levels of concern. Some participants expressed fears that led to disengagement in sexual activity either on behalf of them or their partner(s), with some emphasis that their knowledge of the STI did not absolve these concerns,

Although I know the facts, science etc. A level of fear of fear of transmission still exists. This impacts frequency and type is (sp) sex we have engaged it (sp). We have discussed openly. (Participant 5).
For others, transmission was not a concern at all, or at least not anymore,

[M]y HIV status doesn’t come into play anymore. 18 years ago we were extremely careful and talked about it often. [N]ow it’s just part of the furniture and to be honest we often forget about it. (Participant 17).

Decreasing concerns related to transmission have been frequently reported in the literature as relationships become more stable and long term (Rhodes & Cusick, 2000). These past findings may complicate a strengths-based perspective for some as decreasing concerns potentiate decreasing safer sex practices. When participants highlight that they “often forget about it” (Participant 17) or that “they do not use protection when it is just the two of [them]” (Participant 1), this conflicts with the dominant harm reduction discourse. In exploring the Safer Sex Practices subtheme that I identified, though, the competency participants had regarding safer sex practices ranged far beyond the often used measure of ‘protection’, or rather, condom use (e.g. Rhodes & Cusick, 2000). For the purposes of this analysis, the theme of Safer Sex Practices was conceptualized as any kind of act or tool that was likely to decrease the possibility of negative effects in a sexual relationship. Although it was not always explicitly acknowledged as safer sex practices, most participants discussed either communicating about their sexual boundaries with their partner and/or using some kind of measurable means of safer sex practices that may not be evident if only condom use is considered,

My outbreaks are very mild, so whenever I *think* I might be having one; if something feels or looks even slightly differently than usual, we just avoid having sex until it’s back to normal (just to be on the safe side of things, even though it could have been nothing). But this has happened very rarely (maybe 2 or 3 times since we started dating). Whenever this happens, it isn’t a big deal. I am comfortable letting him know, and his reaction has
never been really negative (just a bit of disappointment that sex will have to wait). (Participant 27).

Condoms are not a problem, and I have been undetectable since shortly after being diagnosed, and starting the meds. My partner and myself are well educated regarding HIV. (Participant 7).

Abstinence during outbreaks (for people living with a STI that may cause outbreaks), and recognition of undetectable viral loads for people living with HIV were raised as important, conscious decisions in this sample. Despite the fact that these two considerations may be missed in studies that focus on risk associated with purely ‘condomless’ sex, both considerations suggest that safer sex practices and knowledge are instilled in this particular sample. Safer sex practices are regularly promoted as harm reduction behaviours that all people should engage in regardless of STI status. Participants’ reports of abstaining from sex during an outbreak (outbreaks being associated with highest risk; Public Health Agency of Canada, 2013) and/or engaging in condomless sex only when undetectable (in the case of HIV; Wilson et al., 2008) suggest that ‘risky’ sex may not actually be increasing as relationships become more stable. Rather, what may be happening and what is worthy of further exploration, is that people who are in relationships where one or more partner is living with a STI may perceive less need for visible safer sex practices as trust and commitment increase. That is, due to the decrease in objective risk when viral loads are undetectable and when an outbreak is not occurring, people may be trusting their partner to communicate this information thereby making communication a form of safer sex practice.
Individual Competencies. Related to, and in some cases overlapping with the subtheme of Safer Sex Practices, were the personal competencies that participants identified and/or exemplified. Some participants displayed strong Self-Awareness, identifying their personal characteristics and, in nearly every case, describing how their awareness of these characteristics helped them to navigate the interactions they had in their relationship,

A really big insight that I have had in overcoming challenges in my relationship is the huge impact that stress and anxiety have on my actions and my thoughts. I have noted that I am much more defensive when I am stressed or anxious, and tend to be more combative. Recognizing these feelings, and letting my partner know when I am feeling that way, has really helped us to manage any conflict in a much more productive way. (Participant 12).

Participants’ responses exemplifying Self-Awareness seemed to illustrate the concept of mindfulness, defined as attentiveness and acceptance of one’s current experience (Bishop et al., 2004). Interestingly, mindfulness practice has been linked to positive marital quality (Wachs & Cordova, 2007) and has been suggested as an intervention strategy for intimate couples where one or more partner(s) is living with a chronic health condition (Johnston, 2012). Mindfulness training and/or practice may serve to support individuals living with STIs, especially in the context of their intimate relationships.

In some cases, the self-awareness described by participants seemed to be directly tied to a particular adversity, such as STI status, and suggested that Acceptance of Adversity could support positive outcomes,

HIV is just one of the parts of my life. It’s embedded in my psyche and informs my approach to everything. I’ve learned to live with this condition. I describe it as a grumpy
uncle I have to take care of. He forces me to do things that I might not like (take care of him, stay in this country, deal with his periodic concerns). But he also teaches me humility, makes me a more compassionate and patient person, and provides nuggets of wisdom about what really matters in life. (Participant 19).

By recognizing that a STI diagnosis provides inherent change to a person’s life and reframing this experience as potentially beneficial, or manageable, participants challenged the stigma associated with living with a STI by simply addressing their STI status as one part of them, rather than a major identifying component.

The subthemes Self-Awareness and Acceptance of Adversity were clearly identified as competencies participants had independently; that is, these competencies primarily served their own self and existed external to their intimate relationship. Participants also identified other competencies that they had developed. These other competencies were described in the relationship context either as having been developed in the relationship or as significantly affecting the participants’ partner (see Competencies in Intimate Relationships).

Competencies in Intimate Relationship. As some research suggests, social support may act as a protective factor against stigma for people living with STIs (e.g. Gao et al., 2010). The participants in the current study echoed this notion, as the data corpus contained rich narratives speaking to the tangible and intangible support participants received from their intimate partners. This support demonstrated that the participants and their partner(s) Recognized each other’s needs, with support coming in the form of “running baths for [them] to sit in to bring relief” (Participant 16) to unconditional acceptance,

I wasn’t anticipating my boyfriend to be so supportive and understanding, but he was there for me and made me feel that everything will be ok. I think having him to talk about
this health concern helped me feel like I wasn’t going through it alone and that was really nice. I also feel like now I know that he’s there to listen no matter what the topic is. (Participant 26).

The unconditional nature of the social support, highlighted by conversations around Commitment and/or trust (classified as Commitment in Figure 1), seemed to offer participants security in the relationship. Participants explained that active engagement in the relationship (in the form of Commitment) was a component of their experience with their partner(s), and it suggests a future direction for research: if support is perceived as temporary and/or forced rather than permanent and/or voluntary, is there a difference in the levels of psychosocial benefits experienced by people living with STIs or other adversities?

Perhaps contributing to the perceptions of unconditional support were perceptions of complete Openness With Partners, regardless of the subject matter. Almost all of the participants reported some form of open communication with their significant other(s), with much of the discussion suggesting comfort in discussing even topics typically perceived as sensitive,

“Disclosing to each other at the very start of the relationship set the stage for us to be able to talk openly about sensitive subjects and to be empathetic very early on. Our supporting each other through those vulnerable conversations helped us start from a place of trust.” (Participant 2)

“On our anniversary, we go out to dinner and talk about what has/has not worked over the past year for us as individuals. We try to tackle it according to spiritual, emotional, professional, sexual, intellectual needs etc.” (Participant 23)

Openness With Partner(s) and comfort with having Difficult Conversations is a relational competency of particular importance for any intimate relationship. Yet, the importance of open
communication seems even greater in the context of relationships where one or more partner(s) live with a stigmatized condition. Since a stigmatizing condition can require ongoing considerations related to medications and/or sexual experiences (Newton & McCabe, 2005), openness in discussing needs and creating a safe space to foster these discussions could be vital to relationship satisfaction. Additional research is needed to explore communication in the context of relationships where a stigmatizing condition is present.

Discussion

This study aimed to explore the experiences of people living with a STI in an intimate relationship using a strengths-based orientation. Adult Canadians living with a chronic STI were invited to participate in an anonymous, online survey to share their experiences of navigating a committed relationship; 28 participants responded. Utilizing the Braun and Clarke (2006) six-phase process for thematic analysis, I identified three themes from the participants’ responses: Contextualized Experiences, Individual Competencies, and Competencies in Intimate Relationship. The contextual information that participants offered regarding their relationship, in general and related to their sexual experiences within the relationship, greatly altered the assumptions that could be made (and likely would have been) if questions were close-ended. Participants also identified a number of competencies, both at the individual level and relational level, that contributed to their overall relationship experiences.

Although the method and number of participants in the current study does not lend credence to generalizations, context was vital to understanding this sample’s experiences in their relationship. The external factors contributing to overall perceptions of the relationship indicated a need to examine experiences within intimate relationships more holistically by considering factors beyond simply STI status. Variables that often influence relationship and sexual
satisfaction, such as employment stability (Leach & Butterworth, 2012) and stress (Bodenmann et al., 2010), were presented as more concerning in this sample than STI status. Despite being important to relationship satisfaction (Leach & Butterworth, 2012), external factors have rarely been explored in the published literature investigating experiences of people living with STIs. By examining these factors further in the context of relationships where one or more partners has a STI, it may be found that external factors are actually contributing more to the negative outcomes than STI status.

