

**Emerging Adults' Experiences as Receivers of Sexually Transmitted Infection Disclosures from
Sexual Partners: A Three-Part Examination**

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Degree
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ABSTRACT

Each year in the United States, over 20 million cases of sexually transmitted infections (STIs) are diagnosed, mostly among those in the developmental period of emerging adulthood (ages 18-29). Research on STI disclosure to romantic and sexual partners has increased over the last two decades, but this research has (a) generally lacked a developmental and theoretical focus, (b) not examined disclosure recipients, and (c) not been systematically and critically synthesized. To address these limitations, I conducted a three-part examination. First, I systematically reviewed the STI disclosure literature and summarized findings, critical limitations, and future research and intervention directions. Next, I designed two cross-sectional studies to understand emerging adults' experiences as receivers of hypothetical (Study 1, $N = 243$) and actual (Study 2, $N = 88$) STI disclosures from sexual partners. After developing the STI Disclosure Reactions Measure (SDRM), I conducted exploratory (Study 1) and confirmatory (Study 2) factor analyses. I examined how STI type (bacterial or viral), relationship type (non-committed or committed), and participant gender differentiated reactions. In Study 1, women anticipated more negative reactions and were less likely to anticipate avoiding the discloser. Men anticipated more anxious and guilty reactions in committed relationships, whereas women anticipated more in non-committed relationships. In Study 2, men had more negative, anxious, and guilty reactions when a bacterial STI was disclosed, whereas women's reactions did not differ based on STI type. Finally, I discuss limitations and implications for future research, sexual health education, intervention, and practice.

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CHAPTER 1:

Introduction

Emerging adulthood is a developmental period in which young adults (ages 18-29) may have opportunities to explore and experiment with sex and relationships while remaining free of other responsibilities, such as work or family maintenance (Arnett, 2015). Sexual and relationship involvement is diverse among emerging adults, including explorations in non-committed casual sex relationships (Garcia et al., 2012), consensually non-monogamous relationships (Olmstead, 2020), and serially monogamous relationships (Olmstead, 2020). Involvement in sexual relationships brings many opportunities for sexual identity exploration and experimentation, but for many emerging adults is also associated with certain risky sexual behaviors, including inconsistent condom use, sex while under the influence of drugs and alcohol, and sex with multiple partners (Arnett, 2015; Turchik & Garske, 2009). In addition to engaging in high-risk sexual behaviors, emerging adults in the United States have the highest sexually transmitted infection (STI) rates among all age groups (Centers for Disease Control and Prevention [CDC], 2019; Kirzinger et al., 2020).

Despite having the highest national STI rates, research on emerging adults' experiences with STIs has not kept pace. Research on the disclosure of STIs to romantic and sexual partners has increased over the last 20 years. Specifically, studies have examined the experiences of disclosers, focusing mostly on reasons for or against disclosure (e.g., Bickford et al., 2007; Lee & Craft, 2002; Nack, 2000; Newton & McCabe, 2008a). These studies have revealed a variety of reasons for and against disclosure, but much of this research has not been guided by theory or incorporated a developmental component to examine disclosure. Second, the STI disclosure literature has scarcely investigated the experiences of STI disclosure recipients. The literature reveals that many motives for and against disclosure are influenced by the individual's perception of the intended receiver, specifically, how they anticipate the partner will react (e.g.,

Green et al., 2003; Myers et al., 2016; Temple-Smith et al., 2010). Yet, to my knowledge, there is limited research examining how receivers react to STI disclosures. Further, emerging adults often hold stigmatizing beliefs about those with STIs (Hirschler et al., 2015), and the perception of STI stigma often inhibits disclosure (Lee & Craft, 2002; Nack, 2000). Yet, it is also unclear how emerging adults anticipate responding to STI disclosures and if these responses are influenced by STI stigma.

Using the Health Disclosure Decision-Making Model (DD-MM; Greene, 2009), this dissertation addressed these critical limitations in three ways. First, I conducted a systematic, critical literature review of the STI disclosure research. Specifically, I used a mixed-methods review strategy (Kågesten et al., 2016), guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA; Liberati et al., 2009) and Enhancing Transparency in Reporting the synthesis of Qualitative research (ENTREQ; Tong et al., 2012) statements, and the DD-MM (Greene, 2009) and emerging adulthood (Arnett, 2015) frameworks, to systematically review and critique the STI disclosure literature. I used a thematic approach to synthesize the literature and mapped findings onto the DD-MM framework (Greene, 2009), summarized critical limitations and omissions in the literature, and suggested future directions for research, education, and intervention.

Next, using the DD-MM (Greene, 2009), I designed and conducted two cross-sectional studies. I used the crowdsourcing site Prolific (Palan & Schitter, 2018) to recruit emerging adults (ages 18-29) for both studies using a series of screening items. To capture the perspectives of emerging adults who have never received an STI disclosure, Study 1 examined their anticipated reactions to hypothetical STI disclosures using vignette scenarios. After screening, I obtain a final sample of $N = 243$ emerging adults for Study 1. The STI Disclosure Reactions Measure

(SDRM) was developed to assess participants' anticipated responses to and outcomes of a sexual partner's STI disclosure. This study also sought to determine if the type of relationship with the discloser, the type of STI disclosed, the receiver's gender, and STI stigma were associated with reactions. Understanding how emerging adults anticipate responding to STI disclosures could validate or challenge the anticipated reactions that disclosers consider when deciding to disclose and reveal future directions for research on actual disclosure recipients. These findings could also have implications for how we pursue sexual health education and interventions in the United States.

Study 2 was designed to build upon Study 1 by examining the actual reactions of emerging adults who had received an STI disclosure from a sexual partner. After screening, I obtained a final sample of $N = 88$ emerging adults (ages 18-29). This study was designed to describe the experiences of emerging adult disclosure recipients, investigate receivers' actual reactions, and determine if relationship type, STI type, gender, and STI stigma also differentiated these reactions. This study addressed a significant gap in the STI disclosure literature by describing the experiences of receivers and their reactions to STI disclosures. Similar to Study 1, these findings could have implications for sexual health education and interventions, to help people improve their efficacy to disclose and receive information about STIs, and to help individuals and couples navigate these potentially difficult experiences.

CHAPTER 2:

A Systematic Critical Review of the Literature on the Disclosure of Sexually Transmitted

Infections to Sexual Partners

Introduction

Each year in the United States, over 20 million new cases of sexually transmitted infections (STIs) are diagnosed (Centers for Disease Control and Prevention [CDC], 2019; Kirzinger et al., 2020). Of all sexually active age groups, emerging adults (ages 18-29) are most worried they will contract a new STI, and rightfully so, as they are at greatest risk for STI contraction (Kirzinger et al., 2020). According to the CDC, chlamydia, gonorrhea, and syphilis have been at record highs for several years and were projected to continue rising into 2020 (CDC, 2019). However, these STI rates have sharply declined in wake of the COVID-19 pandemic, but not because fewer people have STIs (CDC, 2020a). Many STI contact-tracers have been reassigned to trace COVID-19; 60-80% of sexual health clinics have experienced decreases in testing or center closures altogether, some clinics are short on supplies, and people who would otherwise seek treatment for STIs have not due to the quarantine (CDC, 2020a; National Coalition of STD Directors [NCSD], 2020). The CDC even suggested that efforts to contain the COVID-19 pandemic could, in fact, incite the spread of the STI epidemic in the U.S. (2020).

The number of COVID-19 cases diagnosed, as of February 25th, 2021, was approximately 28 million, which is comparable to the number of STIs diagnosed annually (CDC, 2021a). Even prior to the COVID-19 pandemic, research that would reduce the spread of STIs was desperately necessary. Now, given the effect of the COVID-19 pandemic on STI rates, diagnoses, and treatment, this research is critical. One of the most important, if not *the* most important, methods for reducing the spread of STIs is disclosure to sexual partners (Bickford et al., 2007). To date, there is a moderate amount of research that has been published on STI disclosure, but much of this research does not use an explicit guiding framework, has limitations in sampling and

research design, and often excludes the perspectives of disclosure recipients. The purpose of this paper was to conduct a systematic critical review of the literature on STI disclosure, summarize critical limitations and omissions within this literature, and identify essential areas for future research.

Literature Review

Across the last two decades, research on sexually transmitted infection (STI) disclosure has increased. When individuals receive a health diagnosis, they must contend with a variety of emotions and dilemmas, including whether or not they should disclose this information to others (Greene, 2009). Research suggests that individuals diagnosed with an STI(s) experience a variety of emotions, including distress and anxiety (e.g., Kosenko et al., 2012; Melville et al., 2003; Smith et al., 2014), feelings of negative body image (Nack, 2000), and low sexual esteem (Newton & McCabe, 2008b). Further, STI-positive individuals must decide whether they will disclose their STI to others and to whom they will disclose (hereon referred to as “receivers”; Greene, 2009).

The most important receivers to consider disclosing to are sexual partners, as they are at risk for contracting the STI(s). Health disclosure decisions require that individuals weigh the risks and benefits of disclosure for self, others, and relationships (Derlega et al., 1998, 2000; Greene, 2009). The STI disclosure literature suggests that people diagnosed with STIs are motivated to disclose (or not disclose) their STI to partners for a variety of reasons. Given the importance of disclosure in reducing the spread of STIs and the need for a critical synthesis, the purpose of the current paper is to systematically review the extant STI disclosure literature. The aims of this paper are to (a) synthesize and critique the existing research on STI disclosure, (b) summarize critical limitations and omissions in this research, (c) identify essential areas for

future research with methodological recommendations, and (d) identify findings that will inform sexual health education, practice, and policy. This systematic, critical review is important, as there are several limitations of extant research and past review papers, which I outline next.

Extant Limitation 1: Absence of Guiding Frameworks

The STI disclosure research reveals several overlapping themes, but few studies have used an explicit framework to guide their research. Using a framework to guide STI disclosure research is important because it can provide a structure to conduct replicable research and synthesize findings for education, intervention, and policy development (e.g., Coffelt et al., 2021; Smith et al., 2014). As such, in conducting the review, I attended to studies' use of theories and frameworks and made suggestions for the application of theory for future research. Further, I used the Health Disclosure Decision-Making Model (DD-MM; Greene, 2009) to guide the synthesis and review of findings, first briefly summarizing the model below.

The Health Disclosure Decision-Making Model

Regarding the study of communication and disclosure, various theoretical frameworks have been developed to explain the concealing and revealing of information. Theories include the Communication Privacy Management Theory (CPM; Petronio, 2002), the Cycle of Concealment Model (CCM; Afifi & Steuber, 2010), the Revelation Risk Model (RRM; Afifi & Steuber, 2009), the Disclosure Processes Model (DPM; Chaudoir & Fisher, 2010), and the Health Disclosure Decision-Making Model (DD-MM; Greene, 2009). Although each of these frameworks touch upon important aspects associated with disclosure decision-making, the DD-MM focuses specifically on health-related disclosures (Greene, 2009; Magsamen-Conrad, 2014), which is particularly relevant for studying STI disclosure and synthesizing literature. The DD-MM suggests that individuals assess information associated with the diagnosis, the intended

receiver of the diagnosis, and their disclosure efficacy. If they choose to disclose, they then consider and enact strategies for disclosure.

Assessing Information. The DD-MM suggests that individuals assess information associated with the health disclosure in question, including assessing the stigma and symptoms associated with the conditions.

Stigma. A stigma forms when an attribute, condition, or situation is inconsistent with social norms and values (Goffman, 1963). Having an STI is considered a stigmatized condition (Lee & Craft, 2002), and those with STIs are often considered promiscuous, dirty, and immoral by un-infected individuals (Lo et al., 2009; Nack, 2000). The perception of stigma contributes to individuals' decisions about disclosure (Greene, 2009), and also influences others' beliefs about those with STIs (Lo et al., 2009; Nack, 2000). Specifically, after individuals are diagnosed with an STI, many become acutely aware of the stigma associated with the condition (Lee & Craft, 2002; Newton & McCabe, 2005). STI stigma can be very damaging to the sexual self (Lee & Craft, 2002; Nack, 2000; Newton & McCabe, 2008a; Swanson & Chenitz, 1993). Sometimes, the perception of this stigma is so great that it inhibits disclosure to sexual partners (Lee & Craft, 2002; Nack, 2000). Further, many people, particularly emerging adults, perpetuate stigmatizing messages about STIs, as a way to distance themselves from risk and those they perceive as immoral (Hirschler et al., 2015; Nack, 2000).

Symptoms. The symptoms of the health diagnosis in question affect individuals' decisions to disclose. If the condition does not have present, visible, or severe symptoms, an individual may decide that they do not need to disclose (Greene, 2009). STI symptoms often influence the decision to disclose. For example, the visibility of a genital herpes outbreak can motivate individuals to disclose to a partner, while the absence of an outbreak may motivate

individuals to withhold the information (Green et al., 2003; Myers et al., 2016). Additionally, viral STIs, such as herpes, are thought to carry more stigma, given their incurable nature (Lee & Craft, 2002; Swanson & Chenitz, 1993). As such, stigma and symptom assessment are an important component of the STI disclosure decision-making process.

Assessing the Receiver: Anticipated Reactions. All of the aforementioned frameworks take *anticipated responses* into consideration and posit how this affects the process of disclosure (Magsamen-Conrad, 2014). When deciding whether or not to disclose, individuals often consider not only the anticipated receiver responses, but also the anticipated outcomes of the disclosure (Magsamen-Conrad, 2014). Of these disclosure frameworks, the DD-MM (Greene, 2009) uniquely considers both of these concepts and couches them under the umbrella construct *anticipated reactions* (Magsamen-Conrad, 2014). The STI disclosure literature suggests that anticipated reactions (responses and outcomes) are one of the most influential contributors to the disclosure decision-making process (e.g., Green et al., 2003; Lee & Craft, 2002; Myers et al., 2016). Despite including both anticipated responses and outcomes in the model, Magsamen-Conrad (2014) highlights the need for distinction of these concepts, as the differences between them are subtle but important.

Anticipated Response. When an individual discloses sensitive information to another person, the receiver of that information responds and may do so in a variety of ways. A “response” is considered the immediate verbal or nonverbal communication that occurs in direct reply to the disclosure (Magsamen-Conrad, 2014). Therefore, anticipated responses are what individuals believe their intended receiver might say or do immediately following the disclosure (Magsamen-Conrad, 2014). Many potential disclosers describe fear or anxiety about revealing their STI to a significant other. Individuals have discussed anticipating their partner to become

angry and upset, and even “reject” them after they disclose (e.g., Decker et al., 2011; Melville et al., 2003). As both Magsamen-Conrad (2014) and the STI disclosure literature suggests, anticipated responses are distinct from anticipated outcomes.