In terms of sexual experiences, participants also highlighted a need to consider safer sex practices in a broader sense rather than conclude that relationship duration correlates with a lack of safer sex practices (e.g. Rhodes & Cusick, 2000). Although there was some indication that condomless sex was occurring, responses often included statements about undetectable viral loads, and/or abstinence during outbreaks. Since risk of transmission nears zero when people living with HIV have undetectable viral loads (Wilson et al., 2008), and abstinence during outbreaks reduces transmission risk for people living with GH (Public Health Agency of Canada, 2013), there seems to be a shift occurring in the type of safer sex practices rather than a lack thereof. Sexual communication may also be influencing the shift to condomless sex, as many of the participants emphasized their ability to discuss sex (and sensitive topics in general) with some attributing this skill to the initial disclosure process. Although the current analysis does not provide enough evidence to conclude that this competency is a “risk specific process” (Leadbeater et al., 2004, p. 18), it suggests directions for future strengths-based research. The additional considerations that some participants expressed as existing due to their STI (e.g. putting sex “on hold” and the frustration that can ensue) suggests that future support and care could promote pleasure-seeking in other forms (i.e. unrelated to genital contact) to manage
sexual frustration during periods of abstinence, if clients are reporting that this is a struggle within their relationship.

In terms of individual competencies, mindfulness practice and acceptance of adversity were presented as beneficial at an individual and relational level. Several participants described being conscious of, and in control of, personal characteristics that they suggested impacted their ability to navigate relationship conflict. While mindfulness has been empirically explored in the context of intimate relationships (e.g. Wachs & Cordova, 2007), it has only been proposed as a potential intervention for people living with a chronic illness (Johnston, 2012). Future research and practice should explore the use of mindfulness as an intervention strategy in intimate relationships where one or more partners is living with a stigmatized illness. Given the competencies that were identified as important at the individual level in this sample, researchers should also consider integrating a strengths-based orientation to future individual-level investigations of people living with STIs and/or another kind of adversity. By considering the strengths in each analysis involving marginalized groups, research outputs would contribute to the destigmatization process.

Lastly, competencies in the relationships were well-established by participants. Participants described their partner(s) as offering tangible and intangible support, and this appeared to be well-received. This support from partners is likely related to the positive effects observed by social support in general, which has been documented as being beneficial in reducing the effects of stigma (e.g. Gao et al., 2010). Open communication in the relationship, at times being explicitly attributed to the initial disclosure of the STI status, was also frequently described. Some research suggests that sexual self-disclosure is associated with sexual satisfaction (Byers, 2011; Rehman, Rellini, & Fallis, 2011), and disclosure of STI status has been
associated with more positive sexual outcomes (Newton & McCabe, 2008b). Participants’ responses suggest that disclosure may impact more than sexual satisfaction though; future research should explore the impact of disclosure on relationship satisfaction, and communication processes in relationships generally.

Overall, the current analysis problematizes the negative outcomes currently established in the literature and indicates that more holistic approaches to research regarding individuals living with STIs is needed, especially in the context of intimate relationships. Through acknowledging individual and relational competencies of people living with STIs, future applications and future research are evident.

**Applications.** The experiences shared by this sample indicates several directions for formal care and support being offered to people living with STIs, particularly regarding their intimate relationships. First, challenges regarding relationships (sexual and general) were conveyed by participants, and care providers across sectors need to ensure they are engaging their clients in conversations about potential challenges in order to best support them. The Public Health Agency of Canada (2013) advises that persons living with STIs are given individualized education regarding their diagnosis and the potential challenges they may face; this means that health care providers need to be offering education, resources, and referrals to counselling as needed. East, Jackson, O’Brien, and Peters (2010) did not find that this was occurring in their sample of 10 women diagnosed with an STI and called for appropriate care and information for individuals diagnosed with STIs; other researchers made similar calls for individualized approaches to care, especially in populations who engage in higher risk sexual behaviours (e.g. Mayer, Bekker, Stall, Grulich, Colfax, & Lama, 2012). I would like to reiterate this need for individualized care and support following diagnosis (and ongoing). Given the importance of
context in relationships, individualized care is necessary to ensure assumptions are not made that link the concern to STI status arbitrarily. As this sample demonstrated, contextual factors are equally as or more likely to be impacting the experiences of people living with STIs, and these factors need to be addressed in clinical and social care settings.

Second, participants in the current sample identified varying safer sex practices that challenge the dominant discourse of what people should do to prevent STIs and yet the techniques (such as undetectable viral loads) are still reducing the objective risk of transmission (e.g. Wilson et al., 2008). In line with a broadened harm reduction approach, education around STI prevention (individually and in institutions) needs to be done in a neutral way that conveys the measurable risks of transmission in order to offer individuals the opportunity to make their own decisions regarding the best safer sex option for them and their partners, and to work toward destigmatizing relationships with people living with STIs. Researchers and care providers should not be suggesting that conversations around STI status should be determinant in who one engages in sexual activities with but rather what safer sexual practices may be relevant; this has not always been the case (e.g. Sadeghi-Nejad et al., 2010). If people are educated about their safer sex options and are willing to initiate and/or engage in conversations about sexual health, people living with STIs may experience similar experiences to disclosure as the participants in the current sample did. That is, people living with STIs may be more likely to feel open talking to their partner and may evaluate the disclosure process as a bonding experience rather than one that a fearful one.

For individuals who choose abstinence during outbreaks, there was some indication that putting sexual activity on hold can be frustrating. As mentioned previously, these indications suggest that future support and care should promote pleasure-seeking in other forms (including
unrelated to genital contact) to manage sexual frustration during periods of abstinence, if clients are reporting that this is a struggle within their relationship. Clinicians should consider engaging their clients in conversations to determine which safer sex practices they are actually using, and then address potential challenges related to that practice accordingly.

Lastly, competencies at the individual and relational level were identified by participants. Given the past literature suggesting that people living with STIs experience negative psychosocial outcomes (e.g. Foster & Byers, 2008; Newton & McCabe, 2008), this finding is particularly important and should be considered in future practice. Mindfulness, a practice that can be used at the individual and relational level, involves connecting people to their experiences and has been demonstrated to increase acceptance of those experiences (Bishop et al., 2004; Wachs & Cordova, 2007). The success mindfulness practices have had on marital quality (Wachs & Cordova, 2007) suggests it may be helpful for people living with a STI who are experiencing challenges related to their STI status or otherwise.

**Strengths.** This study contributes to the literature in several ways. First, the gap in academic literature regarding sexually transmitted infections in the context of intimate relationships has been acknowledged by many researchers (Foster & Byers, 2013; Guthrie et al., 2009; Newton & McCabe, 2008a; Newton & McCabe, 2008b; Rhodes & Cusick, 2000), with several researchers calling for further exploration of the relationship quality/dynamics (including relationship satisfaction and communication) specifically in relationships where one or more partners is living with a STI. This study contributes to filling this gap. Additionally, the strengths-based orientation of this study offers a fresh, destigmatizing perspective on the experiences of people living with STIs specific to their sexual and intimate relationships.
**Limitations.** Despite these strengths, the study was limited in several ways. Although the sample size of the current sample was appropriate for a thematic analysis, the method (i.e. anonymous, online data collection) resulted in shorter, less-detailed responses than another qualitative methodology could have. Many participants offered responses that could have been probed much further if an in-person interview and/or follow-up had occurred. Additionally, it would be ideal to have participants review the final analytic report to provide member checks (Kornbluh, 2015), which was not possible given the methodological choice. Future research should also aim to recruit more homogenous samples in terms of STI status, as differences between STI status solicited different techniques for management within the intimate relationship context. While the current sample was slightly diverse in terms of sexual minority status and age, this was rather limited. By recruiting larger, more diverse samples, the experiences of intersecting social identities could be explored, which would ultimately provide further support for individuals who may face more complex challenges and experiences of stigma. Lastly, recruitment for the current study was a challenge. Although anonymity was utilized in an attempt to engage participants, it may have detracted from the recruitment process as I did not have the opportunity to build rapport with the participants. Further, much of the research involving people living with HIV now utilizes the “the greater involvement and meaningful engagement of people living with HIV/AIDS (GIPA/MIPA)” (Ontario AIDS Network, 2016) to ensure that research being conducted is meaningful and transformative to the community, and it provides reassurances (and possibly rapport) that the work will be beneficial to people living with HIV. Utilizing GIPA/MIPA principles means engaging people living with HIV in the development and implementation of the research process; this was unfortunately not used in the current study.
**Future research.** Further exploration of communication and relationship processes in larger and more diverse samples of individuals living with STIs is necessary, and it should implore GIPA/MIPA principals (Ontario AIDS Network, 2016) to ensure the research process is sound and meaningful to people living with STIs. The strengths-based approach to research would support GIPA/MIPA principles, and should continue to be implemented in order to continue working towards destigmatizing people living with sexually transmitted infections. One way to implement strengths-based perspectives would be to explicitly consider external factors that could be contributing to the findings. Future research and practice should also explore the use of mindfulness as an intervention strategy in intimate relationships where one or more partners is living with a stigmatized illness.

**Conclusions**

By utilizing a strengths-based approach to explore the experiences of people living with a STI/HIV in intimate relationships, it became clear that context needs to be considered further in research and practice. Through contextualizing their experiences, participants’ responses suggested that STI status was not a primary concern in their intimate relationships. Additionally, when given the opportunity to describe their strengths, people living with STIs shared both individual and relational-level competencies that challenge the current empirical evidence that highlights the negative psychosocial outcomes. Future research should consider adopting a strengths-based orientation to research in order to fully conceptualize findings and work toward destigmatizing a marginalized identity. In terms of practice, clinicians and educators should aim to educate people regarding sexual health in a neutral way, allowing them to make their own, informed decisions about sexual partners and their sexual health. For people living with STIs/HIV, mindfulness training and/or practice may be helpful if they are experiencing
challenges at the individual and/or relational level. Additional research is needed to explore mindfulness as an intervention strategy.
Chapter 5: Quantitative Study

Participants

Participants were required to be living with a chronic STI and in a committed relationship that had lasted for a minimum of four weeks. Due to the nature of the study (i.e. inquiries about sexual experiences), participants were also required to be at least 18 years of age. Additionally, participants needed to be residents of Canada, as the accessibility of certain medications (subsidized for some individuals through the Federal government, and others through the provincial government; CATIE, 2015) could impact experiences of STIs and, consequently, sexual relationships. Since medications have led to reduced transmissions of STIs and/or reduced symptoms (Harper et al., 2004; Lawrence et al., 2004; Loutfy et al., 2013), access to medication is likely an important mediating factor for individuals living with a STI and their sexual experiences. Lastly, participants were required to be able to read and write fluently in English as the study was offered online in English text.

Procedure

Upon receiving ethics approval for the study from the University of Guelph’s Research Ethics Board, participants were recruited using online recruitment strategies, including Facebook and Twitter posts, the Interdisciplinary HIV and Pregnancy Research Group email listserv (with permission from the Principal Investigator of the listserv), the University of Guelph Recruitment website, and word of mouth. The researcher also sent recruitment material to service organizations across Canada who serve people living with STIs and support groups for people living with chronic STIs. The recruitment material included a link to the study, hosted by Qualtrics.
Screening Questionnaire

Upon accessing the Qualtrics link, potential participants were asked to complete a screening questionnaire. The questionnaire presented a list of questions reflecting the inclusion/exclusion criteria and the instructions asked potential participants to check all that applied to them. If all of the inclusion criteria were not met, the individual received a thank you message and was not permitted to continue. If all of the inclusion criteria were met, participants were presented with a consent form and, upon giving consent, they were given access to the study documents (see Measures below).

Demographic Questionnaire

Developed in part by the researchers and in part by the Canadian HIV and Women’s Sexual and Reproductive Health Cohort Study (CHIWOS; 2013), the demographic questionnaire was crafted to address potential confounding factors and to develop a more complete understanding of the participant’s experience. This section asked participants about their sex, gender, current relationship, medications (as medications can inhibit sexual desire and functioning; Ward et al., 2001), and whether or not the participant had disclosed to their current partner. See Appendix F for full demographic questionnaire.

Quantitative Measures

In order to answer the third research question (does the length of the relationship, disclosure of the STI, and communication strategies predict sexual and/or relationship satisfaction?), the following measures were selected.

Communication Patterns Questionnaire – Short Form (Futris, Campbell, Nielsen, & Burwell, 2010). The original Communication Patterns Questionnaire (CPQ) consists of 35-items asking participants to self-report the usual interaction patterns with their partner(s) when a
The CPQ asks participants to rate a list of behaviours using a 9-point Likert-scale, where 1 indicates that the pattern is very unlikely and 9 indicates the behaviour is very likely. Sample items include, “When some problem in the relationship arises … You try to start a discussion while your partner tries to avoid a discussion”, and “After a discussion of a relationship problem … Both feel that the problem has been solved”.

The CPQ has been utilized in different ways since its development, and this has generated some criticism (Futris et al., 2010). Futris et al. (2010) proposed and validated a shortened version of the CPQ (CPQ-SF) consisting of three subscales derived from past research regarding communication interactions in couple relationships: Criticize/Defend, Demand/Withdraw, and Positive Interactions. In their validation of the subscales, Futris et al. (2010) recruited 517 married respondents ranging in age from 18-85 years to complete the CPQ-SF. The model they proposed (consisting of 11 items making up the three aforementioned subscales) best fit the data in comparison to the original model and one other model that had been previously used in the literature (Futris et al., 2010). Internal consistency for the subscales ranged from satisfactory to strong ($\alpha=.83$ for the Criticize/Defend, $\alpha=.71$ for the Demand/Withdraw, and $\alpha=.61$ for the Positive Interactions; Futris et al., 2010). Participants who reported high marital satisfaction were more likely to have higher scores on the Positive Interactions subscale and lower scores on the Criticize/Defend and Demand/Withdraw subscales than the participants who reported low marital satisfaction, providing evidence of validity. Differences were also reported between the scores of Criticize/Defend and Demand/Withdraw subscales, suggesting these are theoretically different constructs. For the purposes of this study, Futris et al.’s 3 scale model was used as predictor variables to address research question 3.
The Global Measure of Relationship Satisfaction (Lawrance & Byers, 1995). The Global Measure of Relationship Satisfaction (GMREL) was utilized as a short assessment to measure relationship satisfaction. The scale consists of 5 items, and participants were asked to respond to each item on a 7-point bipolar scale ranging from negative attributes (1) to positive (7). For example, one item was: “In general, how would you describe your overall relationship with your partner?” and scores ranged from very bad (1) to very good (7; see Appendix F). To determine the final score, the score for all items were summed; higher scores suggested higher levels of relationship satisfaction.

Index of Sexual Satisfaction (Hudson, Harrison, & Crosscup, 1981). The Index of Sexual Satisfaction (ISS) is a 25-item scale used to measure the quality of sexual experiences self-reported by an individual in a sexual relationship (see Appendix F). Participants were asked to rate each item in terms of how often they experience it, ranging from Rarely or none of the time (1) to Most or all of the time (5). Scale items include “I feel that my sex life is lacking in quality”, and “I enjoy the sex techniques that my partner likes or uses.” Scoring occurred as per Hudson, Harrison and Crosscup (1981): negatively worded items were reverse-scored and a final score was then computed. According to the authors, scores of 28 and above are more likely to represent lower quality sexual experiences. The ISS has demonstrated excellent internal consistency (α ranging from .91 to .93 in initial development), test-retest reliability (.93), and discriminant validity (α=.76; Hudson et al., 1981).

Data Analysis

To begin the quantitative data analysis, all measures were summarized using descriptive statistics in SPSS. Variables of interest (i.e. disclosure status, length of relationship, and CPQ-SF subscales to identify communication strategies; see Measures), chosen based on past empirical
evidence and necessary to address research question 3 were tested for normality in order to determine the best approach to the analyses. Bivariate analyses were run with the potential predictor and outcome variables to test correlation of the variables. Original predictor variables were chosen based on past empirical evidence. Past literature suggests that people living with STIs experience less negative outcomes the longer they are in a relationship (Newton & McCabe, 2008; Rhodes & Cusick, 2000). Additionally, communication has been noted as an important area to explore in terms of relationships where one or more partner(s) is living with a STI (Koniak-Griffin et al., 2009; Melville et al., 2003), yet it appears to remain unexplored. Since some of the variables (i.e. relationship duration, relationship satisfaction, and the Criticize/Defend subscale) were at least slightly not normal, bivariate analysis was conducted using Spearman’s rho correlation which does not require normality of the variables (Field, 2013). Variables that were significant \( (p = .05) \) with the corresponding outcome variables (i.e. sexual or relationship satisfaction) were selected for the multiple regression analyses.

Two standard (simultaneous) multiple regression analyses were used to examine the possible predictors of sexual satisfaction and relationship satisfaction. The multiple regression analyses specifically addressed research question 3. Assumptions of regression analyses were tested for each test; the only assumption that was violated was normality of the variables which was not a concern as regression is robust to the violation of this assumption (Field, 2013).

Results

Sample. The final sample consisted of 28 participants, 19 of which identified as women, 8 as men, and 1 as a trans man. Ages ranged from 21 to 56, with a mean age of 34 (SD = 9.6) years. The majority were living with genital herpes \( (n = 13) \) and/or HPV \( (n = 12) \), several were living with HIV \( (n = 6) \) and one was living with Hepatitis B; a few participants reported living
with more than one STI. All participants reported being in a committed relationship with at least one person at the time of data collection, with an average relationship duration of 4.6 years (SD = 5.2 years). Almost all of the participants (n = 27) had disclosed their STI status to their current partner(s). Additional sociodemographic information can be found in Table 2.