Anticipated Outcome. Although an anticipated response might be expecting the receiver to become angry, anticipated outcomes are what potential disclosers expect might happen, in the long run, as a result of the disclosure (Greene, 2009). Anticipated outcomes are the expected resulting effects of disclosure on the discloser, the receiver, and the relationship (Magsamen-Conrad, 2014). These are not just the immediate, emotional or behavioral responses individuals may have to disclosures, but what happens as a result. Some people with STIs discuss the fear that the partner will form some sort of judgment about the individual’s character (e.g., deciding the discloser is promiscuous or a cheater; Decker et al., 2011; Nack, 2000). Others describe being afraid that their partner will terminate the relationship, in response to the disclosure (e.g., Coffelt et al., 2021; Keller et al., 2000; Melville et al., 2003). Not all anticipated outcomes are negative; in fact, some people with STIs disclose because they anticipate that the process will have a positive effect on their overall self-concept (Lee & Craft, 2002).

Assessing the Receiver: Relationship Quality. According to the DD-MM (Greene, 2009), potential disclosers also consider the quality of their relationship with the intended receiver. Typically, if the relationship is perceived as higher-quality, then disclosure is more likely to occur (Greene, 2009). Higher relationship quality has been shown to significantly increase the likelihood of disclosure (Niccolai et al., 2008). Yet, the literature suggests that other relationship-related constructs may be just as, if not more, influential to the disclosure decision. The type of relationship (i.e., a committed or non-committed relationship) the individual has with the potential receiver is arguably the most commonly studied relationship factor (e.g., Arima et

al., 2012; Bickford et al., 2007; Mohammed et al., 2010; Myers et al., 2016). Other common relationship influences are the length of the relationship (Arima et al., 2012; Scrivener et al., 2008), closeness (Scrivener et al., 2008), and transitions in committed relationship milestones, such as moving from a dating relationship to cohabiting (Myers, 2020).

Assessing Disclosure Efficacy. Part of the decision to disclose health-related information is the individual's confidence and ability to do so (Greene, 2009). If an individual feels more equipped to present the information and handle possible responses, they are more likely to disclose than someone who is not confident in their ability to share the information (Greene, 2009). Individuals with STIs may not know what to say or how to approach the conversation, which can motivate non-disclosure (Arima et al., 2012; Kosenko et al., 2012).

Extant Limitation 2: Population and Sampling

In addition to lacking theoretical guidance, the STI disclosure literature is also limited in its population selection. Many studies report broad age ranges, with some reporting no demographic information (e.g., Bickford et al., 2007; Emmers-Sommer et al., 2010). Being able to disaggregate the STI disclosure literature by developmental stage is important. Specifically, understanding disclosure processes among emerging adults is a critical next step to address the staggeringly high rate of STI diagnoses they experience. Although the likelihood of contracting an STI is based on multiple factors, emerging adults tend to engage in more risk-taking sexual behaviors, such as inconsistent condom use and sex with multiple partners (Arnett, 2015; Turchik & Garske, 2009). Further, research suggests that younger adults ($M = 31.44$, $SD = 11.70$) are less likely to disclose an STI to a sexual partner than middle-aged adults ($M = 40.93$, $SD = 13.32$; Myers et al., 2016). As such, I included sample age as a study inclusion criterion, such that studies had to have some or all participants in an 18-29 age range, and I should have

been able to disaggregate findings based on age. Unfortunately, in conducting the review, the majority of studies could not be disaggregated by age. I subsequently removed sample age as an inclusion criterion, but still applied this developmental perspective when analyzing the articles. Further, I approach the implications of this review from this developmental perspective, highlighting how focusing on emerging adults in future research is important.

Extant Limitation 3: Previous Reviews

To my knowledge, there are two prior review papers that address STI disclosure research (see Montgomery et al., 2008; Newton & McCabe, 2005). Both reviews included a small number of STI disclosure studies, did not provide a guiding structure for review, only included one or two STI types (i.e., herpes and HIV), and did not provide a critique of the study methods used. These reviews were published 13 and 16 years ago, and the majority of studies reviewed are over two decades old. Research on STI disclosure has since blossomed and in need of synthesis. To address these limitations, I provide a comprehensive review of the STI disclosure literature, using a structured and critical framework.

Methods

I modeled my systematic critical review methods after Kågesten et al. (2016), and I incorporated and used both the PRISMA (Liberati et al., 2009) and ENTREQ (Tong et al., 2012) statements as guides. I conducted a clear, replicable strategy, which I outline here. First, I designed search strategies to identify peer-reviewed studies that used original data on STI disclosure and conducted the searches. Second, I modified Kågesten et al.'s (2016) title/abstract screening form to assess the articles generated from the search. If the study's title and abstract did not meet the necessary criteria for full-text review, they were excluded at this stage. Third, I conducted a full-text screening of all articles that passed the title/abstract screening. I used a

modified version of Kågesten et al.'s (2016) data extraction and appraisal Excel form. This form has sections for quantitative, qualitative, and mixed-methods studies. The beginning of the form is dedicated to screening the full-text and determining if studies will be excluded or included. If included, the form has a series of questions to direct what data from the articles needs to be extracted (e.g., study methods, analyses, findings), as well as quality assessment tools built into the form. Finally, after all studies that met full-text inclusion criteria were extracted, I synthesized the data generated. Using PRISMA's flowchart (Liberati et al., 2009), I outline the number of articles found, assessed, and extracted (see Figure 1; all tables and figures for Chapter 2 are in Appendix 1).

Step 1: Search Strategy

I used a systematic approach to identify studies using original data on STI disclosure. This review includes academic, peer-reviewed articles from the PsycINFO and PubMed databases, with no publication date restriction (i.e., from earliest recorded article to October 1st and 6th, 2020, the respective dates of the searches). I determined search terms by conducting a cursory review of several STI disclosure articles and divided them into the categories “STIs” and “disclosure” (see Tables 1 and 2 for the search strategy). I consulted a university librarian, who reviewed my search terms and made suggestions. After finalizing our search terms, we identified controlled vocabulary terms in PsycInfo and Medical Subject Headings (MeSH) terms (see Tables 1 and 2). For the PsycInfo search, we used (a) the controlled vocabulary, (b) the key terms, and (c) the controlled and key terms combined, limiting the search to “anywhere but full-text” (NOFT), articles written in English, and articles that were peer-reviewed. The combined search generated $n = 598$ article results. Many of these results were irrelevant to my review (e.g., met exclusion criteria; different research topic). For the final PsycInfo search step, we added

exclusion terms (NOT) to remove irrelevant articles (Table 1), yielding $n = 200$ articles. Based on our results from the PsycInfo search, the university librarian created the search strategy for PubMed (Table 2), which yielded $n = 53$ articles.

I cross-referenced the results from the database searches with the two extant review articles on STI disclosure (Montgomery et al., 2008; Newton & McCabe, 2005). Specifically, I first reviewed the titles and abstracts of studies included in their reviews and their reference lists to determine relevance to my review. From Montgomery et al. (2008), nine articles appeared relevant for title/abstract review, three of which were already included from the database searches. From Newton and McCabe (2005), seven articles appeared relevant for review. One article was already included from the database searches and was one of two duplicates from Montgomery et al. (2008). After these searches were completed, two additional studies emerged that appeared relevant. The first was found when looking for literature from a separate project. This paper was published after the databases searches were conducted. The second was sent to me by a collaborator for the same separate project. It was not generated in any of the database searches. Thirteen articles were included from these other sources, and $n = 253$ from database searches, for a total of $n = 266$ articles to be screened.

Step 2: Abstract Screening

I used an abstract screening template adapted from Kågesten et al. (2016). The abstract screening template included five questions designed to efficiently filter out irrelevant studies. Studies had to (a) introduce primary data, (b) include participants ages 18-29, and (c) not exclusively examine HIV/AIDS to be included for full-text screening (Table 3). I also noted whether I could tell from the abstract that studies examined self-disclosure of an STI and factors associated with disclosure and/or disclosure decision-making. These two questions were not used

to officially filter studies, as many abstracts did not include enough detail in this respect. If I was unable to determine that the focus of the study included STI disclosure from the abstract, but it met the other criteria, I included it for full-text review. Of the $n = 266$ abstracts screened, 219 were excluded, leaving a total of $n = 47$ full-texts screened.

Step 3: Full-Text Screening, Data Extraction, and Critical Appraisal

I conducted the full-text screening, data extraction, and critical appraisal simultaneously. I used a modified version of the standardized template developed by Kågesten et al. (2016) to screen the full-text articles, extract the data, and conduct the critical appraisal. This template is consistent with the PRISMA (Liberati et al., 2009) and ENTREQ (Tong et al., 2012) statements for reporting systematic reviews. The template is an Excel file with three separate forms for quantitative, qualitative, and mixed-methods studies. The template is divided into distinct sections. The first section contains a series of full-text screening questions to determine if the study should be included or excluded. After completing this section, I noted studies that should be excluded and stopped completing the form. Based on the screening requirements, a total of $n = 18$ studies were excluded because they either did not focus on the self-disclosure of an STI, focused exclusively on HIV disclosure, or were rated as very low quality.

For included studies, I continued to the second section of the form. This contains data extraction and appraisal questions. These questions were organized in the order that this data would generally appear in a manuscript (i.e., participants, procedures, measures, analyses, findings, limitations, conclusions), to make progression through the form efficient. For example, questions about the study's sampling method and sample size are presented and immediately followed by quality appraisal questions associated with sampling. At the end of the form is a dedicated section for calculating a global quality score.

I used the same quality appraisal protocols as Kågesten et al. (2016). The ENTREQ guide for synthesizing qualitative data recommends appraising the quality of articles using one of a variety of appraisal tools (Tong et al., 2012). The PRISMA statement does not suggest specific quality assessment tools but does indicate it should not be used for assessment (Liberati et al., 2009). I used Kågesten et al.'s (2016) modified versions of the Quality Assessment Tool for Quantitative Studies (QATQS) developed by the Effective Public Health Practice Project (EPPHP, 2021) to appraise the quantitative studies, and the Critical Appraisal Skill Programme [Program] (CASP, 2018) to appraise the qualitative studies. Finally, I used Kågesten et al.'s (2016) protocol for appraising the quality of mixed-method studies, a hybrid protocol of the QATQS and CASP.

Kågesten et al. (2016) did not include studies that received low quality scores in their analysis of articles. I chose to include low-quality articles in my analyses for several reasons. First, of the 220 article hits, only 29 were retained. Second, even though some studies received a low-quality rating, it is important to analyze all qualified studies, to identify the existing limitations and make suggestions for improvements in future research.

Step 4: Analysis of Articles

I used a mixed-methods synthesis approach to analyze the studies. I created a summary table for all included studies, with information on setting, objective, design, theory, sampling, data collection and analysis, main findings, and quality of the study (see Table 4). I first analyzed descriptive statistics of the studies as a whole, including the number of studies that used theory, reported mean age, type of STI, and others.

Next, rather than analyze qualitative, quantitative, and mixed-methods studies separately, I used the data from the summary table (Table 5) to conduct a thematic synthesis for all studies. I

used the DD-MM (Greene, 2009) as a loose template for synthesizing findings, allowing for additional themes to emerge. From the summaries of the findings, I noted all relevant findings from each study. Next, I reviewed my notes and began to organize the findings into emergent categories hierarchically. First, I specified the overarching STI disclosure construct. Next, I noted the sub-themes of that construct. Third, I explained each sub-theme. It became evident that most findings had strong overlap with the DD-MM. I created a thematic codebook (Table 5) and then mapped the findings onto the DD-MM, making suggestions for expansions (Figure 2). Finally, I used the themes as codes to determine the number of studies that had findings in each theme.

Results

Study Characteristics

Of the final 29 studies included for analysis, 9 were quantitative, 14 were qualitative, and 6 were mixed-methods. Of the 9 quantitative studies, 6 were cross-sectional, 1 was longitudinal, 1 was a randomized control trial, and 1 was a cross-sectional quasi-experimental design. Of the 14 qualitative studies, 5 used Grounded Theory, 1 used Interpretive Phenomenology, and 8 did not specify the methodology used. All of the mixed-methods studies were cross-sectional and did not specify the methodology used for the qualitative portion of the study.

After beginning the data extraction process, I dropped the requirement that studies should have findings for emerging adults disaggregated. Most studies had broad age ranges and/or no information that would enable disaggregation. Of the 29 studies included, 18 reported the mean age of participants. Ten studies explicitly mentioned and used a theoretical framework: 1 quantitative study, 2 mixed-methods studies, and 7 qualitative studies (2 of these did not mention a theory but used a Grounded Theory methodology; 2 studies explicitly used a theory; 3 studies

used both an explicit theory and Grounded Theory). Sixteen of the studies used predominantly White samples, and an additional 8 studies did not report the race/ethnicity of participants. Three studies included men only, 9 included women only, and 17 included samples with men and women (Mohammed et al., 2010 analyzed men and women separately).

A variety of STIs were included in the studies. Herpes ($n = 8$) and HPV ($n = 8$) were most common. Three studies examined included herpes and HPV. Three examined chlamydia only, and 3 examined chlamydia and gonorrhea, one of which also included the parasitic STI trichomoniasis (Mohammed et al., 2010). The remaining 4 either did not specify the STIs included or described including bacterial, viral, and parasitic. Thus, 19 studies examined viral STIs, 6 examined bacterial, and 4 were unspecific.

The mean sample size for quantitative studies was $M_N = 462$ ($range = 54-1282$), $M_N = 43$ ($range = 5-151$) for qualitative studies, and $M_N = 148$ ($range = 50-291$) for mixed-methods studies. The studies were published between 1993 and 2021. The quantitative studies were published between 2008 and 2020 (2 published before 2010, 7 published in or after 2010). The qualitative studies were published between 1993 and 2018 (9 published before 2010, 5 published in or after 2010). The mixed-methods studies were published between 2000 and 2021 (4 published before 2010, one published in 2010, and one published in 2021). In total, I rated 3 studies as strong quality, 19 as moderate, and 7 as low quality. I rated 1 quantitative and 2 qualitative studies as strong; 7 quantitative, 9 qualitative, and 3 mixed-methods studies as moderate; and 1 quantitative, 2 qualitative, and 3 mixed-methods as low.

Thematic Synthesis

The themes found in the study findings aligned with and expanded on the Health Disclosure Decision-Making Model (Greene, 2009). Specifically, the findings validate the use of

the DD-MM for STI disclosures but also highlight the DD-MM's limitations as applied to STIs. The entire thematic summary can be found in Table 5. Here I provide an overview of findings. My conclusions are not necessarily generalizable but are situated within the context of the studies reviewed. Also note that although the majority of included studies examined actual (non) disclosers, some examined uninfected individuals' perspectives.