Table 2 Socio-Demographics of Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>25-29</td>
<td>9 (32.1)</td>
</tr>
<tr>
<td>30-34</td>
<td>5 (17.9)</td>
</tr>
<tr>
<td>35-39</td>
<td>3 (10.7)</td>
</tr>
<tr>
<td>40-44</td>
<td>3 (10.7)</td>
</tr>
<tr>
<td>45-49</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>50-54</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>55-59</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td><strong>Positive STI Statusa</strong></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>6 (21.4)</td>
</tr>
<tr>
<td>GH</td>
<td>13 (46.4)</td>
</tr>
<tr>
<td>HPV</td>
<td>12 (42.9)</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>19 (67.9)</td>
</tr>
<tr>
<td>Men</td>
<td>8 (28.6)</td>
</tr>
<tr>
<td>Trans men</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>10 (35.7)</td>
</tr>
<tr>
<td>Lesbian</td>
<td>2 (7.1)</td>
</tr>
<tr>
<td>Gay</td>
<td>6 (21.4)</td>
</tr>
<tr>
<td>Queer</td>
<td>4 (14.3)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>5 (17.9)</td>
</tr>
<tr>
<td>Pansexual</td>
<td>1 (3.6)</td>
</tr>
</tbody>
</table>
### Current Relationship Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casually dating one or more partners</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>Seriously dating one or more people</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>Seriously dating one person</td>
<td>12 (42.9)</td>
</tr>
<tr>
<td>Engaged</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>Married</td>
<td>7 (25)</td>
</tr>
<tr>
<td>Common-law</td>
<td>5 (17.9)</td>
</tr>
<tr>
<td>Committed common-law, seriously dating and casually involved with others&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1 (3.6)</td>
</tr>
</tbody>
</table>

### Participants’ Partners’ Identified Gender<sup>c</sup>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>7 (14.3)</td>
</tr>
<tr>
<td>Men</td>
<td>23 (71.4)</td>
</tr>
<tr>
<td>Trans men</td>
<td>3 (7.1)</td>
</tr>
</tbody>
</table>

### Relationship Duration<sup>d</sup>

<table>
<thead>
<tr>
<th>Duration</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 6 months</td>
<td>1 (3.6)</td>
</tr>
<tr>
<td>6 months - &lt; 1 year</td>
<td>4 (14.3)</td>
</tr>
<tr>
<td>1 year - &lt; 5 years</td>
<td>13 (46.4)</td>
</tr>
<tr>
<td>5 years - &lt; 10 years</td>
<td>5 (17.9)</td>
</tr>
<tr>
<td>10+ years</td>
<td>5 (17.9)</td>
</tr>
</tbody>
</table>

### Disclosure to Partner<sup>d</sup>

<table>
<thead>
<tr>
<th>Disclosure</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>27 (96.4)</td>
</tr>
<tr>
<td>No</td>
<td>1 (3.6)</td>
</tr>
</tbody>
</table>

### Living with Partner<sup>d</sup>

<table>
<thead>
<tr>
<th>Living with Partner</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23 (82.1)</td>
</tr>
<tr>
<td>No</td>
<td>5 (17.9)</td>
</tr>
</tbody>
</table>

<sup>a</sup>Numbers adding up to >100% are due to co-infections.  
<sup>b</sup>One “Other” option was selected and specified.  
<sup>c</sup>Participants were asked to identify socio-demographics of all romantic partners.  
<sup>d</sup>Participants with more than one partner only specified this variable for one partner.

Through the descriptive statistics, it was determined that Disclosure Status needed to be removed from subsequent analyses due to the lack of variability (27/28 participants had disclosed). Therefore, to address research question 3 (i.e. does the length of the relationship, disclosure of the STI, and communication strategies predict sexual and/or relationship satisfaction?), the assumptions associated with bivariate analysis (i.e. normality of the variables) were tested for excluding Disclosure Status. Normality of the potential predictors of Relationship
Satisfaction and Sexual Satisfaction (i.e. Relationship Duration and Communication Strategies) were tested. The dependent variables, Relationship Satisfaction (GMREL) and Sexual Satisfaction (ISS) were also tested for normality (see Table 3).

Table 3

Normality of the Predictor and Outcome Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Zskewness</th>
<th>Sig.</th>
<th>ZKurtosis</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Duration (in months)</td>
<td>3.290</td>
<td>p &lt; .01</td>
<td>1.269</td>
<td>ns</td>
</tr>
<tr>
<td>GMREL</td>
<td>-6.147</td>
<td>p &lt; .001</td>
<td>9.434</td>
<td>p &lt; .001</td>
</tr>
<tr>
<td>ISS</td>
<td>1.183</td>
<td>ns</td>
<td>0.516</td>
<td>ns</td>
</tr>
<tr>
<td>Criticize/Defend</td>
<td>2.192</td>
<td>p &lt; .05</td>
<td>0.210</td>
<td>ns</td>
</tr>
<tr>
<td>Positive Interaction</td>
<td>1.590</td>
<td>ns</td>
<td>0.168</td>
<td>ns</td>
</tr>
<tr>
<td>Demand/Withdraw</td>
<td>1.849</td>
<td>ns</td>
<td>0.041</td>
<td>ns</td>
</tr>
</tbody>
</table>

The Sexual Satisfaction measure (ISS) and two of the CPQ-SF subscales were normally distributed (see Table 3). All other variables had significantly non-normal distributions. For this reason, Spearman’s rho correlation was used to determine bivariate correlations (as it does not require normality of the variables; Field, 2013). Bivariate correlation analysis was used to determine if any of the predictor and outcome variables intended to address research question 3 (Relationship Duration, the 3 CPQ-SF subscales, Relationship Satisfaction, and Sexual Satisfaction) correlated with one another (see Table 4).

**Sexual Satisfaction.** Sexual satisfaction significantly correlated with all three CPQ-SF subscales: Criticize/Defend, Positive Interactions, and Demand/Withdraw (see Table 4).
**Relationship Satisfaction.** A similar pattern of correlations was found for the independent variables and Relationship Satisfaction, such that the Criticize/Defend and Positive Interactions subscales significantly correlated with Relationship Satisfaction. No other variables significantly correlated with Relationship Satisfaction (see Table 3).

**Other correlations.** Three other significant correlations were also present between the independent variables relevant to the multiple regression analyses. The Criticize/Defend subscale positively correlated with Relationship Duration and the Demand/Withdrawal subscale negatively correlated with the Positive Interactions subscale. The Demand/Withdraw subscale also negatively correlated with the Positive Interactions subscale. All other relationships between the variables were determined to be not significant (see Table 4), including a relationship between Relationship Satisfaction and Sexual Satisfaction.
<table>
<thead>
<tr>
<th></th>
<th>Relationship Satisfaction</th>
<th>Relationship Duration</th>
<th>Criticize/Defend</th>
<th>Positive Interactions</th>
<th>Demand/Withdraw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Satisfaction</td>
<td>ρ = -.392, ns</td>
<td>ρ = .309, ns</td>
<td>ρ = .518, p &lt; .01</td>
<td>ρ = -.547, p &lt; .01</td>
<td>ρ = .459, p &lt; .05</td>
</tr>
<tr>
<td>Relationship Satisfaction</td>
<td>ρ = -.270, ns</td>
<td>ρ = -.588, p &lt; .01</td>
<td>ρ = .727, p &lt; .01</td>
<td></td>
<td>ρ = -.326, ns</td>
</tr>
<tr>
<td>Length of Relationship</td>
<td>ρ = .488, p &lt; .01</td>
<td></td>
<td>ρ = -.149, ns</td>
<td></td>
<td>ρ = .209, ns</td>
</tr>
<tr>
<td>Criticize/Defend</td>
<td></td>
<td></td>
<td></td>
<td>ρ = -.544, p &lt; .01</td>
<td>ρ = .628, p &lt; .01</td>
</tr>
<tr>
<td>Positive Interactions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ρ = -.643, p &lt; .01</td>
</tr>
</tbody>
</table>

Note: ^aCorrelation is significant at the .01 level (2-tailed); ^bCorrelation is significant at the .05 level (2-tailed).
Standard (simultaneous) multiple regression was used to examine the possible predictors of Sexual Satisfaction. Predictor variables were selected based on the bivariate correlations above; variables that significantly correlated (p < .05) with Sexual Satisfaction at the bivariate level were used (i.e. Positive Interactions, Criticize/Defend, and Demand/Withdraw). The highest value for Pearson’s correlation existed between the Demand/Withdraw and Criticize/Defend subscales of the CPQ-SF (r=.674) suggesting that multicollinearity was not an issue in the model (Field, 2013). Additionally, the VIF values for the predictor variables were all less than 10 and the average of the VIF values was not substantially higher than 1 (1.978; Field, 2013). The Durbin-Watson test was used to test for serial correlations between errors and yielded a value of 1.756, meaning that the residuals were uncorrelated and another assumption of the regression analysis was met (Field, 2013). The P-P Plot of Regression Standardized Residual was not a concern (Field, 2013).

The model was statistically significant ($F(3, 20) = 4.081, p < .05$), accounting for 61.6% of the total variance (adjusted $R^2 = 38\%$). However, all of the variables had confidence intervals that included zero, suggesting that this was not a good model for predicting sexual satisfaction. Lastly, none of the independent variables were found to significantly contribute to the model (see Table 5).
Table 5
Linear Model Of Predictors Of Sexual Satisfaction, With 95% Confidence Intervals Reported In Parentheses

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>57.499</td>
<td>28.516</td>
<td>.057</td>
<td></td>
</tr>
<tr>
<td>(-1.985, 116.983)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticize/Defend</td>
<td>1.087</td>
<td>0.622</td>
<td>.425</td>
<td>.096</td>
</tr>
<tr>
<td>(-.209, 2.384)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Interactions</td>
<td>-.1366</td>
<td>1.051</td>
<td>-.303</td>
<td>.209</td>
</tr>
<tr>
<td>(-3.559, .827)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand/Withdraw</td>
<td>-.074</td>
<td>0.576</td>
<td>-.034</td>
<td>.899</td>
</tr>
<tr>
<td>(-1.276, 1.127)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Standard (simultaneous) multiple regression was also used to examine the possible predictors of Relationship Satisfaction. As with the first model, predictor variables were selected based on variables that were significantly correlated with Relationship Satisfaction at the bivariate level (p < .05); these variables were the Positive Interactions and Criticize/Defend subscales. As with the first regression, multicollinearity was not a concern based on Pearson Correlations and the VIF values (all less than 10) and VIF average (1.438). The Durbin-Watson test was also in range (1.693). The residuals of the regression were checked for normality using the P-P Plot of Regression Standardized Residual and were relatively normal.