Feelings and Emotions about Disclosure

Participants experienced a variety of feelings and emotions regarding their diagnosis and the prospect of disclosure. Some experienced anger with/blamed the partner who infected them (Cunningham et al., 2007; Kosenko et al., 2012; Melville et al., 2003; Niccolai et al., 2008; Perrin et al., 2006; Swanson et al., 1993). Many people experienced worry and anxiety associated with several aspects of their STI, particularly about the process of disclosure (Bickford et al., 2007; Duncan et al., 2001; Kosenko et al., 2012; McCaffery et al., 2006; Melville et al., 2003; Nack, 2000; Newton & McCabe, 2008a; Perrin et al., 2006; Shepherd, 2010; Smith et al., 2014). Some people also experienced guilt or self-blame for possibly exposing their partner (Duncan et al., 2001; Feinstein et al., 2018; McCaffery et al., 2006; Melville et al., 2003; Perrin et al., 2006; Temple-Smith et al., 2010).

The most salient emotion was fear. By-and-large, participants were fearful of their partner's reaction (i.e., emotional reactions such as anger; Arima et al., 2012; Decker et al., 2011; Duncan et al., 2001; Green et al., 2003; Lee & Craft, 2002; Myers et al., 2016; Nack, 2000; Temple-Smith et al., 2010), of how their partner would perceive them (i.e., being viewed negatively or as promiscuous; Green et al., 2003; Melville et al., 2003; Nack, 2000; Perrin et al., 2006; Scrivener et al., 2008), being broken up with (Arima et al., 2012; Coffelt et al., 2021; Keller et al., 2000; Melville et al., 2003; Shepherd, 2010), and being rejected by their partner.

Fear of rejection could either be fear that a committed partner would reject them, or that a casual partner would reject sex with them, if they disclosed (Arima et al., 2012; Bickford et al., 2007; Cunningham et al., 2007; Decker et al., 2011; Green et al., 2003; Kosenko et al., 2012; Melville et al., 2003; Nack, 2000; Newton & McCabe, 2008a; Niccolai et al., 2008; Scrivener et al., 2008; Shepherd, 2010; Swanson & Chenitz, 1993; Temple-Smith et al., 2010).

Reasons for Disclosure

Despite experiencing a host of negative emotions and feelings, many individuals chose to disclose and reported various reasons for disclosure. Some believed that being honest about the STI was the best policy, especially in the context of committed relationships; honesty and transparency were important aspects of commitment identified by participants (Arima et al., 2012; Keller et al., 2000; Myers, 2020; Scrivener et al., 2008). Many people believed that they had a moral obligation to disclose. Disclosing the STI is morally correct and the “right thing to do.” Some emphasized that it is not just a moral choice but an obligation to disclose, to prevent the spread of infection, and because the partner has a right to know, so that they can care for their own health and make informed decisions about engaging in sexual behaviors (Arima et al., 2012; Cunningham et al., 2007; Keller et al., 2000; Kosenko et al., 2012; Lee & Craft, 2002; Myers, 2020; Newton & McCabe, 2008a; Scrivener et al., 2008; Smith et al., 2014; Swanson & Chenitz, 1993; Temple-Smith et al., 2010).

In a similar vein, some participants were motivated to disclose out of concern for the partner’s health/to protect their partner (Cunningham et al., 2007; Keller et al., 2000; Nack, 2000; Scrivener et al., 2008; Swanson & Chenitz, 1993; Temple-Smith et al., 2010). This could be general health concern or associated with specific STI consequences. For example, some participants diagnosed with chlamydia often discussed how undiagnosed/untreated chlamydia

can lead to infertility, and they wanted to protect their partner from this experience (Temple-Smith et al., 2010). Beyond caring about their partner's health, some people disclosed out of general caring for their partner. More specifically, they "cared about" and/or "loved" their partner, so they were motivated to disclose (Arima et al., 2012; Green et al., 2003; Keller et al., 2000).

Some disclosure motivations were rooted in the self-assessment/confirmation process (Lee & Craft, 2002; Nack, 2000). Specifically, for some, disclosure was therapeutic and helped them address and combat the STI stigma they experienced (Lee & Craft, 2002; Nack, 2000; Perrin et al., 2006). Some disclosed to solicit support and identity-confirming messages from their partner (Lee & Craft, 2002; Nack, 2000; Perrin et al., 2006; Swanson & Chenitz, 1993). Some also disclosed to maintain their involvement in romantic and sexual relationships (Lee & Craft, 2002). Although disclosure brought the risk of rejection, some individuals believed that non-disclosure meant they must avoid sex and relationships altogether, and this was not a sacrifice they were willing to make (Lee & Craft, 2002). Thus, they risked rejection rather than avoid relationships altogether.

Other reasons for disclosure were more circumstantial or forced. Some participants used their diagnosis as a way to confront their partner for transmitting the STI, confronting the possibility of infidelity or the partner knowingly putting them at risk (Keller et al., 2000; Scrivener et al., 2008; Temple-Smith et al., 2010). For others, disclosure was not necessarily voluntary but forced by the emergent need to explain the use of prophylaxis (condoms or medication) or the presence of STI symptoms/outbreaks (Arima et al., 2012; Keller et al., 2000; Scrivener et al., 2008; Swanson & Chenitz, 1993).

Reasons against Disclosure

Fear or anticipation of emotional reactions, behavioral responses, and rejection were arguably the most salient reasons for non-disclosure. Anticipating or fearing negative emotional reactions (Arima et al., 2012; Decker et al., 2011; Duncan et al., 2001; Green et al., 2003; Myers et al., 2016; Nack, 2000; Temple-Smith et al., 2010) or responses (Arima et al., 2012; Cunningham et al., 2007; Decker et al., 2011; Green et al., 2003; Kosenko et al., 2012; Nack, 2000; Niccolai et al., 2008; Scrivener et al., 2008; Temple-Smith et al., 2010) were abundant. Many anticipated specific responses that motivated non-disclosure, such as being accused of cheating, the partner sharing the information with unintended others, or even experiencing violent retaliations. Similarly, fear of rejection (Arima et al., 2012; Cunningham et al., 2007; Emmers-Sommer et al., 2010; Lee & Craft, 2002; McCaffery et al., 2006; Myers et al., 2016; Newton & McCabe, 2008a; Shepherd, 2010; Swanson & Chenitz, 1993) and relationship termination (Arima et al., 2012; Coffelt et al., 2021; Keller et al., 2000) were also common. Rather than face the possibility of being rejected or abandoned, these participants choose to keep the information to themselves.

The next most salient reason for non-disclosure was the belief that there was no obligation to tell. Participants who chose not to disclose believed that they were not obligated to inform the partner, for various reasons. This was most often the case with non-committed, casual sex relationships. These participants believed that the nature of the relationship did not necessitate disclosure (Arima et al., 2012; Emmers-Sommer et al., 2010; Green et al., 2003; Keller et al., 2000; Newton & McCabe, 2008a; Niccolai et al., 2008; Perrin et al., 2006; Scrivener et al., 2008; Swanson & Chenitz, 1993). For example, one respondent said, “If I would have a one-night-stand type of situation, I wouldn’t tell...” (Swanson & Chenitz, 1993, p. 290).

Some particularly concerning reasons for non-disclosure were identified. Specifically, some participants had false beliefs about the transmissibility of their infections, believing they did not need to disclose because the STI was not transmissible (Emmers-Sommer et al., 2010; Green et al., 2003; Keller et al., 2000; McCaffery et al., 2006; Scrivener et al., 2008). For example, some believed that if they did not have a visible herpes outbreak and were on antiviral suppressive therapy, the herpes was not contagious and disclosure was therefore unnecessary (Green et al., 2003). One respondent said, “The way I see it is that if I am in control of the herpes and I can control it with my tablets [antiviral suppressive medication]...then I don’t feel I have to tell” (Green et al., 2003, p. 43). Some participants believed that if they were using condoms, that disclosure was not required (Arima et al., 2012; Green et al., 2003; Keller et al., 2000; Scrivener et al., 2008). Finally, in the context of HPV disclosures, some individuals reported not disclosing based on advice received from their health practitioners (Keller et al., 2000; McCaffery et al., 2006; Nack, 2000). Specifically, if there are no recurrences of HPV, or after a series of normal pap smears, HPV is often considered to be inactive (Jewell, 2020). Based on this inactivity, it appears that these individuals’ providers were emphasizing that there was no need to tell future partners about the HPV (Keller et al., 2000; McCaffery et al., 2006; Nack, 2000).

Disclosure and Non-Disclosure Strategies

A few studies described the use of strategies for disclosure and non-disclosure. Some participants used “priming messages” to gauge/assess their partner’s potential reaction, not disclosing their STI initially, but initiating conversations about STIs generally. These could include broaching the subject of STIs generally, or telling jokes about STIs and seeing how the partner reacts (Coffelt et al., 2021; Green et al., 2003; Swanson & Chenitz, 1993). Some also used message framing to decrease the likelihood of a negative reaction (Coffelt et al., 2021;

Green et al., 2003; McCaffery et al., 2006; Perrin et al., 2006). These participants downplayed the severity of symptoms or framed the STI in a different way (e.g., emphasizing HPV as a cancer-related issue and not sexually transmitted), hoping to decrease the possibility of negative responses. One study examined how framing of HPV as an STI vs. a cancer-causing infection possibly increased disclosure intentions, but they did not find an effect of framing (Yang et al., 2017). Two studies found that participants used partner's disclosures or symptoms (e.g., a cold sore) to reciprocate disclosure (Lee & Craft, 2002; Swanson & Chenitz, 1993).

Regarding non-disclosure strategies, some participants described “passing” as uninfected to avoid disclosing (Lee & Craft, 2002). Because most STIs are not typically visible in daily interactions, these participants were able to pass as healthy and avoid disclosure (Lee & Craft, 2002). Many described slowing down the sexual progression of relationships to avoid disclosure or withdrawing from/ending relationships altogether. Rather than face the potential for rejection, some decided to forgo pursuing sexual and romantic relationships (Lee & Craft, 2002; Melville et al., 2003; Nack, 2000; Newton & McCabe, 2008a). Finally, some described using the presence or absence of outbreaks (i.e., herpes outbreaks) to time their sexual interactions. These participants would abstain from sex when experiencing an outbreak and engage in sex when no symptoms were present, due to their belief that a lack of symptoms indicated the herpes was not transmissible (Green et al., 2003; Swanson & Chenitz, 1993).

Disclosure Timing

Several studies investigated the timing of STI disclosures. Research suggests that people generally believe that disclosure should always occur prior to sexual activity (Emmers-Sommer, 2010). Across studies, disclosure occurred prior to sexual debut around 50% of the time. Myers (2020) found that 59% of participants disclosed prior to receiving oral sex, and 46% prior to

giving oral sex. Further, just over half disclosed before vaginal (59%) and anal (56%) intercourse. Bickford et al. (2007) found that 44% of participants reported always disclosing before, but 56% disclosed sometimes before (25%) or always after (31%). Some individuals described uncertainty about the best time to disclose (Kosenko et al., 2012). For example, one woman with HPV said, “It was just, ‘When do I tell him?’ Because I don’t want it to be like I was trying to deceive him or something, and I didn’t want to say it too late or early. So, it was very much like, ‘What’s the best timing?’” (Kosenko et al., 2012, p. 540).

Relationship Factors

The characteristics of relationships (i.e., relationship type, duration, closeness, and quality) were common across studies and contributed to the disclosure decision-making process. Specifically, disclosure was more likely to occur in committed, longer-lasting, closer, and higher-quality relationships (Arima et al., 2012; Bickford et al., 2007; Coffelt et al., 2021; Cunningham et al., 2007; Duncan et al., 2001; Green et al., 2003; Keller et al., 2000; Mohammed et al., 2010; Myers et al., 2016; Niccolai et al., 2008; Pfeiffer et al., 2016; Scrivener et al., 2008; Swanson & Chenitz, 1993). There are several overlapping themes that can explain why these characteristics elicited disclosure, such as caring about/loving the partner, beliefs about honesty in relationships, and beliefs about the obligation to disclose to casual partners. Further, transitions in relationships were important catalysts for disclosure. Myers (2020) found that as participants moved through relationship milestones indicative of increases in commitment (e.g., moving from engagement to marriage), they were more likely to disclose. This finding is consistent with Green et al.’s (2003) finding that transitions to cohabitation elicited disclosure.

Individual Factors

A handful of individual-level factors were examined. Sexual partner number was associated with disclosure; people with fewer sexual partners were more likely to disclose their STI to current partners (Arima et al., 2012; Mohammed et al., 2010). Age was also a significant predictor; participants who were 23-years-old or younger (Mohammed et al., 2010) and late 20s to early 30s (Myers et al., 2016) were less likely to disclose their STIs than participants who were 24-years-old or older and in their early 40s, respectively. Across studies, gender (Coffelt et al., 2021; Cunningham et al., 2007; Duncan et al., 2001; Mohammed et al., 2010; Pfeiffer et al., 2016) and STI type (Coffelt et al., 2021; Cunningham et al., 2007; Newton & McCabe, 2008b; Temple-Smith et al., 2010) did not differentiate disclosure, but researchers often described the differences in stigma between viral and bacterial STIs and the sexual double standard. Participants echoed these constructs. Very poignantly highlighting the stigma that women with STIs experience, one young woman said, “They wouldn’t say nothing to the guy. It would all be on the girl. The girl would just be called a freak...She burning, she dirty, she a freak,” (Cunningham et al., 2007, p. 47). A young man diagnosed with chlamydia discussed the emotional difficulty of disclosing but speculated how disclosure of “more serious” STIs could elicit suicide: “...and I can see how someone would commit suicide for that reason. They’d rather just kill themselves than tell the other partner. Not necessarily chlamydia, but with a serious or half serious one, you know” (Temple-Smith et al., 2010, p. 421).

Outcomes of Disclosure and Non-Disclosure

Several studies asked participants what the outcomes of the disclosure were. Some disclosers reported their partner reacted negatively, rejected them, broke up with them, denied the STI, and threatened or became violent, which is consistent with many of the fears

surrounding disclosure (Arima et al., 2012; Decker et al., 2011; Emmers-Sommer et al., 2010; Feinstein et al., 2018; Green et al., 2003; Nack, 2000; Shepherd, 2010; Temple-Smith et al., 2010). Others reported their partner reacted positively, provided emotional support, asked questions and sought knowledge; some partners were even relieved, believing the disclosure was going to be something worse (Arima et al., 2012; Emmers-Sommer et al., 2010; Green et al., 2003; McCaffery et al., 2006; Nack, 2000; Scrivener et al., 2008; Shepherd, 2010; Swanson & Chenitz, 1993; Temple-Smith et al., 2010). Further, some disclosers reported that as a result of the disclosure, they experienced increases in commitment, communication, and closeness with their partner (Melville et al., 2003; Newton & McCabe, 2008a; Scrivener et al., 2008; Temple-Smith et al., 2010). Non-disclosers had (or the authors discussed this possibility) higher levels of anxiety and depression and lower levels of sexual-esteem and satisfaction than disclosers, and expressed guilt and regret about their decision to withhold disclosure (Duncan et al., 2001; Keller et al., 2000; Newton & McCabe, 2008b; Scrivener et al., 2008; Swanson & Chenitz, 1993).