The model was statistically significant (F(2, 23) = 14.074, p < .001). One of the independent predictor variables, the Criticize/Demand subscale (t(25) = -3.273, p < .05), was found to significantly contribute to the model. The model summary demonstrated that the model accounted for 74.2% of the total variance (adjusted R² = 55%). However, the Positive Interactions confidence intervals included zero suggesting it was not a good predictor of Relationship Satisfaction (see Table 6).
Table 6

Positive Interactions and Criticize/Defend Significantly Predict of Relationship Satisfaction, 95% confidence intervals reported in parentheses

<table>
<thead>
<tr>
<th></th>
<th>b</th>
<th>SE B</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>27.641</td>
<td>5.769</td>
<td>.000a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(15.708, 39.575)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticize/Defend</td>
<td>-.412</td>
<td>.126</td>
<td>-.549</td>
<td>.003a</td>
</tr>
<tr>
<td></td>
<td>(-.672, -.151)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Interactions</td>
<td>.379</td>
<td>.226</td>
<td>.281</td>
<td>.107</td>
</tr>
<tr>
<td></td>
<td>(-.089, .846)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: aCorrelation is significant at the .01 level (2-tailed); significant values have been highlighted

Discussion

This study aimed to explore the experiences of people living with a STI in an intimate relationship using a strengths-based orientation. 28 Canadians between the ages of 21 to 56 (mean age = 34, SD = 9.6) living with a chronic STI/HIV participated in the anonymous, online survey to share their experiences of navigating a committed relationship. To address research question 3 (Does the length of the relationship, disclosure of the STI, and communication strategies predict sexual and/or relationship satisfaction?), bivariate correlations and two multiple regressions were utilized. Assumptions of these statistical analyses were also tested for. On average, the sample was skewed such that participants reported significantly high Relationship Satisfaction. The three communication subscales, Positive Interactions, Criticize/Defend, and Demand/Withdraw were found to significantly predict Sexual Satisfaction together, yet none of the independent variables significantly contributed to the model independently. Relationship Satisfaction was significantly predicted by the Positive Interactions and Criticize/Defend model, and the Criticize/Defend subscale significantly predicted Relationship Satisfaction on its own.
Sexual Satisfaction was predicted by the three communication subscales, and Relationship Satisfaction was significantly predicted by two of the three: Positive Interactions and Criticize/Demand. Research has well-established that Relationship Satisfaction (e.g. Futris et al., 2010) and Sexual Satisfaction (e.g. Byers, 2011) are significantly impacted by the communication within the relationship. Exploring communication within the context of relationships where one partner is living with a STI was important, though, as communication has been suggested as a particular challenge for these relationships (Foster & Byers, 2013, 2016; Newton & McCabe, 2008). Given the small sample size (generally, a minimum standard of 10 participants per variable is recommended; Field, 2013), it was unsurprising that, for the most part, the communication variables did not predict relationship and or sexual satisfaction independently as one or two participants in a sample this size could significantly impact the results. Interestingly, though, Criticize/Demand did significantly predict Relationship Satisfaction independently despite this small sample size, suggesting that this may be an important factor to be explored in research and practice when exploring relationships where one or both partners is living with a STI. Future research should consider exploring the communication in relationships where one or more partners is living with a STI further with larger sample sizes.

**Limitations.** As has been established, the small sample size limited the analyses of the current study. Additionally, on average, participants were very satisfied in their relationships (in general). This extreme report could have an impact on the regression models given the sample size. While the regressions in this analysis suggest a need to explore communication further in the context of intimate relationships where one or more individuals are living with a STI, very few conclusions can be drawn from the quantitative portion of this study.
Chapter 6: Overall Conclusions

The current study utilized quantitative and qualitative measures to explore the experiences of people living with a STI/HIV in intimate relationships. By utilizing a strengths-based approach to the research, the study served to challenge the current literature and offer new directions for research and practice. Through online recruitment strategies, 28 Canadians living with a chronic STI responded anonymously to the quantitative and qualitative questions via an online survey platform. The qualitative responses demonstrated that people living with STIs have specific competencies in their relationships, and that context is vital to understanding their specific needs within those relationships. The quantitative responses suggested that communication may be in need of further exploration, particularly regarding the sexual and relationship satisfaction of people living with STIs. In regards to the qualitative results, participants’ offered contextual information regarding their experiences that suggested STI status was not a primary concern in their intimate relationships. Additionally, people living with STIs shared both individual and relational-level competencies – strengths that are largely missing from current literature. Both the quantitative and qualitative results indicate that future research and practice needs to further explore communication in relationships where one or more partners is living with a stigmatized condition. Future research should also utilize GIPA/MIPA principles, along with a strengths-based orientation to continue destigmatizing people living with STIs. In terms of practice, clinicians and educators should aim to educate people regarding sexual health in a neutral way, allowing them to make their own, informed decisions about sexual partners and their sexual health. Mindfulness training and/or practice may also be a possible intervention for people living with STIs at both the individual and relational level.
References


Byers, S. E. (2011). Beyond the birds and the bees and was it good for you?: Thirty years of research on sexual communication. *Canadian Psychology, 52*(1), 20-28.


Appendix A: Ethics Approval

RESEARCH ETHICS BOARDS

Certification of Ethical Acceptability of Research

Involving Human Participants

<table>
<thead>
<tr>
<th>APPROVAL PERIOD:</th>
<th>November 2, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXPIRY DATE:</td>
<td>November 2, 2016</td>
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<tr>
<td>REB NUMBER:</td>
<td>15AU018</td>
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<tr>
<td>TYPE OF REVIEW:</td>
<td>Delegated Type 1</td>
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<tr>
<td>PRINCIPAL INVESTIGATOR:</td>
<td>Neustifter, Ruth</td>
</tr>
<tr>
<td></td>
<td>(<a href="mailto:rneustif@uoguelph.ca">rneustif@uoguelph.ca</a>)</td>
</tr>
<tr>
<td>DEPARTMENT:</td>
<td>Family Relations &amp; Applied Nutrition</td>
</tr>
<tr>
<td>SPONSOR(S):</td>
<td>N/A</td>
</tr>
<tr>
<td>TITLE OF PROJECT:</td>
<td>Health and Intimate Relationships</td>
</tr>
</tbody>
</table>

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:

- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:

- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
Submit a **Status Report** to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the **EXPIRY DATE**, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature:  
Date: November 2, 2015
CONSENT TO PARTICIPATE IN RESEARCH

Health and Intimate Relationships

You are asked to participate in a research study conducted by Angela Underhill, a graduate student from the Department of Family Relations and Applied Nutrition at the University of Guelph. The results from your participation will contribute to Angela Underhill’s Master’s thesis. The student researcher is working under the supervision of Dr. Ruth Neustifter, an Assistant Professor in the Family Relations and Applied Nutrition Department at the University of Guelph. Dr. Neustifter can be contacted at rneustif@uoguelph.ca or 519-824-4120 ext. 53975

If you have any questions or concerns about the research, please feel free to contact Angela Underhill at aunderhi@uoguelph.ca.

PURPOSE OF THE STUDY

To gain a better understanding of the experiences people living with STIs have in their committed relationships.

PROCEDURES

Your participation would involve completing an anonymous, online survey. The survey itself will take between 0.5 and 1.5 hours, depending on how much you would like to share. In order to participate in this study, you must:

• be living with a sexually transmitted infection (STI) and/or HIV;
• be a Canadian resident;
• currently be in a committed relationship for a minimum of four weeks; and,
• you must be 18 years or older.

During the survey, you will be asked about your experiences as a person in a committed relationship affected by a STI and/or HIV. After the completion of the study, the data will be transferred onto a password protected, encrypted computer and/or USB. All study materials will be retained for seven years in a locked office at the University of Guelph. Data obtained in this study may be used in future publications, presentations, and as secondary data analysis in the future. Your name and other personal identifiers will not be collected.
After the completion of this study, the results will be written up for Angela Underhill’s Master’s thesis. After her graduation (expected in August 2016), participants will be able to access the results in the completed Master’s thesis by contacting the faculty supervisor, Dr. Ruth Neustifter at neustif@uoguelph.ca

POTENTIAL RISKS AND DISCOMFORTS:

There is some psychological risk involved in participating in this study. Some people may be embarrassed or feel uncomfortable discussing their health status, sexual experiences or their personal relationships. If there is a privacy breach, there could also be negative effects to your relationship. To minimize this risk, we encourage all participants to clear their browser history and their internet cache once the survey is completed, and to close the browser. You can decline to answer any question or withdraw from the survey at any time by exiting the online survey. If there is something that upsets you during the course of your participation in this study, please consider calling the Wellington Dufferin Crisis Line at 1-877-822-0140.

CONFIDENTIALITY AND DATA STORAGE:

Data will be stored on a password protected, encrypted computer and/or USB. Devices that contain data will be kept in a secure location behind a locked door when not in use. As the data is being collected over the internet, confidentiality cannot be guaranteed. Personal identifiers and/or IP addresses will not be collected. E-mail communication with participants will be deleted after questions/concerns are resolved.