Discussion

The purpose of this review was to systematically and critically synthesize the extant disclosure literature, identify critical limitations and omissions, and provide recommendations for future research, education, and intervention. The results from this review suggest that studies conducted to date have been mostly qualitative, moderate in quality, and without theoretical guidance.

Application to DD-MM

Additions to the Model

The DD-MM suggests that individuals assess a wealth of information when deciding whether to disclose a health condition. The model begins by suggesting that individual first

assess information associated with the diagnosis, including its symptoms, associated stigma, and relevance to others. The review findings reveal that when processing the decision to disclose, individuals are assessing concepts that precede information assessment. When diagnosed with an STI, people are confronted with their former beliefs about STIs (East et al., 2010). They are often challenged by their former opinions about people with STIs (e.g., dirty, promiscuous) and proceed through complex identity-healing experience (East et al., 2010; Lee & Craft, 2002; Nack, 2000).

When confronted with the decision to disclose, personal beliefs and values emerged as common reasons for disclosure, including the beliefs that honesty is important, disclosure is morally correct, and people with STIs are obligated to disclose. These beliefs could stem from pre-diagnostic ideals, which is the first added construct (*Pre-Diagnosis Beliefs*). Additionally, although stigma is already present in the DD-MM, stigma assessment also occurs upon diagnosis. Individuals may first assess the STI stigma upon diagnosis, but then must reassess when the opportunity to disclose is present. Diagnosis is an important turning point in this process and is the second added component to the model (*Diagnosis [Emotions and Experiences]*).

The emotions and experiences that individuals have upon diagnosis directly influence experiences of the “self” (East et al., 2010; Nack, 2000). For many, the sexual self is damaged upon diagnosis (Nack, 2000), and these deeply meaningful, symbolic processes certainly influence disclosure decision-making. As such, the third added construct is *Assessing the Self*. Emotions, beliefs, and self are currently absent from the DD-MM but are part of the disclosure decision-making process. Thus, I propose that these constructs could be added to the beginning

of the model, to better represent the complete process that individuals with STIs experience when deciding to disclose. See Figure 2 for additions.

Expansions to the Model

Beyond these proposed additions, I also found constructs that expand upon the existing model. The DD-MM describes the process of *assessing the receiver* as two-fold: assessing the quality of the relationship and anticipated reactions. Findings from this review suggest that quality is an important predictor of disclosure, but there are other relationship constructs that are important as well. Specifically, the type of relationship the discloser has with their intended receiver is an incredibly important factor to consider when disclosing. Several studies found that many people believed that non-committed casual sex relationships did not require disclosure, and thus withheld disclosure. An individual could describe their relationship with a casual sex partner as high quality but withhold disclosure because they are not committed to the partner.

Other important relationship constructs were length, closeness, and relationship milestones. Individuals who have been with partners longer and who are closer to them are more likely to disclose. Changes in relationships may also elicit disclosure. For example, transitioning from being in a committed relationship to cohabiting (a milestone; Myers, 2020) can facilitate disclosure. For example, Green et al. (2003) found that several participants identified moving in together as the catalyst for disclosure, because it either made hiding herpes outbreaks or antiviral medication more difficult, or it was symbolic of a greater commitment. As such, I posit that the stage *Assess the Receiver* should be expanded to *Assess Anticipated Reactions (Responses and Outcomes)* and *Assess the Relationship*. Assessing the relationship involves considering the type, length, closeness, milestones, *and* quality of the relationship.

Finally, the DD-MM includes a step in the model to describe the outcomes of the disclosure but does not specify what these outcomes are (Greene, 2009). As both Greene (2009) and Magsamen-Conrad (2014) describe, the research on the outcomes for discloser, receiver, and relationship are limited. The literature review reveals four outcome areas, although these findings are fewer than those of preceding parts of the model. Specifically, there are receiver responses (positive and negative), receiver outcomes (positive and negative), relationship outcomes (positive), and non-discloser outcomes (negative). These do not represent the full scope of possible outcomes, but rather what was revealed in the STI disclosure literature in this review.

Based on these findings and Magsamen-Conrad's (2014) discussion, I propose that the DD-MM stage *Outcomes* should be expanded to *Responses and Outcomes* and contain the following components, all of which can be positive, negative, or neutral: *(Non) Discloser Outcomes*, *Receiver Responses*, *Receiver Outcomes*, and *Relationship Outcomes*. *(Non) Discloser Outcomes* may include emotional outcomes that the individual experiences as a result of disclosing (e.g., relief) or withholding disclosure (e.g., guilt). *Receiver Responses* are the actual responses that receivers have to the disclosure, including emotional (feelings and behaviors), support, reciprocity, and avoidance. *Receiver Outcomes* can include emotional (e.g., negative feelings toward discloser) and informational (e.g., becoming more educated about STIs) outcomes that the receiver experiences after the disclosure. *Relationship Outcomes* can include positive (e.g., increased commitment) or negative (e.g., relationship dissolution) outcomes that occur as a result of the disclosure.

Implications

For Research

This review has highlighted the areas of STI disclosure that have been addressed in research and highlights the need for future research within these topics. Further, these findings also highlight the importance of future research directions, including assessing receiver experiences. The person with the STI is only one part of the relationship dyad (or triad). In order to understand the complexity of this process, research must examine the expectations and experiences of disclosure recipients, which is the purpose of the next two dissertation studies. Further, after understanding more clearly disclosers and receivers, researchers should investigate how these processes transpire among couples. Each individual has their own unique experience, but these are occurring within the context of the relationship. Examining these relationship dynamics will further illuminate the disclosure process.

For Education and Intervention

The findings from this review highlight individuals' gaps in sexual health knowledge. Many believed that dormancy and prophylaxis were enough to prevent transmission and thus negated the necessity to disclose. This highlights that many individuals are not receiving sufficient sexual health education. This is not surprising, particularly in the United States, as comprehensive sexual education is often the taboo, rather than the norm (Fields et al., 2015). Rather than being taught how to correctly use prophylaxis, identify its limitations, and understand the scope and transmissibility of STIs, youth are only encouraged to be abstinent (Fields et al., 2015). These findings highlight the need for continuous comprehensive sexual health education throughout the life course.

Findings from this review suggest that many individuals with STIs are not confident in their ability to disclose and have dangerous misconceptions about the transmissibility of their infections. This highlights the need for interventions aimed at improving disclosure efficacy and addressing knowledge gaps regarding STIs. Health practitioners are often the first people individuals interact with after their diagnosis. Their interactions with health providers may determine how they pursue disclosure in the future. If practitioners are stigmatizing, individuals may internalize that stigma and withhold disclosure. Further, practitioner advice about the necessity of disclosure may influence these decisions. Individuals diagnosed with STIs should immediately be referred to counseling or coaching services to process the diagnosis and develop strategies for disclosure. Shepherd (2010) found that cognitive behavioral therapy greatly improved disclosure efficacy and skills, and reduced false beliefs and cognitive distortions about disclosure.

Limitations and Strengths

There are several limitations of the review that must be considered. First, this review lacks the strength of multiple reviewers. Kågesten et al. (2016) used multiple reviewers to extract and critique data. My findings and conclusions may be subjective. Including multiple reviewers would have improved the objectivity of findings and conclusions. Another potential limitation of this review are the exclusion criteria I applied to the articles. First, I excluded HIV disclosure from the review. HIV disclosure has been reviewed and studied extensively (Greene, 2009), and the process of HIV disclosure is thought to be different from the disclosure of other STIs due to its unique stigma (Greene, 2009; Nack, 2000). However, excluding these studies may have omitted important findings, such as describing how the disclosure of other STIs are similar to or different from HIV disclosure. Further, I initially had intentions of excluding studies where age

could not be disaggregated. Specifically, I was interested in describing the STI disclosure research in the context of emerging adulthood. Unfortunately, many of the studies did not provide enough details about the sample to be able to disaggregate by age. As such, I included studies, regardless of age. This could be considered a strength, as well, as the review became more inclusive and comprehensive.

One strength of this review is the systematic approach used. Specifically, I used the PRISMA (Liberati et al., 2009) and ENTREQ (Tong et al., 2012) statements to guide the review, and assessed the quality of articles using the QATQS (EPPHP, 2021) and CASP (2018). Using these standardized guides enabled me to remain as empirical and unbiased as possible and provided structure to the review. Second, I consulted a university librarian with extensive experience in systematic literature reviews. The librarian helped me develop and refine the search strategies, providing guidance for best practices. Another strength of this review is the use of the DD-MM as a guide, and ability to map review findings onto this framework. Despite the lack of theoretical guidance in the majority of studies, the findings suggest that the DD-MM is an applicable framework for the study of STI disclosure. Further, findings from this review provided possible expansions to the DD-MM to improve the model.

Overall, the results from this review synthesize many of the factors associated with the STI disclosure decision-making process and reveal important directions for future work. Individuals diagnosed with STIs are often in vulnerable positions and must make difficult decisions that can be threatening to their identity and relationships. The process of disclosure is complex. Certain contexts, particularly committed relationships, elicit disclosure, whereas others inhibit disclosure. Perhaps the key factor that determines whether or not an individual will disclose is the intended receiver. How the receiver will react and respond and the relationship

with the receiver can be critical influences on the discloser. As such, it is imperative that we begin to investigate the experiences of receivers. The health and well-being of disclosers is important to investigate and protect, but we must also attend to receivers' experiences, health, and well-being.

CHAPTER 3:

How Do Emerging Adults Think They Would React to a Partner's Sexually Transmitted Infection (STI) Disclosure? Developing and Analyzing the STI Disclosure Reactions Measure (SDRM)

Introduction

Emerging adulthood (ages 18-29), for many, is considered a time of increased sexual exploration and decreased perception of susceptibility to sexual risks (Arnett, 2015; Hirschler et al., 2015). Historically, attitudes toward sexual activity among emerging adults continue to grow more permissive (Arnett, 2015), yet attitudes toward sexually transmitted infections (STIs) and those who have been diagnosed with an STI remain highly stigmatized (Hirschler et al., 2015; Lo et al., 2009; Nack, 2000). Emerging adults may underestimate their risk for STI contraction (Ethier et al., 2003) and may distance themselves from perceived risk by perpetuating stigmatizing ideas about STIs (Hirschler et al., 2015). The perpetuation of STI stigma, as well as misinformation about sexual health and STIs, impedes the reduction of STI transmission (Hirschler et al., 2015). Emerging adults may perceive “others” with STIs as deviant, but we do not know how they perceive STI-positive others with whom they would otherwise engage sexually. It is important to understand how emerging adults perceive sexual partners with STIs in an effort to inform and improve sexual and relationship health education and reduce STI transmission. Although emerging adults generally perceive themselves as low risk for negative sexual outcomes, like STIs (Arnett, 2015; Hirschler et al., 2015), they have the highest rate of STI contraction in the United States (CDC, 2019; Hirschler et al., 2015; Kirzinger et al., 2020).

Research on STIs and disclosure has primarily focused on the experiences of disclosers. There are a variety of reasons for and against disclosure to a sexual partner, and we have a vague understanding of how these disclosure experiences vary based on pertinent factors, such as relationship type, STI type, and gender. The literature suggests that people with STIs who withhold disclosure often do so due to anticipated negative reactions (e.g., Green et al., 2003; Lee & Craft, 2002; Myers et al., 2016; Niccolai et al., 2008; Temple-Smith et al., 2010), but it is

unclear how receivers actually react and respond to these disclosures. As such, it is critical that we begin to understand how emerging adults anticipate responding to disclosures from a sexual partner.

Much of the extant STI disclosure research has not been explicitly guided by theory, which can be important for conducting replicable research and designing interventions. To address this gap, I used the Health Disclosure Decision-Making Model (DD-MM; Greene, 2009) to guide research question, hypothesis, and scale development. The purpose of this study was to develop and test a theoretically-informed measure of anticipated reactions to a hypothetical STI disclosure scenario using an emerging adult sample, and to examine how relationship type, STI type, and gender potentially differentiate these reactions.

Literature Review

Sexually transmitted infection disclosure to a sexual partner is necessary in order to prevent or reduce STI transmission (Bickford et al., 2007). Potential disclosers often consider multiple factors when making the decision whether or not to disclose having an STI (Greene, 2009). Most of these factors are contingent upon various aspects of the intended receiver of the disclosure. For example, if potential disclosers anticipate that their partner will react in a negative or rejecting way, they may be motivated to withhold disclosure (e.g., Decker et al., 2011; Green et al., 2003; Kosenko et al., 2012; Scrivener et al., 2008). Other important factors that individuals consider are their beliefs about the obligation to disclose (e.g., Keller et al., 2000; Myers, 2020; Swanson & Chenitz, 1993; Niccolai et al., 2008), and their use of prophylaxis (e.g., Arima et al., 2012; Green et al., 2003; Keller et al., 2000; Swanson & Chenitz, 1993), to name a few. As such, it is important to understand the factors individuals consider when making the decision to disclose, in order to also study how potential receivers may react

(Greene, 2009; Magsamen-Conrad, 2014). The DD-MM is a framework that specifies the processes of health disclosures and the factors individuals take into consideration when making these decisions (Greene, 2009). I use concepts from the DD-MM to focus on the factors that disclosers consider important, highlight how these DD-MM concepts overlap with the extant STI disclosure literature, and specify how using this framework guided hypothesis development to examine non-receivers' anticipated reactions to STI disclosures.

Guiding Framework

The DD-MM explains the process of deciding to disclose or not disclose a health diagnosis (Greene, 2009). Disclosing health-related issues within interpersonal contexts is distinctly different from other self-disclosures, as health issues often have wide-reaching implications for all involved parties (Greene, 2009). When progressing through the disclosure decision-making process, individuals consider many aspects of the health diagnosis and disclosure, including their relationship with the intended receiver, information associated with their diagnosis, such as stigma and symptoms, and the relevance of their diagnosis to others (Greene, 2009).

Assessing the Relationship

Disclosers of health conditions assess their relationship with the intended receiver when making the decision to disclose (Greene, 2009). The DD-MM suggests that the quality of the relationship is associated with the likelihood of disclosure, such that higher-quality relationships predict disclosure (Greene, 2009), which has also been found in the STI disclosure literature (Niccolai et al., 2008). However, Greene (2009) noted that disclosure research has not examined the impact of quality well, and that other unexplored variables may confound the effect of

quality. Further, individuals in low-quality relationships may still disclose and those in high-quality relationships may not disclose (Greene, 2009).

Results from the systematic critical literature review suggest that other relationship factors, beyond quality, are important and contribute to the decision-making process. Several studies examined the effect of relationship type on disclosure attitudes, decision-making, and actual disclosure, and found that when the intended receiver was a committed partner, pro-disclosure attitudes and behaviors were more likely/more frequently discussed (e.g., Arima et al., 2012; Mohammed et al., 2010; Myers et al., 2016). In contrast, some individuals reported that disclosure was not necessary in casual, non-committed relationships, and used this belief as a rationale for non-disclosure (e.g., Emmers-Sommer et al., 2010; Newton & McCabe, 2008a). Although the DD-MM focuses exclusively on relational quality, I have adapted the concept for the purposes of this study to assess *relationship type*, to be congruent with the extant STI disclosure literature. As such, this study examined how emerging adults' anticipated responses to hypothetical STI disclosures vary based on the type of relationship with the discloser (committed or casual).

Assessing Information

When deciding to disclose a health condition, individuals also consider important information associated with their diagnosis, including symptoms and stigma.

Symptoms: STI Type. Disclosure of health conditions may depend on associated symptoms (Greene, 2009). The presence or absence of STI symptoms influences disclosure decision-making. The nature of STIs (i.e., curable or not) may also influence disclosure decision-making. For example, if an STI can be cured with antibiotics (e.g., chlamydia; CDC, 2016), then a partner may be more likely to disclose, because it can be readily eradicated. However, the type

of STI and its effect on disclosure may also depend on how the STI was acquired. Contracting an STI from a former committed partner, particularly if the individual was lied to, is more tolerable than contracting one from cheating or promiscuous behaviors (Emmers-Sommer et al., 2010). In the circumstances of a committed relationship, disclosing a viral STI could be less stigmatizing, because the discloser could have had herpes for a long period of time, whereas the disclosure of a bacterial STI could indicate that the discloser cheated and acquired the STI from sexual infidelity. On the other hand, viral STIs tends to be associated with more stigma than bacterial STIs (Newton & McCabe, 2005) and could receive a more negative reaction than a bacterial disclosure. In light of this information, I examined how STI type (bacterial or viral) differentiated emerging adults' anticipated responses to hypothetical STI disclosures, where the situation in which the STI was acquired was not from sexual infidelity.

Stigma. Certain health conditions are associated with disproportionate amounts of stigma, which can affect the decision to disclose (Greene, 2009). Research suggests that being diagnosed with an STI often highlights the presence of STI stigma and affects individuals' decisions to disclose (Green et al., 2003; Melville et al., 2003; Nack, 2000). In addition to influencing disclosure decisions, stigma also influences societal beliefs about those with STIs (Lo et al., 2009; Nack, 2000). Specifically, people with STIs are often considered promiscuous, dirty, or immoral (Lo et al., 2009; Nack, 2000). This is especially true for women (East et al., 2010; Nack, 2000). As such, I included a measure of STI stigma to control for the influence of participants' beliefs about STIs.

Gender

Although not inherently part of the DD-MM, gender is an important construct to consider in STI disclosure research. Cultural gender norms suggest that women are more highly

stigmatized for having STIs than men (Nack, 2000), but we do not know if the gender of the receiver differentiates responses to STI disclosures. According to the sexual double standard, young men are often celebrated for their sexual conquests, whereas young women are often shamed and blamed for unwanted outcomes (East et al., 2010). It is possible that, because of their predisposition to experiencing sexual stigma and shame, women may perceive the disclosure from a more empathetic perspective and react more positively (or less negatively) to STI disclosures than men. Contrarily, because of this same predisposition, it is possible that women may react more negatively to disclosures, because they may now be “damaged goods,” if they contracted the STI (Nack, 2000, p. 106). Thus, I examined whether emerging adults’ responses to hypothetical disclosures were differentiated by their gender.

Vignette Disclosures

I used vignette scenarios to examine how emerging adults anticipate reacting to a disclosure. Short, written vignettes are commonly used in cross-sectional research designed to assess participants’ responses to a certain scenario (Hughes & Huby, 2004). It is important that researchers consider the participants and groups when designing and implementing vignettes. The vignettes must be engaging and relevant (Hughes & Huby, 2004). Additionally, it is recommended that researchers match the type of vignette to specific participant groups (Hughes & Huby, 2004). I designed two distinct vignette scenarios describing an STI disclosure from a partner. One vignette described a scenario where a committed partner disclosed an STI, and the other described a disclosure from a casual sex partner. To ensure that participants immersed themselves into the vignette scenario, the vignettes were assigned based on the participants’ current or most recent relationship type (casual or committed), and the specific relationship type stated in the vignette was matched to the type they indicated earlier in the survey (e.g., married,

casual sex relationship). The STI type (bacterial or viral) was randomly assigned. I describe the vignettes in detail in the methods section.

Outcome Variables: Anticipated Reactions

When considering disclosing health conditions, people also consider how they anticipate the intended receiver will react (Greene, 2009). In order to make the decision to disclose, individuals typically must perceive the reaction will be positive (Greene, 2009). However, when considering STI disclosure, most people anticipate negative reactions, which inhibits disclosure (e.g., Myers et al., 2016; Temple-Smith et al., 2010). Receiver reactions have generally been overlooked when examining STI disclosure. As such, it is important to operationalize “reactions,” as there are various conceptualizations across information management frameworks (Magsamen-Conrad, 2014). The DD-MM conceptualizes “anticipated reactions” as both responses and outcomes but does not clearly define each of these (Magsamen-Conrad, 2014). I draw from Magsamen-Conrad’s (2014) conceptualizations of responses and outcomes to supplement the DD-MM; I use the author’s discussion to operationalize anticipated reactions to an STI disclosure.

Responses

Responses to disclosures are how the receiver communicates, behaves, answers, or replies, verbally and/or non-verbally, immediately following the disclosure (Magsamen-Conrad, 2014). Information management frameworks suggest there are four dimensions of response: emotional reaction, support, reciprocity, and avoidance.

Emotional reactions. Emotional reactions are the positive, negative, or neutral feelings and behaviors receivers experience as a result of a disclosure (Magsamen-Conrad, 2014). Potential disclosers may be more likely to report anticipated negative emotional reactions

(Greene, 2009; Magsamen-Conrad, 2014), which is also consistent with the STI disclosure literature (e.g., Myers et al., 2016). In response to an STI disclosure, receivers may experience positive or negative feelings (e.g., happiness, anger) in response to the disclosure, as well as enact behavioral responses (e.g., embracing or criticizing the partner).

Support. Receivers may extend or withdraw social support in response to a disclosure (Magsamen-Conrad, 2014). Support for disclosers can be emotional (e.g., being “there for” the discloser), instrumental (e.g., driving discloser to the doctor), and informational (e.g., providing advice). Anticipating support may facilitate disclosure (Magsamen-Conrad, 2014). As such, it is also essential to examine how those who have not been the recipient of an STI disclosure anticipate engaging in supportive actions.

Reciprocity. Receivers of disclosures may engage in reciprocal disclosure when confronted with a partner’s disclosure (Magsamen-Conrad, 2014). Receivers can reciprocate a disclosure with information similar to that disclosed (e.g., “I also have an STI”), or may engage in broader reciprocal sharing of personal or private information (Magsamen-Conrad, 2014). The STI disclosure literature does not suggest that individuals anticipate reciprocal STI disclosures when making the decision to disclose, but it is possible that they may expect the receiver to display some level of reciprocity, disclosing information that may be private or sensitive.

Avoidance. In relationships, individuals often avoid discussing certain topics, especially if the information is sensitive (Magsamen-Conrad, 2014). Discussing STIs with sexual partners can be difficult, given the sensitive nature and stigmatization of STIs. Receivers can avoid discussing a health disclosure using silence, topic change, or blatant refusal (Magsamen-Conrad, 2014).

Outcomes

Disclosure outcomes can be divided into several parts, including outcomes for the discloser, the receiver, and the discloser-receiver relationship (Magsamen-Conrad, 2014). These can be positive, neutral, or negative, and are essentially what happens after initial responses (Magsamen-Conrad, 2014). Positive and negative outcomes are not conceptualized as being on one emotional spectrum, but rather two separate outcomes, as multiple outcomes are possible.

Receiver outcomes. Receiver outcomes have largely been overlooked when studying disclosure and are typically reported from the perspective of the discloser (Magsamen-Conrad, 2014). There are a variety of potential outcomes that receivers can experience, including positive outcomes, such as becoming more educated about the condition or feeling closer to the partner, or experiencing negative outcomes, such as having hurt feelings (Magsamen-Conrad, 2014).

Relationship outcomes. There are also a variety of possible outcomes for the relationship between a discloser and receiver, as a result of the disclosure. Examples of relationship outcomes include alteration of the relationship status (e.g., breaking up), changes in the closeness of the relationship, and changes in feelings between the discloser and receiver (e.g., the receiver no longer liking their partner; Magsamen-Conrad, 2014). Similar to receiver outcomes, relationship outcomes can be both positive (e.g., increased closeness) and negative (e.g., decreased quality).

Current Study

The purpose of the current study was twofold: (1) to develop theoretically-informed measures of individuals' anticipated responses to and outcomes of an STI disclosure from a sexual partner and test its factor structure, and (2) determine if and how relationship type, STI

type, and gender differentiate these responses and outcomes among an emerging adult sample, controlling for STI stigma. Specifically, I asked the following research questions:

RQ1: Controlling for STI stigma, do relationship type, STI type, and participant gender differentiate emerging adults' anticipated (a) feelings, (b) behaviors, (c) supportive responses, (d) reciprocal disclosures, (e) avoidant responses, (f) outcomes for themselves, and (f) outcomes for the relationship in response to an STI disclosure?

RQ2: Are there two-way interaction effects of (1) relationship type and STI type, (2) relationship type and gender, (3) STI type and gender, and a three-way interaction effect of relationship type, STI type, and gender on the outcome variables (a-f)?

Methods

Procedures

Participants were recruited via the crowdsourcing site Prolific. Prolific is an online platform designed for subject recruitment (Palan & Schitter, 2018). It is specifically designed for and caters to research (Palan & Schitter, 2018). Prolific has acceptable recruitment standards, is reasonably priced, and takes careful steps to ensure researchers obtain quality data (Palan & Schitter, 2018). I used data provided by Prolific to obtain my sample population. Specifically, participants who indicated the following demographic characteristics in their Prolific profile were given a subsequent screening survey: they were between the ages of 18 and 29, they were residing in the U.S., and their first language was English. Qualified potential participants were invited to take a brief screening survey (see Appendix 2 for specific screening items) to determine their eligibility for the current study or another study. Participants who had never experienced an STI disclosure from a sexual partner were invited to participate in the current

study. All Prolific participants who completed the screener, regardless of eligibility, were compensated \$0.25 United States dollars (USD).

The study was approved by the university's Institutional Review Board (IRB). All qualified participants were invited to complete the survey. Participants who chose to complete the survey were informed of the purpose of the study, and after providing informed consent, completed a restricted access online survey in Qualtrics. Participants were compensated \$3.25 USD for completing the 30-minute survey, consistent with Prolific's compensation policy (<https://researcher-help.prolific.co/hc/en-gb/articles/360009223533-What-is-your-pricing->).

Participants

Data were collected in October of 2020. Based on sample size suggestions for conducting Exploratory Factor Analyses (EFAs; Thompson, 2004) and a priori power analyses, my minimum target sample size was 211. A total of 975 Prolific participants completed the screening survey, and 305 were eligible for the current study. Of the 305 invited to participate, 243 completed the study. Demographic characteristics of the sample can be found in Table 6 (all tables for Chapter 3 are in Appendix 3).

Measures

Outcome Variables

Drawing from the DD-MM, Magsamen-Conrad's paper, and the STI disclosure literature, I developed a scale designed to assess emotional reactions (feelings [e.g., angry, upset, sympathetic] and behaviors [e.g., withdraw from, accept, yell at]). The scale assessed three types of support: emotional (e.g., "I would let my partner know that I was there for them"), informational (e.g., "I would give my partner useful information about STIs"), and instrumental (e.g., "I would offer to help my partner with whatever they needed"). The scale also assessed

avoidance (e.g., “I would refuse to discuss the disclosure with my partner”), receiver outcomes (e.g., “My feelings would be hurt”), and relationship outcomes (e.g., “Our relationship would not be as good as it was before the disclosure;” see Appendix 4 for all measures used in this study).

All responses were measured on a five-point Likert-type scale (emotional reactions, receiver outcomes, and relationship outcomes: 1 = *not at all* to 5 = *extremely*; support and avoidance: 1 = *not at all* to 5 = *completely*). I used an adapted version of the Self-Disclosure Index (Miller et al., 1983) to measure reciprocity. The only adaptations made were to the prompt (“How much do you think you would discuss the following topics with your partner immediately after they told you about their STI?”), and the first item was changed from “My personal history” to “My personal sexual history.” Responses were measured on a five-point Likert scale (1 = *would not discuss at all* to 5 = *would discuss fully and completely*). Cronbach’s alpha indicated acceptable reliability ($\alpha = .92$).

Vignette Scenarios

To capture the anticipated reactions of emerging adults’ who have never received an STI disclosure, participants were read a vignette scenario that detailed an experience where their partner disclosed an STI. To examine the effect of relationship type on the responses, the vignette scenario was programmed in Qualtrics to populate the relationship type based on the participant’s current or most recent relationship. Rather than leaving the definition of committed relationship up to participant interpretation, I provided a definition of “committed romantic relationships” to ensure all participants were using the same standard to classify their relationship, developed from Stanley et al.’s (2010) theoretical discussion of commitment. Participants received the following “yes or no” question early in the survey:

Would you describe your *most recent* sexual relationship as “a committed romantic relationship?” By “committed romantic relationship,” we mean a relationship where you and your partner depend on one another and are a team, view the relationship as long-term, are willing to make sacrifices for one another, and would find it difficult to end the relationship.

Participants were then asked, “Which of the following options best describes your relationship with this sexual partner?” Participants who answered “yes” to the first question were given the following options to select for the second question: *committed dating relationship, cohabiting/living together, engaged, married/domestic partnership, and other (please specify)*. Participants who answered “no” to the first question were given the following response options for the second question: *casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup), casually dating/talking, and other (please specify)*.