It should be noted that Angela Underhill, the graduate student investigator of this study, is also a research assistant at Women’s College Hospital. However, Angela does not have access to patient data in her role at Women’s College Hospital, and therefore there is no risk of participant identification based on her position there. During the duration of her studies at the University of Guelph, Angela Underhill will be charged with the stewardship of the data under the PI, Dr. Ruth Neustifter. Upon Angela Underhill’s graduation, Dr. Ruth Neustifter will be in charge of the data, and it will be made accessible to Angela Underhill in the event that there is a need to review data for the purposes of release/publication of results or for the purpose of future secondary data analysis.

PARTICIPATION AND WITHDRAWAL:

You can choose whether or not to be in this study. If you volunteer to be in this study, you may withdraw at any time up until the final page of the survey is submitted. You may also refuse to answer any questions you do not want to answer and still remain in the study. The student researcher may withdraw you from this research if circumstances arise that warrant doing so.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY:
Participants will gain a better understanding of their own identity and their personal relationship, perhaps allowing greater understanding of their current relationship. This
research will benefit the discipline and society as it will allow for a better understanding of the potential impacts of sexually transmitted infections on committed relationships (if there are any) and may have an influence on therapeutic priorities for people living with sexually transmitted infections who experience concerns in their intimate relationships.

RIGHTS OF RESEARCH PARTICIPANTS:
This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Director, Research Ethics   Tel: (519) 824-4120, ext. 56606
University of Guelph   E-mail: sauld@uoguelph.ca
437 University Centre   Fax: (519) 821-5236
Guelph, ON N1G 2W1

Before moving forward, please consider printing this consent form for your records.

By clicking “next”, you are acknowledging that you have read the information provided for the study and are consenting to participate.
Appendix C: Recruitment Material

Post for Social Media

Are you currently in a committed relationship and living with HIV or a sexually transmitted infection? I am looking for individuals living in Canada who have been diagnosed with HIV/STI to partake in an anonymous online survey to learn more about their experiences with their current partner(s).

Participants will be asked to complete an anonymous online survey that will take between 0.5 and 1.5 hours to complete.

For more information, please check out the website at http://tinyurl.com/health-intimacy or pass on my e-mail (aunderhi@uoguelph.ca) to those who might be interested in participating. This study has received approval from the University of Guelph’s Research Ethics Board (#15AU018) and is part of a graduate student research project.

Please share this call for participants!

Twitter Post

In a committed relationship and living with HIV or a STI? Share your experience @ http://tinyurl.com/health-intimacy #relationships
Recruitment Poster (Used Online)

In a committed relationship and living with a sexually transmitted infection and/or HIV?
Share your experience!

Are you eligible? To participate:

1. Get comfortable – it takes 0.5 – 1.5 hours to complete
2. Visit: http://tinyurl.com/health-intimacy
3. Complete the anonymous survey
4. You’re done!

Are you...

- Currently in a committed relationship (that began at least four weeks ago)?
- Living with a chronic STI or HIV?
- 18 years or older?
- A resident of Canada?

If you answered YES to all of the above questions, you are eligible!

The goal of this study is to better understand how STIs and/or HIV impact relationships to provide better support for people living with or affected by STIs and/or HIV. It has been approved by the University of Guelph’s Research Ethics Board.
Questions or concerns? Contact aunderhi@uoguelph.ca
Appendix D: Screening Questionnaire

Thank you for your interest in the study: Health and Intimate Relationships! Below is a brief screening list for you to complete. Please check all that apply and click continue.

I am 18 years old or older. (If not checked, participants received a thank you message)

I consider myself to be in a committed relationship. (If not checked, participants received a thank you message)

I have been in my current relationship for four weeks or more. (If not checked, participants received a thank you message)

I am a resident of Canada. (If not checked, participants received a thank you message)

I am currently living with: (If none of the options below were checked, participants received a thank you message)

HIV (human immunodeficiency virus)