The language in the vignette adapted based on the relationship type selected. Participants who indicated they were in an “other” committed relationship were randomly assigned a committed vignette, and those in an “other” non-committed relationship were randomly assigned a non-committed vignette. To examine the effect of STI type on the responses, the vignette scenario was programmed to randomly assign either chlamydia (a bacterial STI) or genital herpes (a viral STI) as the STI type. Participants who indicated their most recent relationship was a committed relationship were assigned the following vignette scenario:

Imagine that you are [*matched relationship types: in a committed dating relationship; cohabiting/living with a partner; engaged to someone; married/domestic partners*]. You are committed to this person, and you have sex with them (this may include oral, vaginal, and/or anal sex). (If you are currently [*matched relationship types: in a committed dating*

relationship; cohabiting/living with a partner; engaged to someone; married/domestic partners], then think about this relationship). Since you two began your relationship, they have not had sex with anyone else, except for you, and you have not had sex with anyone else, either. One day, after you've had sex, your partner tells you that they have [randomly assigned STI types: chlamydia; genital herpes], a sexually transmitted infection (STI), and you may have been exposed.

Participants who indicated their most recent relationship was non-committed received the following vignette scenario:

Imagine that you [matched relationship types: are in a casual sex relationship; are casually dating/talking] with someone. You are not committed to this person, but you have sex with them (this may include oral, vaginal, and/or anal sex). (If you currently [matched relationship types: are in a casual sex relationship; are casually dating/talking], then think about this partner). Since you two started having sex, they have not had sex with anyone else, except for you, and you have not had sex with anyone else, either. One day, after you've had sex, your partner tells you that they have [randomly assigned STI types: chlamydia; genital herpes], a sexually transmitted infection (STI), and you may have been exposed.

A total of twelve vignette scenarios were possible (see Table 7).

Independent Variables

I examined how relationship type, STI type, and gender differentiated participants' responses. The relationship and STI type variables were derived from the parameters assigned to participants in the vignette scenarios.

Relationship type. In the vignettes, the relationship type presented was matched to participants' current/most recent relationship type. Six different relationship type options were available (see Appendix 4). After examining the assumptions for main analyses, I ultimately coded relationship type as a dichotomous variable (0 = *non-committed relationship* and 1 = *committed relationship*). Forty-one participants were coded as non-committed, and 202 were coded as committed.

STI type. In the vignette scenarios, participants were randomly assigned either chlamydia, a bacterial STI, or genital herpes, a viral STI, as the STI disclosed. A total of $n = 122$ participants received the chlamydia vignette and $n = 121$ received the genital herpes vignette. A dichotomous variable was created for analyses and coded as 0 = *bacterial STI* and 1 = *viral STI*.

Gender. I coded gender as dichotomous, based on cell sizes, where cisgender men ($n = 100$), transgender men ($n = 3$), and nonbinary individuals who were assigned "male" at birth ($n = 1$) were coded as 0 = *men*; cisgender women ($n = 127$), transgender women ($n = 3$), and nonbinary individuals assigned "female" at birth ($n = 9$) were coded as 1 = *women*. See Appendix 4 for the full measure of gender.

Control Variables

STI Stigma. STI stigma was measured using Fortenberry et al.'s (2002) five-item STD-Related Stigma Scale. To be consistent with contemporary lexicon, I changed "sexually transmitted disease (STD)" to "sexually transmitted infection (STI)" in the scale. It is measured on a five-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*), with higher scores indicating more stigmatizing attitudes toward STIs. The scale demonstrated acceptable reliability for this study ($\alpha = .79$).

Social Desirability. Vignettes have the potential to generate socially desirable responses, potentially biasing the results (Hughes & Huby, 2002). Thus, I proposed to control for socially desirable responding in the analyses. Social desirability was measured using the Balanced Inventory of Desirable Responding Short Form (BIDR-16; Hart et al., 2015). The BIDR-16 a 16-item measures that assesses participants' propensity toward impression management (IM), defined as consciously over-reporting positive attributes and underreporting negative attributes, and self-deceptive enhancement (SDE), defined as the unconscious tendency to portray a positive image of oneself. Items were measured on a scale from 1 = *not at all true* to 7 = *very true*. The scale demonstrated acceptable reliability for this study ($\alpha = .83$). Ultimately, none of the outcome variables were associated with the BIDR-16 (Table 8), so I did not include this as a covariate in the final analyses.

Missing Data

I examined the patterns of missing data using Little's Missing Completely at Random (MCAR) test and found that the data were missing completely at random, $\chi^2(7046) = 7228.30, p = .06$. For the exploratory factor analyses (EFAs), I did not impute any missing values, as the resulting factor loadings may differ based on imputed data. For the main analyses, I used series mean imputation for variables with missing values.

Analyses and Results

Exploratory Factor Analyses

Because there are no established measures for assessing responses to and outcomes of STI disclosures, I developed a series of measures based on the DD-MM (Greene, 2009). I designed these measures to be adaptable for assessing both anticipated reactions (e.g., using a vignette scenario) and actual reactions (e.g., retrospective reports from actual receivers). In this

study, I conducted a series of EFAs determine the factor structure of the items I designed to measure emerging adults' anticipated responses to and outcomes of a partner's STI disclosure.

I hypothesized twelve constructs to be predicted by at least three observed indicators. I examined the eigenvalues and Scree plots to determine the number of factors to extract. Eigenvalues ≥ 1.0 indicate the number of factors that should be extracted, but factors with eigenvalues of .950 – .999 could be retained and 1.005 – 1.100 ignored, if there are strong theoretical grounds (Thompson, 2004). When more than one factor emerged, I conducted factor rotations. I began with the Promax (an oblique) rotation, which assumes the extracted factors are correlated. If no value in the component correlation matrix was above $|.32|$, I would have used an orthogonal rotation (this never occurred). I then examined the loadings, conducting alternative rotation methods if necessary, to ensure a clear factor structure emerged and to identify low loadings. A loading value of $|.30|$ was used as the default cutoff and adjustments were made as necessary. Below I report the results of the EFAs. See Tables 9-14 for full EFA tables.

Emotional Reactions

Feelings. I expected two factors to emerge from the 20 items designed to measure participants' feelings in response to the disclosure. I expected 13 items to load onto a negative feelings factor and 7 items to load onto a positive feelings factor. I used a Promax rotation; there were values in the component correlation matrix above $|.32|$, so I did not change rotation methods. The Kaiser-Meyer-Olkin (KMO) Test for Sampling Adequacy was .87 and Bartlett's Test of Sphericity was significant ($\chi^2 (190) = 2626.68, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. Four eigenvalues above 1.0 emerged, which suggested four factors should be extracted. Three items (sympathetic, distressed, and guilty) had cross-loadings. The distressed variable lowly loaded onto factors 1 ($\lambda = .40$) and 3 ($\lambda = .41$), suggesting

the item was not contributing to the factor structure. After removing the distressed item, I re-ran analyses. Two items (sympathetic and happy) had cross-loadings. The sympathetic item loaded highly onto factor 1 ($\lambda = -.75$) and lowly onto factor 3 ($\lambda = .36$). The happy item had a moderately high loading on factor 2 ($\lambda = .66$) and low loading on factor 3 ($\lambda = -.35$). Thus, I suppressed loadings below $|0.4|$ and ran analyses a third time. Rather than loading onto two factors, a clear, four-factor structure emerged.

Factor 1: Negative Emotional Reactions. Ten items loaded onto factor 1 (eigenvalue = 6.74), which I labeled “Negative Emotional Reactions.” These 10 items encompass the angry, hostile, suspicious, and unsympathetic reactions a receiver might have to a disclosure. Two items that were originally designed as “positive emotional reaction” items loaded negatively onto this construct (Table 9).

Factor 2: Positive Emotional Reactions. Four items loaded onto factor 2 (eigenvalue = 2.80), which I labeled “Positive Emotional Reactions.” These four items encompass happy, relieved and proud reactions (Table 9).

Factor 3: Anxious Emotional Reactions. Two items, after eliminating the poorly-loading “distressed” item, loaded onto factor 3 (eigenvalue = 1.67), which I labeled “Anxious Emotional Reactions.” These two items were the nervous ($\lambda = .83$) and scared ($\lambda = .81$) items. Although factors extracted should ideally have three or more loadings, I retained this factor due to its clear structure and high loadings (Table 9).

Factor 4: Guilty Emotional Reactions. Three items loaded onto factor 4 (eigenvalue = 1.05), which I labeled “Guilty Emotional Reactions.” These three items were guilty ($\lambda = .79$), calm ($\lambda = -.64$), and ashamed ($\lambda = .52$). This factor seems to encompass feelings of guilt, fear,

and shame, suggesting the receiver transmitted the infection to the discloser, or was fearful they may have (Table 9).

Behaviors. I expected two factors to emerge from the 11 items designed to measure participants' behaviors in response to the disclosure. I expected 6 items to load onto a rejecting behaviors factor and 7 items to load onto an accepting behaviors factor. I used a Promax rotation; there were values in the component correlation matrix above $|\lambda| \geq .32$, so I did not change rotation methods. The KMO was .86 and Bartlett's test was significant ($\chi^2(55) = 1417.76, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. Two eigenvalues above 1.0 emerged, suggesting a two-factor structure. Three items (violent, compliment, and accept) had cross-loadings. The violent item had a moderately high loading on factor 1 ($\lambda = .624$) and low loading on factor 2 ($\lambda = .310$). The compliment and accept items had moderate-to-high loadings on factor 2 ($\lambda = .781; \lambda = .643$) and low loadings on factor 1 ($\lambda = .349; \lambda = -.352$). I suppressed loadings below $|\lambda| \geq .4$ and re-ran analyses. A clear factor structure emerged with no cross-loadings.

Factor 1: Rejecting Behavioral Reactions. As hypothesized, six items loaded onto a "Rejecting Behavioral Reactions" factor (eigenvalue = 5.02). These items represent the immediate rejecting verbal or physical responses a receiver might have to a disclosure. Verbal responses (insult, yell, reject, and criticize) had stronger loadings on this factor than physical responses (withdraw and violent; Table 10).

Factor 2: Accepting Behavioral Reactions. As hypothesized, five items loaded onto an "Accepting Behavioral Reactions" factor (eigenvalue = 1.88). These items represent the immediate accepting verbal or physical emotional responses a receiver might have. The verbally affirming behaviors compliment and praise had the highest loadings, followed by hug, encourage, and accept (Table 10).

Avoidance

I expected four items to underlie this single factor. Factor extraction is not conducted when analyzing a single component. To ensure all items loaded onto the factor, I conducted a Principal Component Analysis. The KMO was .65 and Bartlett's test was significant ($\chi^2(6) = 191.20, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. All four items had moderate-to-high loadings on the factor "Avoidance" (eigenvalue = 2.11; Table 11).

Support

I expected three factors to emerge from the 14 items designed to measure participants' supportive responses to the disclosure. I expected 8 items to load onto an emotional support factor, 3 onto an informational support factor, and 3 onto an instrumental support factor. I used a Promax rotation; there were values in the component correlation matrix above $|\lambda| \geq .32$, so I did not change rotation methods. The KMO was .93 and Bartlett's test was significant ($\chi^2(91) = 2714.91, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. Two eigenvalues above 1.0 emerged, suggesting a two-factor structure. One item ("I would not take my partner's disclosure seriously" [Not Serious]) had a low cross-loading ($\lambda = .41$) on factor 1 and high cross-loading ($\lambda = .72$) on factor 2. I suppressed loadings at or below $|\lambda| \geq .41$.

Factor 1: Providing Support. Ten items strongly loaded onto the factor "Providing Support" (eigenvalue = 8.00). These items encompassed the emotional, informational, and instrumental support receivers may provide their partners after receiving a disclosure. All items had loadings of .80 or above (Table 12).

Factor 2: Unsupportive. Four items moderately-to-strongly loaded onto the factor "Unsupportive" (eigenvalue = 1.56). These items encompass responding to a disclosing partner

with indifference (i.e., not providing support or taking the disclosure seriously) and by withdrawing support (Table 12).

Receiver Outcomes

I expected two factors to emerge from the 10 items designed to measure participants' anticipated outcomes as a result disclosure for themselves. I expected five items to load onto a negative receiver outcomes factor and five items to load onto a positive receiver outcomes factor. I used a Promax rotation; there were values in the component correlation matrix above $|\lambda|$, so I did not change rotation methods. The KMO was .87 and Bartlett's test was significant ($\chi^2(45) = 1667.36, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. Three eigenvalues above 1.0 emerged, suggesting a three-factor structure. One item ("I would become more educated about sexually transmitted infections" [more educated]) singularly loaded ($\lambda = .983$) onto a separate factor. Additionally, the items "My emotional health would be positively affected" (positive health) and "I would become more empathetic toward my partner" (empathy) had cross-loadings on the other two factors. Respectively, they loaded lowly onto factor 1 ($\lambda = .43$; $\lambda = -.32$) and moderately high onto factor 2 ($\lambda = .81$; $\lambda = .63$).

First, I removed the more educated item and re-ran the analysis. The assumption statistics grew more favorable (KMO = .87; $\chi^2(36) = 1672.39, p < .001$), and the extracted factors' eigenvalues and variance percentages increased. The same items cross-loaded onto the two factors. Positive health had cross-loadings of $\lambda = .48$ on factor 1 and $\lambda = .79$ on factor 2. Empathy had cross-loadings of $\lambda = -.36$ on factor 1 and $\lambda = .66$ on factor 2. I suppressed loadings at or below $|\lambda|$.

Factor 1: Negative Receiver Outcomes. As expected, five items strongly loaded onto a "Negative Receiver Outcomes" factor (eigenvalue = 4.97). These items represent the potential

negative outcomes that receivers may experience as a result of the disclosure, such as feeling cold and less affectionate toward the partner, becoming distant from the partner, and experiencing hurt feelings and negative effects on emotional health (Table 13).

Factor 2: Positive Receiver Outcomes. With the exception of the more educated item, four items moderately-to-strongly loaded onto a “Positive Receiver Outcomes” factor (eigenvalue = 1.79), as expected. These items represent the potential positive outcomes that receivers may experience, including feeling closer, more affectionate, and more empathetic toward their partner, and experiencing positive effects on emotional health (Table 13).

Becoming More Educated as an Outcome. The more educated item, originally hypothesized to load onto the positive receiver outcomes factor, generated a third factor with a very high loading ($\lambda = .983$). Although not included in the final factor structure of this measure, I do include this item as a separate variable in the subsequent analyses.