Genital herpes

Hepatitis B

Hepatitis C

Hepatitis D

HPV (human papillomavirus)
Appendix E: List of Initial Codes

1. Work-life balance, negative, more work than life
2. Work-life balance, negative, more school than life
3. Work-life balance, partner’s priority is work
4. Work-life balance, positive, both prioritize career
5. Hoping for change/Working for Change, hoping for individual level change to help relationship
6. Hoping for change/working for change, moving in together
7. Hoping for change/working for change, sex life
8. Hoping for change/working for change, hoping for children
9. Hoping for change/working for change, hoping for a more “full life”
10. Hoping for change/working for change, hoping for better mental health
11. Hoping for change/working for change, more balance
12. Hoping for change/working for change, conflict management
13. Hoping for change/working for change, partner’s substance use
14. Hoping for change/working for change, family dynamics
15. Hoping for change/working for change, to build trust
16. Hoping for change/working for change, vague
17. Hoping for change/working for change, goal setting together
18. Hoping for change/working for change, finances
19. Sexual desire, lower than partner’s/less engaged than partner
20. Sexual desire, not impacted by STI
21. Sexual desire, lower due to medication
22. Sexual desire, partner has a lower drive than participant, attributed to work stress
23. Sexual desire, lower than partner’s, attributed to school stress
24. Sexual desire, changed over time
25. Differing Needs, in terms of sexual desire
26. Differing Needs, in terms of sexual frequency
27. Differing Needs, in terms of priority/sexual frequency
28. Differing Needs, coping style/conflict resolution
29. Differing Needs, in terms of communication
30. Differing Needs, sex/intimacy
31. Differing Needs, financial
32. Differing Needs, sex
33. Differing Needs, related to “ideals”
34. Differing Needs, physical affection
35. Differing Needs, coping style
36. Stres sor, work
37. Stressor, finances under “concerns in relationship” question
38. Stressor, frequency of sex
39. Stressor, school
40. Stressor, substance use
41. Stressor, finances
42. Stressor, transmission risk
43. Stressor, job loss
44. Stressor, finances, due to job loss
45. Stressor, trying to expand family
46. Medical assistance, negative medication side effects
47. Medical assistance, positive, made HIV just a part of life
48. Medical assistance, medications, try to avoid
49. Medical assistance, medication, negative, not decreasing symptoms
50. Medical assistance, testing was challenging
51. Medical assistance, medication, considering
52. Medical assistance, positive medication effects (minimized symptoms)
53. Medical assistance, medication, decision-making
54. Medical assistance, medical care, negative
55. Medical assistance, negative effects of medication
56. Medical assistance, medications, neutral
57. Medical assistance, HCP, positive
58. Mental health, challenge
59. Past challenges in relationship
60. Past challenges in the relationship, STI
61. Past challenges in the relationship, regarding intimacy/sexuality
62. Past challenges in the relationship, regarding intimacy, now resolved
63. Past challenges in the relationship, sex life by STI, no longer contributed to STI
64. STI symptoms, physical
65. STI symptoms, physical, frequent
66. STI symptoms, physical, mild, rare
67. STI symptoms, fear they will come back
68. Stress, leads to STI symptoms (not other way around)
69. Stress, from work, contributing to STI symptoms
70. Sexual functioning, improving with medication
71. Sexual functioning, no change due to STI
72. Sexual functioning, vulvodynia, symptom of GH
73. Sexual functioning, impacted by stress
74. Social support, lacking social network (desiring more)
75. Social support, not supportive of partner’s social network
76. Social support, positive, separate supports in place
77. Sexual exploration, desiring
78. Sexual exploration, changed since transmission occurred
79. Sexual exploration, limited due to STI status
80. Sexual exploration, not occurring
81. Sexual exploration, perhaps affected by age
82. Negotiating boundaries, in relationship, interested in exploring
83. Negotiating boundaries, related to safer sex
84. Negotiating boundaries, external to relationship/impacting relationship
85. Negotiating boundaries, communication boundaries
86. Negotiating boundaries, in relationship (re: monogamy – perhaps explicitly establishing boundaries instead)
87. Negotiating boundaries, physical
88. Negotiating boundaries, physical affection
89. Negotiating boundaries, free time
90. Consensual non-monogamy, interested/fearful
91. Consensual non-monogamy, concerns about disclosure with additional partners
92. Consensual non-monogamy, disclosing to additional partners
93. Body image, self, negative
94. Body image, partner, negative
95. Personality traits, of partner, negative
96. Personality traits, of partner, very positive
97. Personality traits, of partner
98. Personality traits, of self, neutral (working on self-improvement)
99. Personality traits, empathy, working toward
100. Personality traits, mutual, patience
101. Personality traits, partner, easily hurt
102. Personality traits, understanding on both parts, positive
103. Power dynamics, age
104. Power dynamics, gender
105. Mutual decision-making
106. Mutual decision-making, working together
107. Mutual decision-making, regarding finances
108. Mutual decision-making, to address conflicts better
109. Finances, under the “concerns in relationship” question
110. Finances, concern in relationship but not a source of conflict
111. Finances, major concern
112. Finances, negative, too many financial demands
113. Finances, negative, source of conflict
114. Finances, accepts financial privilege & responsibility
115. Finances, main concern
116. Finances, positive, working together
117. Communication style, discussion of pros/cons
118. Household responsibilities, difficult to negotiate
119. Household responsibilities, different expectations than partner
120. Household responsibilities, under “challenges in relationship” question
121. Coping strategy, humour
122. Coping strategy, needs time to process
123. Coping strategy, partner needs to talk right away
124. Coping strategy, different from partner’s coping strategy
125. Coping strategy, communication, rational rather than emotional
126. Coping strategy, taking breaks, being explicit, compromise
127. Humour, to lighten sex conversations
128. Humour, regarding STI status
129. Humour, positive, ends conflicts
130. Humour
131. Substance use, negatively perceived by both
132. Substance use, perceives partner to use alcohol excessively
133. Substance use, support to stop
134. Adjustment, within relationship, adjusting to living situation
135. Adjustment, within relationship, adjusting to change in sex life
136. Adjustment, lost job, difficult to recover
137. Adjustment, sex life with age
138. Role negotiation, blended family
139. Role negotiation, no longer interested in traditional roles
140. Role negotiation, accommodating
141. Role negotiation, blended family
142. Values, differ from partner’s
143. Values, mutual
144. Values, differ in terms of significance of STIs
145. Values, teaching daughter through hardships
146. Values, same as partner’s
147. Goals
148. Goals, discrepancy with partner’s goals
149. Goals, setting goals together
150. Goals, following through with goals
151. Goals, similar goals
152. Goals, setting relationship goals
153. History, discrepancy with partner’s history
154. History, difficult, different ideals
155. Conflict resolution, differing styles
156. Conflict resolution, strategies, same style
157. Conflict resolution, strategies, trying to find common ground
158. Conflict resolution, humour, repetition
159. Conflict resolution, strategies, let it go, apologize, space
160. Conflict resolution, strategies, frequent style
161. Conflict resolution, strategies, working together
162. Conflict resolution, unsuccessful
163. Conflict resolution, positive, humour
164. Conflict resolution, recognizing partner’s needs
165. Conflict resolution, let it go
166. Conflict resolution, stay positive
167. Conflict resolution, taking breaks when needed
168. Conflict resolution, differing, positive
169. Conflict resolution, strategies, not taking things personally
170. Conflict resolution, maintaining control/awareness
171. Presence/investment in relationship, partner disengaged
172. Presence/investment in relationship, partner disengaged because of breach of trust
173. Presence/investment in relationship, continuous engagement
174. Presence/investment in relationship, commitment
175. Presence/investment in relationship, planning, working together
176. Presence/investment in relationship, worked through it
177. Presence/investment in relationship, positive
178. Presence/investment in relationship, regarding finances
179. Presence/investment in relationship, explicit, strong
180. Embracing good with bad
181. Trauma, recent, death of family member
182. Trauma, past, regarding STI acquisition
183. Trauma, recent, workplace violence
184. Trauma, past, working through
185. Grief, death of a family member
186. Intention to change, specific to communication
187. Recognition of a mistake, in relationship
188. Recognition of a mistake, strategies for handling mistakes
189. Trust, lacking trust from partner
190. Trust, positive
191. Trust, lacking trust for partner
192. Trust, working on building
193. Trust, trust, in progress
194. Sexual exploration, changing with age, working on it
195. Sexual exploration, changing with age
196. Acceptance, changes in sex life due to age
197. Acceptance, self, STI
198. Acceptance, regarding STI by current partner
199. Acceptance, about insecurities, stigma, STI
200. Acceptance, of partner’s readiness
201. Acceptance, of differences
202. Acceptance, positive, of differences
203. Acceptance, of different coping styles
204. Difficult to talk about, relationship change, moving in together
205. Difficult to talk about, in past, HIV status
206. Difficult to talk about, use of medication as safer sex practice
207. Difficult to talk about, sexual frequency
208. Difficult to talk about, moving in together
209. Difficult to talk about, safer sex (happened with doctor instead)
210. Difficult to talk about, intimacy
211. Safer sex practices, medication as an option
212. Safer sex practices, abstaining during outbreaks
213. Safer sex practices, avoid kissing during breakout
214. Safer sex practices, viral load undetectable, positions
215. Safer sex practices, undetectable, sexual positioning due to STI
216. Safer sex practices, past, communication
217. Safer sex practices, to prevent pregnancy not transmission
218. Safer sex practices, communication as a safer sex practice
219. Safer sex practices, condoms, viral load
220. Safer sex practices, viral load undetectable
221. Safer sex practices, medication as an option, sex positions
222. Safer sex practices, minimal, no protection when just the dyad
223. Safer sex practices, used when partners beyond dyad involved
224. Safer sex practices, used at first, communicated
225. Safer sex practices, implemented since diagnosis
226. Safer sex practices, still used
227. Safer sex practices, condoms, clear communication
228. Transmission risk, unclear on what precautions are ‘enough’
229. Transmission risk, fear of transmission not existent
230. Transmission risk, fear impacts presence during sex
231. Transmission risk, relative to partner’s GH, not so much in relation to participant’s HPV
232. Transmission risk, fear, high
233. Transmission risk, minimal
234. Transmission risk, partner not concerned
235. Transmission risk, impacts sexual frequency/acts
236. Sexual relationship, under “concerns in relationship”
237. Sexual relationship, affected by STI
238. Frequency of conflict, high, negative
239. Family growth, trying to have a baby
240. Relationship growth, improved communication
241. Relationship growth, have overcome challenges
242. Relationship growth, emotional, spiritual, trust
243. Relationship growth, moving in together – not happening
244. Relationship growth, moving forward from conflict
245. Learning from partner, communication style
246. Learning from partner, reciprocal, regarding body dysmorphia
247. Worry-free, in relationship, generally
248. Worry-free, regarding transmission
249. Worry-free, regarding sex
250. Expressions of love/intimacy, physical
251. Encouragement from partner, partner encouraged participant to get medical care
252. Support from partner, positive
253. Support from partner, caring behaviours
254. Support from partner, STI concerns
255. Support from partner, regarding diagnosis, intimacy
256. Support from partner, regarding sexual decision-making
257. Support from partner, continuous, positive
258. Support from partner, regarding STI status
259. Support from partner, emotional, regarding insecurities
260. Support from partner, love, open communication
261. Support from partner, positive, very communicative
262. Support from partner, positive, led to personal growth
263. Support from partner, positive, career related
264. Support from partner, regarding social network
265. Support from partner, positive, empathetic
266. Openness with partner, communicates beliefs about partner to partner (unclear if positive or negative)
267. Openness with partner, explicit about wants/needs
268. Openness with partner, regarding outbreaks, received well
269. Openness with partner, complete, positive
270. Openness with partner, not open, negative
271. Openness with partner, from the beginning
272. Openness with partner, regarding sex, transmission
273. Openness with partner, positive, mitigates insecurities
274. Openness with partner, fear of transmission, discussion around it
275. Openness with partner, honesty has led to positive outcomes
276. Openness with partner, positive, relief
277. Openness with partner, empathy in relationship
278. Openness with partner, readiness to engage in sex
279. Openness with partner, positive
280. Openness with partner, positive, re: conflict
281. Openness with partner, neutral, vague
282. Openness with partner, to solve conflicts
283. Openness with partner, neutral
284. Openness with partner, positive, from partner
285. Openness with partner, expresses feelings
286. Openness with partner, positive, explicit about needs
287. Openness with partner, positive, only way to resolve conflict
288. Openness with partner, positive, routine
289. Openness with partner, positive, reduces assumptions
290. Openness with partner, transmission risk, sexual decision-making
291. Support for partner, financial support
292. Support for partner, very positive
293. Support for partner, regarding body dysmorphia
90

294. Support for partner, regarding substance use
295. Support for partner, patient with partner’s situation
296. Support for partner, career-related
297. Support for partner, positive, social network
298. Willingness to listen, to partner
299. Willingness to listen, occurring, positive
300. Willingness to listen, to partner, work in progress
301. Willingness to listen, positive
302. Willingness to listen, positive, translates into support
303. Professional help, neutral, still trying
304. Professional help, pursued, unsuccessful
305. Professional help, ongoing
306. Minimizing problems, in terms of conflict
307. Minimizing problems, optimistic
308. Recognition of own needs, positive, positive relational impacts
309. Recognition of own needs, became evident due to HIV status
310. Recognition of own needs, with relational implications
311. Recognition of own needs, healthy communication
312. Recognition of own needs, sexual desire
313. Recognition of own needs, contributing to relationship change
314. Recognition of own needs, explicit about them
315. Mutual desires, monogamy
316. Mutual desires, learned about them from STI
317. Mutual desires, created mutual goals for change
318. Consent, intimacy
319. Self-reflection, learning about self
320. Self-reflection, positive
321. Self-reflection, growth
322. Self-reflection, abstaining during outbreaks can be frustrating
323. Self-reflection, STI has not had major impact on sex life
324. Self-reflection, STI did not affect sex life
325. Self-reflection, STI not a big deal relatively
326. Self-reflection, no sexual impact from STI
327. Self-reflection, STI impacts sex, not relationship
328. Self-reflection, STI not a concern in relationship
329. Self-reflection, learning about self contributes to relationship
330. Self-reflection, on self and partner
331. Self-reflection, tentative
332. Self-reflection, neutral, about self/partner
333. Self-reflection, STI not an identity factor
334. Situational factors, depersonalizing concerns in relationship
335. Stigma, age
336. Stigma, wish it could be reduced
337. Stigma, fear of it
338. Stigma, social, strong influencer of past
339. Stigma, social, ignores
340. Stigma, past rejections
341. Stigma, social
342. Stigma, social, negative
343. Stigma, STI, social
344. Stigma, social, fighting it with humour
345. It’s a fact not a factor, age
346. It’s a fact not a factor, STI
347. It’s a fact not a factor, STI not often thought about anymore
348. It’s a fact not a factor, only a factor during outbreaks
349. It’s a fact not a factor, STI on sex life
350. It’s a fact not a factor, fact of relationship, not a factor
351. It’s a fact not a factor, STI status in relationship context
352. It’s a fact not a factor, STI status in terms of identity
353. Interests differ from partner’s, positive
354. Recognition of partner’s needs, trying to find better ways to communicate
355. Recognition of partner’s needs, positive, working on it
356. Recognition of partner’s needs, conflict resolution strategy
357. Recognition of partner’s needs, positive, helpful
358. Control, over self to help relationship
359. Reflection on relationship, on relationship, together
360. Disclosure, to additional partners, minimal impact
361. Disclosure set stage for difficult conversations
362. Sensitive topics, easy to talk about because of initial disclosure
363. Support for one another
364. Support, social
365. Support from partner through communication, reassurance
366. Support from partner, emotional, physical
367. Acquisition of STI, neutral, acknowledged, not a concern
368. Acquisition of STI, trauma
369. Vulnerability, led to protectiveness over participant
370. Vulnerability strengthened intimacy
371. Vulnerability, talking about STI in beginning contributed to relationship
372. Vulnerability, sharing this experience makes it seem like anything can be shared with partner
373. Knowledge, regarding STI built empathy
374. Knowledge, educated about STI risks, aware there is little relevant research
375. Knowledge, reduces concerns regarding transmission
376. Knowledge does not eliminate fears regarding transmission
377. Sexual frequency, impacted by STI
378. Sexual frequency, rarely impacted by STI
379. Sexual frequency, impacted by STI when outbreaks occur
380. Empathetic, partner acknowledges insecurities, offers reassurance
381. Insecurities, STI related, partner’s responses positive
382. Insecurities, not present regarding STI
383. Insecurities, very strong
384. Foundation of trust started with disclosure
385. Easy to talk about, outbreaks and sex
386. Resentment attributed to STI
387. Resentment regarding STI
388. Reaction to diagnosis, negative, surprised/embarrassed/awkward
389. Reaction to diagnosis, more concerned than partner
390. Sexual options, limited during outbreaks
391. Experience with study, positive
392. Experience with study, negative
393. Experience with study, hopeful
394. Self-growth, positive, attributed to HIV status
395. Relationship satisfaction, low
Appendix F: Demographic Questionnaire

This questionnaire asks about some background information. If you take this opportunity to participate, please do so seriously and honestly. Your responses should only represent your own personal thoughts and experiences.

1. Please enter your date of birth. (drop down menu for month, year).

2. What was your biological sex at birth? 
   Select one.
   Male
   Female
   Intersex
   Undetermined
   Other, please specify ________________

3. With respect to your gender, how do you currently identify?
   Woman
   Man
   Trans man (female to male)
   Trans woman (male to female)
   Two-spirited
   Intersex
   Gender Queer
   Other, please specify ________________

4. What gender do you currently live as in your day-to-day life?
   Woman
   Man
   Trans man (female to male)
   Trans woman (male to female)
   Two-spirited
   Intersex
   Gender Queer
   Other, please specify ________________

5. With respect to your sexual orientation, how do you currently identify?
   Select all that apply.
   Heterosexual/straight
   Lesbian
   Gay
   Queer
   Bisexual
   Two-spirited
   Questioning
   Other, please specify: ____________________
Don’t know
Prefer not to answer

6. What is your current relationship status?
Select one.
Single  (If selected, participant will receive a thank you message for participating)
Casually dating one or more partners
Serious dating one or more people
Serious dating one person, casually involved with one or more others
Serious dating one person
Engaged
Married
Common-law
Other, please specify: ____________________________
Prefer not to answer.

7. How would you describe the gender of your current partner?
Woman
Man
Trans man (female to male)
Trans woman (male to female)
Two-spirited
Intersex
Gender Queer
Other, please specify ______________ 

8. For how long have you and your partner been in a relationship? (Please indicate the number of years and/or months):  
______________ years ______________ months

9. Have you disclosed your STI status to your current partner?
Yes
No

10a. (If the participant answers yes to question 9). Why did you decide to disclose to your current partner?

10b. (If the participant answers no to question 9). Why did you decide not to disclose to your current partner?

11. (If the participant answers yes to question 9). How long ago did you disclose to your current partner?
______________ years ______________ months

11. Are you currently living with your partner?
12. Do you and/or your partner have children?
Yes
No

13. If yes, how old are they? _________________________

14. To what extent do you consider yourself a religious person?
Not at all
A little bit
Somewhat
A lot
Very much

15. To what extent do you consider yourself a spiritual person?
Not at all
A little bit
Somewhat
A lot
Very much

16. Are you currently taking any prescription medications?
Yes
No

17. If yes, please list them: ______________________________________

18. What do you consider to be your racial/ethnic background?

19. What is the highest level of formal education you have completed?
Select one.
No formal education
Elementary/grade school
GED (General Education Diploma)
Trade or technical training
CEGEP/College
Undergraduate university
Post-graduate education
Other, please specify: _______________________
Don’t know
Prefer not to answer
Appendix G: Quantitative Measures

The Global Measure of Relationship Satisfaction (GMREL; Lawrence & Byers, 1998)²

Thinking about your current committed relationship, please answer the following questions.

1. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very Bad 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very Good 7</th>
<th>I choose not to answer</th>
</tr>
</thead>
</table>

2. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very unpleasant 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very pleasant 7</th>
<th>I choose not to answer</th>
</tr>
</thead>
</table>

3. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very negative 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very positive 7</th>
<th>I choose not to answer</th>
</tr>
</thead>
</table>

4. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Very unsatisfying 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very satisfying 7</th>
<th>I choose not to answer</th>
</tr>
</thead>
</table>

5. In general, how would you describe your overall relationship with your partner?

<table>
<thead>
<tr>
<th>Worthless 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Very valuable 7</th>
<th>I choose not to answer</th>
</tr>
</thead>
</table>

² Please note that the title was not included in the study
Index of Sexual Satisfaction (Hudson, Harrison, & Crosscup, 1981)<sup>3</sup>

Thinking about your current relationship, please answer the following questions.

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>Very rarely</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good part of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
<th>Not Applicable</th>
<th>Choose not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that my partner enjoys our sex life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our sex life is very exciting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex is fun for my partner and me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex with my partner has become a chore for me. (R)</td>
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<tr>
<td>I feel that our sex life is dirty and disgusting. (R)</td>
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<tr>
<td>Our sex life is monotonous. (R)</td>
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<tr>
<td>When we have sex it is too rushed and hurriedly completed. (R)</td>
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<tr>
<td>I feel that my sex life is lacking in quality. (R)</td>
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<tr>
<td>My partner is sexually very exciting.</td>
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<tr>
<td>I enjoy the sex</td>
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</tbody>
</table>

<sup>3</sup> Please note that the title was not included in the study.
<table>
<thead>
<tr>
<th>technique</th>
<th>column1</th>
<th>column2</th>
<th>column3</th>
<th>column4</th>
<th>column5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that my partner wants too much sex from me. (R)</td>
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<tr>
<td>I think our sex is wonderful.</td>
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<tr>
<td>My partner dwells on sex too much. (R)</td>
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<tr>
<td>I try to avoid sexual contact with my partner. (R)</td>
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<tr>
<td>My partner is too rough or brutal when we have sex. (R)</td>
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<tr>
<td>My partner is a wonderful sex mate.</td>
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<tr>
<td>I feel that our sex life is a normal function of our relationship.</td>
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<tr>
<td>My partner does not want sex when I do. (R)</td>
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<tr>
<td>I feel that our sex life really adds a lot to our relationship.</td>
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<tr>
<td>My partner seems to avoid sexual contact with me. (R)</td>
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<tr>
<td>It is easy for me to get</td>
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<td>Statement</td>
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<tr>
<td>sexually excited by my partner.</td>
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<tr>
<td>I feel that my partner is sexually pleased with me.</td>
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<tr>
<td>My partner is very sensitive to my sexual needs and desires.</td>
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<tr>
<td>My partner does not satisfy me sexually. (R)</td>
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<tr>
<td>I feel that my sex life is boring.</td>
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</tbody>
</table>
Communication Patterns Questionnaire – Short Form

Directions: We are interested in how you and your partner typically deal with problems in your relationship. Please rate each item on a scale of 1 (=very unlikely) to 9 (very likely).

A. When some problem in the relationship arises,

<table>
<thead>
<tr>
<th></th>
<th>Very unlikely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both members avoid discussing the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both members try to discuss the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>You try to start a discussion while your partner tries to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Your partner tries to start a discussion while you try to avoid it.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM,

<table>
<thead>
<tr>
<th></th>
<th>Very unlikely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both members blame, accuse, and criticize each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both members express their feelings to each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Both members suggest possible solutions and compromises.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Your partner pressures, nags, or demands while you withdraw, become silent, or refused to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>You pressure, nag, or demand your partner while your partner withdraws, becomes silent, or refuses to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>You criticize while your partner defends themselves.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>Your partner criticizes while you defend yourself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: All instances of “The man” have been changed to “You”; all instances of “the woman” have been changed to “your partner”. This has been done to be more inclusive of potential participants.

\[^4\]Please note that the title was not included in the study.