Relationship Outcomes

I expected two factors to emerge from the nine items designed to measure participants’ anticipated outcomes as a result disclosure for the relationship. I expected five items to load onto a negative relationship outcomes factor and four items to load onto a positive relationship outcomes factor. I used a Promax rotation; there were values in the component correlation matrix above $|.32|$, so I did not change rotation methods. The KMO was .85 and Bartlett’s test was significant ($\chi^2(28) = 1449.24, p < .001$), suggesting sampling adequacy and sphericity assumptions were met. Two eigenvalues above 1.0 emerged with no cross-loadings, suggesting a clear two-factor structure.

Factor 1: Negative Relationship Outcomes. As hypothesized, four items strongly loaded on the factor “Negative Relationship Outcomes” (eigenvalue = 4.36). These items

encompass the negative relationship outcomes that receivers anticipate may result from the disclosure. These are feelings that the relationship would not be as strong, good, and secure as it was, and the receiver would not like their partner as much as they did, before the disclosure (Table 14).

Factor 2: Positive Relationship Outcomes. As hypothesized, four items strongly loaded onto the factor “Positive Relationship Outcomes” (eigenvalue = 1.85). These items encompass the positive relationship outcomes that receivers anticipate may result from the disclosure. These are feelings that the relationship would become stronger, better, and more secure after the disclosure, and the receiver would like their partner more than they did before the disclosure (Table 14).

Descriptive Statistics and Bivariate Associations

Before conducting the primary analyses, I calculated the mean values for each outcome variable. Participants tended to score higher on negatively valenced emotional and behavioral reactions, as well as negative receiver and relationship outcomes compared to positively valenced measures. Contrarily, participants tended to score higher on providing support and reciprocity, compared to being avoidant or unsupportive. Means, standard deviations, and actual range of response options can be found in Table 15.

Next, I conducted bivariate correlations among the outcome variables and proposed control variables. The social desirability, measured using the BIDR-16 (Hart et al., 2015), was not significantly correlated with any of the outcome variables (Table 8). As such, I chose to conduct analyses without controlling for social desirability. The STI stigma measure was highly correlated with all of the negatively valenced outcome variables, as well as positive emotional reactions (see Table 8). The STI stigma variable was not correlated with accepting behavioral

reactions, providing support, reciprocity, and positive receiver and relationship outcomes. As such, I planned to conduct nine three-way analyses of covariance (ANCOVAs) and five three-way analyses of variance (ANOVAs). For all analyses, the three independent variables were STI type, relationship type, and participant gender. The covariate in the ANCOVAs was STI stigma. I analyzed each dependent variable separately.

Three-Way ANOVA and ANCOVA Assumptions

Before conducting these analyses, I examined the data to ensure the ANOVA and ANCOVA assumptions were met. There were a handful of influential outliers that I assessed. Specifically, for the rejecting behavioral responses, there were five participants with influential outliers in their cells and one participant with an influential outlier for avoidance, as assessed by a boxplot. For each outlying value, I replaced the outlying value with the next highest value, to avoid loss of power (Osborne & Overbay, 2008).

The assumptions also stipulate that the dependent variables should be normally distributed in each cell of the model. I examined the studentized residuals using the Shapiro-Wilk test for normality. If the dependent variable had normality violations in five or more of the cells (i.e., positive emotional reactions, unsupportive, avoidance), I log-transformed the dependent variables and ran the ANCOVAs, with the exception of positive emotional reactions. Over 90% of respondents had scores of 1 (*not at all*) for anticipating positive emotional reactions; log transformations would not correct the distribution. I conducted a separate series of *t*-tests for positive emotional reactions, to determine if there were mean differences based on STI type, relationship type, and gender. After log transforming avoidance, the ANCOVA still failed Levene's test for equality of error variances. I conducted a separate analysis for this variable as well. Specifically, I coded avoidance as a dichotomous variable and conducted chi-square tests to

determine if any of the independent variables were associated. I then conducted a binary logistic regression, to determine if gender and STI stigma predicted avoidance.

If the dependent variable had four or fewer (i.e., negative, anxious, and guilty emotional reactions, rejecting behavioral responses, and negative receiver and relationship outcomes) violations, I proceeded with analyses and next examined Levene's test for homogeneity of variances. I used this approach because despite violations of normality, ANCOVAs provide robust estimates (Rutherford, 2011). If greater than half of the cells had normality violations, I decided a transformation of the variable was required.

The ANOVA dependent variables (accepting behavioral responses, providing support, reciprocity, and positive receiver and relationship outcomes) were fairly normally distributed, as determined by examining the Q-Q plots and skewness and kurtosis values. On the Q-Q plots, the residuals generally followed a linear pattern. There were no skewness values above |1.55| (all but one below |1.03|) and no kurtotic values above |2.50| (all but one below |.94|). The skewness and kurtosis values were within the acceptable range proposed by West et al. (1996). Values of skewness should be less than |2| and of kurtosis less than |7|. I conducted all ANOVAs with untransformed dependent variables. For all ANOVAs and ANCOVAs, I used Bonferroni confidence interval corrections to adjust for multiple comparisons.

Three-Way ANCOVA Results

For all ANCOVAs, STI stigma was a significant covariate at $p < .001$ (negative emotional reactions [Table 16], anxious emotional reactions [$p = .01$; Table 17], guilty emotional reactions [Table 18], rejecting behavioral responses [Table 19], unsupportive [Table 20], negative receiver outcomes [Table 21], and negative relationship outcomes [Table 22]; see Tables 16-29 for all ANCOVA results). There were significant main effects of gender on

negative ($p < .05$), anxious ($p < .001$), and guilty ($p < .001$) emotional reactions (Table 23). Specifically, the estimated marginal means (EMM) were higher for women than men (Table 23). There were no main effects of relationship type (Table 24). The main effect of STI type on unsupportive responses approached significance ($p = .06$; Table 25). Specifically, the log-transformed EMMs were higher for participants who received the bacterial STI vignette than the viral STI vignette (Table 25).

There were no interaction effects of gender by STI type (Table 26). There were interaction effects of gender by relationship type for anxious ($p < .05$) and guilty ($p < .05$) emotional reactions (Table 27). Specifically, among men, anxious and guilty emotional reactions were higher in the committed vignette scenarios than non-committed; among women, anxious and guilty reactions were higher in the non-committed scenarios than committed (Table 27). There were no interaction effects of STI type by relationship type (Table 28). There were no significant three-way interactions (Table 29).

Three-Way ANOVA Results

For all ANOVAs, the models were not significant. Specifically, there were no significant differences in accepting behavioral reactions, providing support, reciprocity, and positive receiver and relationship outcomes for any independent or interactions terms. In other words, gender, STI type, and relationship type did not differentiate participants responses. This suggests that these emerging adults had lower anticipated levels (see Table 15 for means) of positive responses and outcomes, and the context of the disclosure did not matter, nor did their identified gender. There was more variability in these responses than the positive emotional reactions variable, but the means were still relatively low.

Avoidance

Because I was not able to conduct the ANCOVA, I examined the distribution of responses and transformed avoidance into a binary variable. After analyzing the distribution of responses and to maintain an adequate count in each cell, I chose to split the data at the response value 1.25. Participants who had an avoidance score between 1-1.25 ($n = 139$) were coded as 0 (*less avoidance*), and 1.49-3.50 ($n = 104$) as 1 (*more avoidance*). Original response options were 1 (*not at all*), 2 (*a little*), 3 (*moderately*), 4 (*quite a bit*), and 5 (*completely*). I conducted a series of chi-square tests to determine if the independent variables were associated with avoidance; gender was significant, $\chi^2(1) = 6.18, p = .013$. Because STI stigma was also associated with avoidance, I conducted a binary logistic regression to determine if gender and stigma predicted avoidance levels. There was no interaction effect of gender and stigma, so I used the more parsimonious model. Both stigma ($\beta = .37, SE = .16, p = .02$; OR = 1.45 [CI = 1.06 – 1.96]) and gender ($\beta = -.69, SE = .27, p = .01$; OR = .50 [CI = 0.30 – 0.85]) were significant. The results suggest that women were 50% less likely to anticipate avoiding the discloser and discussion than men; the results also suggest that those with higher STI stigma scores were 45% more likely to anticipate avoidance than those with lower levels of STI stigma.

Positive Emotional Reactions

Over 90% of respondents indicated they would not anticipate having any positive emotional reactions (i.e., selected 1 = *not at all* for all positive emotional reaction items). As such, I was unable to run an ANCOVA and decided to run *t*-tests to determine if there were any mean differences between relationship type, STI type, and gender. For relationship type and gender, Levene's test for equality of variances was violated ($F = 31.87, p < .001$; $F = 14.26, p < .001$), so I interpreted assuming unequal variances. There were no significant differences in

positive emotional reactions for relationship type ($t = 1.74, p = .09$) nor gender ($t = 1.81, p = .07$). Equal variances were assumed for STI type ($F = 0.43, p = .45$); there were no differences in positive emotional reactions ($t = .36, p = .72$). These results suggest that the circumstances of disclosure and gender did not differentiate participants' anticipated positive reactions.

Discussion

The purpose of this study was (a) to develop the STI Disclosure Reactions Measure (SDRM) and use exploratory factor analyses to determine its factor structure, and (b) to determine whether relationship type, STI type, and gender differentiated these responses and outcomes among an emerging adult sample, controlling for STI stigma. Clear factor structures emerged from analyses, some supporting and others challenging the structures I hypothesized, resulting in a theoretically-informed and data driven measure of STI disclosure reactions. The ANCOVA results suggest that STI stigma was an important covariate across analyses, and that gender differentiated participants' anticipated responses and outcomes.

The STI Disclosure Reactions Measure

Results from the EFAs suggest a factor structure that closely aligns with Magsamen-Conrad's (2014) operationalization of reactions to disclosures, with a few notable exceptions. The exceptions are not emergent factors that do not fit within Magsamen-Conrad's (2014) framework, but rather suggest additions and adjustments that should be made when assessing reactions to STI disclosures, specifically.

Consistent with my hypotheses, negative and positive emotional reactions, accepting and rejecting behaviors, and negative and positive receiver and relationship outcomes emerged as clear factors. When studying emerging adults as receivers of STI disclosures, we can expect them to experience a range of feelings, behaviors, and outcomes. Based on Magsamen-Conrad's

(2014) framework, I expected three forms of support to emerge as factors (i.e., emotional, informational, and instrumental support), with positive and negative valences emerging as positive and negative factor loadings, not as distinct factors. Instead, the factor structure that emerged was not about the type of support provided, but the presence or absence of support. Specifically, supportive actions that were emotionally, informationally, and instrumentally positive (e.g., “I would let my partner know that I was there for them”; “I would offer to help my partner with whatever they needed”) loaded onto a factor; actions that were either passively (e.g., “I would be indifferent to my partner’s needs”) or actively (e.g., “I would cut off support for my partner”) unsupportive (i.e., negative valence) loaded onto another factor. This suggests that, in this sample, the type of support is not as important as is the action of being supportive or unsupportive itself.

Regarding emotional reactions, both negative and positive reactions emerged as factors, as expected. However, two additional unexpected factors emerged. Although only two items loaded onto this factor, the Anxious Emotional Reactions construct emerged. The items that loaded onto this construct were anticipating feeling nervous and scared. I asked participants to speculate about their responses *immediately* following the disclosure; nowhere in the vignette scenario did the discloser provide any information about the nature and treatability of the STI. Providing information may alleviate some of the anxiety that receivers may feel when receiving a disclosure, but this information would not likely be shared immediately; research suggests that a clear disclosure message is delivered first, followed by explanations (Coffelt et al., 2021). Because an STI is something that is highly stigmatized and can affect one’s health (either temporarily or permanently, depending on STI and length of time untreated), it is reasonable to expect receivers to have anxious reactions.

The second unexpected factor that emerged under emotional reactions was Guilty Emotional Reactions. Although items were included that captured this construct (e.g., guilty, ashamed), I expected these, as well as the other negatively valenced items, to load onto one construct. However, guilt emerged as a distinct construct. Unlike support, where presence or absence was more important than type of support, emotional reactions seem to be driven not only by valence but also type of reaction. There are a variety of possible reasons a receiver may experience feelings of guilt upon disclosure. First, it is possible that, after being told by a sexual partner that they have an STI, a receiver may begin to question if they had the STI first and possibly exposed their partner. Another possibility may be that receivers did have an STI and were aware of the fact and now feel guilty for transmitting to their partner. It is also possible that receivers feel guilty for having negative emotional reactions as a result of the disclosure. That is, they feel guilty for reacting in a negative way. Finally, it is possible that these feelings of guilt are actually mirroring the disclosers feelings, as a way of experiencing empathy. It is unclear exactly why receivers anticipate feeling guilty, but it is clearly an important emotional reaction to STI disclosures.

Stigma, Gender, and Relationship Type

The most salient construct to differentiate responses and outcomes was STI stigma. Participants who endorsed more stigmatizing attitudes toward STIs tended to anticipate more negatively valenced responses and outcomes. Research suggests that emerging adults often perpetuate stigmatizing ideas about STIs (Hirschler et al., 2015). This stigma and beliefs about people with STIs are associated with expecting to react in negative ways. These results may have important socio-cultural implications regarding the perception of STIs. Although sexual views among emerging adults are becoming increasingly progressive (Arnett, 2015), perceptions of

people with STIs remain stigmatizing (Hirschler et al., 2015; Lo et al., 2009; Nack, 2000). Despite the prevalence of STIs, many believe they are symbolic of moral flaws (Nack, 2000). Being diagnosed with an STI is, of course, not a good or positive phenomenon, but attitudes about those diagnosed can affect responses to disclosures.

Stigmatizing attitudes toward those with STIs are pervasive, as are stigmatizing attitudes toward gender and sexuality. Research suggests that men and women experience sexuality differently on a social level, based on the Sexual Double Standard (Petersen & Hyde, 2010). Men are often encouraged to be sexual and promiscuous, whereas women tend to be shamed for any sexual activity whatsoever. The Sexual Double Standard intersects with STI stigma and experiences. Women are more frequently blamed for STIs and are considered tainted, damaged goods once they contract one (East et al., 2010; Nack, 2000). Consistent with such an explanation, the women in the current sample anticipated experiencing more negative, anxious, and guilty emotional reactions than men.

Further, I found interaction effects of gender and relationship type on anxious and guilty reactions. Men who received the committed vignette scenario had more anticipated anxious and guilty emotional reactions, whereas women who received the non-committed scenario had more anxious and guilty reactions. Not only are women highly stigmatized and shamed for having STIs, they are also shamed for engaging in casual sex (Conley et al., 2013; Petersen & Hyde, 2010). Thus, women who imagined being in a casual sex relationship and discovering their partner had an STI experienced more anxious and guilty feelings than men. Conversely, men reported more anxious and guilty feelings in the committed relationship scenario. Because men are typically encouraged to, or at least excused for, engaging in casual sex (Conley et al., 2013; Petersen & Hyde, 2010), it is reasonable that they would be less anxious and guilty in these

scenarios. Participants were matched to vignettes based on their current or most recent relationship; thus, men in the committed scenarios were likely imagining this conversation with their current or most recent committed partner, which could explain the higher levels of anxiety and guilt. Finally, I found that women were less likely to anticipate avoiding the discloser than men. Because sexual health responsibility is often placed on women (East et al., 2010), it is understandable that women would be less likely to avoid the discloser.

Counter to hypotheses, STI type was not particularly important in differentiating emerging adults' anticipated responses and outcomes. The results from the ANCOVA examining unsupportive responses suggested that participants imagined they would be slightly more unsupportive for disclosures of chlamydia than herpes ($p = .06$). Most STIs are stigmatized, but some research has suggested that viral STIs are more highly stigmatized than bacterial STIs (Lee & Craft, 2002; Temple-Smith et al., 2010). This study finding indicates that emerging adults may be less supportive for bacterial, which suggests that viral STI stigma may be less pervasive. There are several possible explanations for this. Even though herpes is incurable, it does not have nearly the same negative health outcomes as untreated chlamydia (i.e., infertility). Second, participants may have read the scenario and interpreted the partner to have cheated, if the STI was chlamydia. Even though the scenario specified no extra-dyadic sex occurred, participants may have found that more believable when the STI was herpes. Third, it is possible that the participants in the study, and emerging adults generally, simply do not know the differences between viral and bacterial STIs (Hirschler et al., 2015), and thus see them as roughly the same. Examining unsupportive responses in the context of other STIs would be an important next step, as well as controlling for the level of STI knowledge.

Limitations

There are several important limitations of this study that should be considered when interpreting the results. The first limitation is the inequality of participants in the relationship type groups. By design, I chose to assign participants to the vignette scenario that most closely aligned with their recent relationship experiences (Hughes & Huby, 2004). Unfortunately, the majority of participants were assigned to the committed vignettes. This unequal group size may bias results and disguise effects. Future researchers should consider either randomizing relationship type or over-sampling participants in casual sex relationships.

Although the sample is purposive in terms of inclusion criteria, the sample was still acquired via convenience. Using Prolific ensured the quality of the data would be better, but participants self-selected into the study. These individuals may be fundamentally different from individuals who chose to not participate or who were not captured in sampling. The majority of participants in this study were White/Caucasian and heterosexual. This is an important limitation, as racial and sexual minorities (particularly men who have sex with men [MSM]) may be more susceptible to STI contraction and experience more STI-related stigma than White, heterosexual individuals (CDC, 2019).

There are some limitations with the data analyses that should also be taken into consideration. Specifically, many of the dependent variables were highly correlated with one another. If the data had sufficient cell sizes and were normally distributed at all levels, multivariate analyses of covariance (MANCOVAs) would have been more appropriate analyses. Finally, the use of vignettes can be considered both a strength and limitation. Obtaining samples of individuals with STIs is difficult, given the sensitive nature of the topic. Using vignettes allowed me to capture emerging adults' perspectives on STI disclosure with a larger sample size.

Further, this study shed light on how emerging adults who have never received an STI disclosure anticipate reacting, and these findings have a variety of implications for future research and education. Yet, the use of vignettes to measure anticipated reactions is limited, as it does not truly capture the perspective of receivers. To address this limitation, I also collected data from emerging adults who had received an STI disclosure from a sexual partner and examined their reported actual reactions in the next study.

Implications

Despite these limitations, the results from this study have several important implications. First, I developed a theoretically-informed measure of disclosure reactions and found a clear factor structure. With this measure, we can begin to understand the experiences of receivers of both hypothetical and actual STI disclosures. Second, the results from this study validate the fears and concerns of disclosers: emerging adults did anticipate having negative reactions to the discloser. However, participants did not anticipate particularly high levels of rejecting and unsupportive responses. There is an important distinction to be made between the feelings experienced in reaction to a disclosure and the behaviors enacted in response. Disclosers often anticipate rejection, but support and acceptance are important to their emotional and relational health. Participants in this study reported anticipating some rejecting reactions, but reported higher levels of anticipated support. Although future research is needed, this information could be incorporated into educational messages for those recently diagnosed with an STI.

Overall, the results from this study have implications for future research. Validating the SDRM in other developmental populations, such as adolescents, adults, and older adults, would be an important next step. Further, given the unique experiences of racial and sexual minorities in the contexts of STIs (CDC, 2019), future research should purposively sample from these

populations, to determine if there are differences in anticipated responses based on race and sexual orientation.

Findings from this study also have broader, socio-cultural implications. STI stigma was strongly associated with many of the outcome variables. The perpetuation of STI stigma among emerging adults is common (Hirschler et al., 2015) and has numerous psychosocial effects on individuals with STIs (e.g., Newton & McCabe, 2008a; 2008b). There are a variety micro- and macro-level messages that influence people's beliefs about STIs, but one area that may be particularly influential is sexual health education. The majority of youth in the U.S. are only exposed to sex education that emphasizes abstinence-only, often using tactics that induce fear of and disgust with STIs (Fields et al., 2015). It is quite possible that emerging adults form stigmatizing ideas about STIs based on their experiences in sex education. Knowing that having more stigmatizing attitudes toward STIs is associated with anticipating negative responses and outcomes, and that perceiving STI stigma inhibits disclosure (e.g., Lee & Craft, 2002; Myers et al., 2016; Nack, 2000), it is important that we begin reconsidering how youth are educated about STIs and disclosure. Incorporating curricula about stigmatization and its dangers would be an important modification to make in sexual health education.

These findings may also have socio-cultural implications regarding gender and relationship type. Specifically, the women in this study anticipated more negative, guilty, and anxious reactions than men, and in particular, women with the casual sex scenario anticipated more anxious and guilty reactions. These results highlight the pervasiveness of the Sexual Double Standard. Sexual health programs should not only strive to reduce stigmatizing attitudes toward STIs, but also toward women, and in particular, women who engage in casual sex relationships.

Finally, these results have implications for practitioners and therapists who interact with potential disclosers and receivers. Practitioners can provide more detailed information to recently-diagnosed individuals about research on disclosure motivations and potential receiver reactions. Although this research cannot, and should not, be used to definitively say how receivers might respond, having a general understanding of emerging adults' anticipated responses could help potential disclosers improve their disclosure efficacy. Additionally, couples' counselors can use the information generated from this study and the extant disclosure research to help couples work through the processes of disclosing and receiving information about STIs, helping couples to feel validated in their feelings and also acknowledge the importance of being cognizant of STI stigma and possible harmful reactions.

CHAPTER 4:

Emerging Adults as Sexually Transmitted Infection (STI) Disclosure Recipients: Effects of Gender, Relationship Type, and STI Type on Disclosure Reactions

Introduction

When proceeding through the disclosure decision-making process, individuals with STIs often anticipate their partner's responses (Greene, 2009). Most often, these individuals anticipate negative responses and reactions to their disclosure (e.g., Decker et al., 2011; Green et al., 2003; Myers et al., 2016; Temple-Smith et al., 2010). Furthermore, anticipated negative reactions is one of, if not the, most commonly cited reason for non-disclosure (e.g., Arima et al., 2012; Duncan et al., 2001; Myers et al., 2016; Nack, 2000; Temple-Smith et al., 2010). Although anticipated responses are one of the most important reasons for non-disclosure, few studies have examined actual receiver responses of disclosures from the receivers' perspectives. Some studies report that disclosers indicate that their partner's reaction was better than anticipated (e.g., McCaffery et al., 2006; Scrivener et al., 2008; Shepherd, 2010), but it is unclear how receivers perceive these exchanges. The purpose of the current study was to extend beyond anticipated responses and understand how emerging adults who have received an STI disclosure actually responded. Do their actual responses mirror the anticipated responses of emerging adults who have never received a disclosure, and how do gender, STI type, and relationship type differentiate these responses?

Literature Review

After being diagnosed with an STI, many people go through complex emotional processes. Many experience feelings of worry and anxiety (e.g., Duncan et al., 2001; Kosenko et al., 2012; Melville et al., 2003; Newton & McCabe, 2008b) and guilt (e.g., McCaffery et al., 2006; Temple-Smith et al., 2010). Many must endure a complex stigma-confrontation process, where they struggle to reincorporate their sexual identity with their self-concept (Lee & Craft, 2002; Nack, 2000; Newton & McCabe, 2005). If these individuals are to engage in romantic

and/or sexual relationships post-diagnosis, they must then confront their feelings and beliefs about disclosure. The anticipated reaction of the receiver greatly influences the disclosure process (Greene, 2009). The literature suggests that many individuals fear or anticipate negative responses and outcomes of the STI disclosure (e.g., Bickford et al., 2007; Decker et al., 2011; Myers, 2016; Nack, 2000), but the nature of receivers' actual responses and the outcomes of disclosure are largely unknown. Further, Newton and McCabe (2005) suggested that researchers seek to understand receiver and relationship characteristics that encourage disclosure. To address these gaps, I designed this study using the Health Disclosure Decision-Making Model (DD-MM; Greene, 2009) and extant disclosure research to describe the experiences of STI disclosure recipients and determine if their responses to and outcomes of the disclosure were differentiated by receiver and relationship characteristics.

Guiding Framework

The DD-MM postulates that individuals tend to anticipate the intended receiver's reactions (responses and outcomes) when making the decision to disclose (Greene, 2009). Based on the results from the systematic critical literature review (Chapter 2), individuals with STIs anticipate responses and outcomes, and these are often motivators for (non) disclosure. A few studies revealed the actual responses to and outcomes of the disclosure (e.g., Scrivener et al., 2008; Shepherd, 2010) from the disclosers' perspective, but only one examined receivers' reports and did not investigate reactions (Coffelt et al., 2021). It is unclear how receivers of disclosures describe their responses to and the outcomes of STI disclosures. Yet, it is important that these reactions be investigated and documented.

The Importance of Response

Receivers of disclosures may respond in positive, negative, or neutral ways (Magsamen-Conrad, 2014). For individuals who disclose STIs to sexual partners, the experience of receiving negative or rejecting responses may encourage individuals to withhold disclosure in the future (Nack, 2000), whereas receiving positive responses may encourage further disclosure (Swanson & Chenitz, 1993). Anticipating a partner's response is one of many important components in the disclosure decision-making process (Greene, 2009). Scholars have called for investigation into the nuances of responses. For example, Myers et al., (2016) recommended that future research determine specifically what constitutes negative reactions.

Results from the systematic review (Chapter 2) reveal that individuals tend to anticipate mostly negative responses from disclosers, and that anticipation is not unwarranted. Many disclosers have reported that their partner did, in fact, react negatively. Negative responses can include experiencing/expressing emotions such as anger, rejecting the discloser, or even threatening them/becoming violent (e.g., Decker et al., 2011, Nack, 2000; Temple-Smith et al., 2010). Positive responses are also possible, and some disclosers have reported these, including providing emotional support, asking questions and seeking knowledge, and expressing relief (e.g., Arima et al., 2012; Scrivener et al., 2008; McCaffery et al., 2006). The way a partner responds to a disclosure can feed back into the individual's decision-making processes in the future. Negative responses can discourage future disclosures, whereas positive responses can encourage further disclosure (Cunningham et al., 2007; Swanson & Chenitz, 1993). Thus, from an STI prevention standpoint, positive receiver responses elicit more favorable outcomes.

Disclosure Outcomes

Findings from the systematic review (Chapter 2) also revealed some of the outcomes resulting from disclosure, described mostly from disclosers' perspectives. Specifically, the literature identified outcomes for non-disclosers, and relationship outcomes for disclosers. The outcomes for non-disclosers were generally negative, in that they reported higher levels of anxiety and depression and lower levels of sexual-esteem and satisfaction (Newton & McCabe, 2008b). Feelings of guilt and regret about the decision to withhold disclosure were also reported (e.g., Duncan et al., 2011; Keller et al., 2000). From the perspective of the disclosers, relationship outcomes were reported as generally positive, including increases in commitment, communication, and closeness with their partners (Melville et al., 2003; Newton & McCabe, 2008a; Scrivener et al., 2008; Temple-Smith et al., 2010). Again, the limitation of these findings is that they are from the perspective of the discloser. In addition to examining the reported responses of receivers, I also examined their reported outcomes of the disclosure, both for themselves and for the relationship (Magsamen-Conrad, 2014).

Individual and Relationship Factors

Scholars have suggested that research should investigate characteristics that elicit disclosure and facilitate acceptance of the disclosure (Newton & McCabe, 2005). The most salient characteristics to emerge in the literature is the relationship context. Specifically, disclosure is more likely to occur in relationships that are longer, closer, of higher quality, and committed, rather than non-committed (e.g., Arima et al., 2012; Mohammed et al., 2010; Myers et al., 2016; Pfeiffer et al., 2016; Scrivener et al., 2008; Niccolai et al., 2008). Other characteristics that may influence STI disclosure, as well as responses to disclosure, are gender (Coffelt et al., 2021; Cunningham et al., 2007; Mohammed et al., 2010) and the type of STI

disclosed (i.e., bacterial vs. viral; Coffelt et al., 2021; Cunningham et al., 2007; Newton & McCabe, 2008b). As such, I examined how receivers' responses to and their reported outcomes (for themselves and the relationship) of disclosures were differentiated by relationship type (committed vs. non-committed), STI type, and gender.

Emerging Adults and STIs

In this study, I focused exclusively on those most likely to contract STIs: emerging adults (ages 18-29; Kirzinger et al., 2020). Emerging adults are responsible for almost half of all of the 20 million newly diagnosed STIs every year in the United States (CDC, 2019). Emerging adults tend to underestimate their susceptibility to sexual risks (Arnett, 2015; Hirschler et al., 2015), particularly for STI contraction (Ethier et al., 2003). In addition to a lack of risk perception, emerging adults are also less likely to engage in prophylaxis use consistently (Turchik & Garske, 2009). Another preventative measure, disclosure, may also be a function of age. Specifically, research has found that participants in their early twenties (Mohammed et al., 2010) and late twenties to early thirties (Myers et al., 2016) were less likely to disclose their STI than participants in their late twenties and early forties, respectively. From these studies, it is not clear whether this age effect is influenced by developmental period; however, given the fact that (a) emerging adults often engage in sexual exploration and experimentation (Arnett, 2015), (b) consistently underestimate risks (Ethier et al., 2003; Hirschler et al., 2015), and (c) engage in risky sexual behaviors and neglect to consistently use prophylactics (Turchik & Garske, 2009), it seems the age effect on disclosure is potentially developmentally driven. Despite these facts, the majority of the STI disclosure research has neglected to examine these phenomena from a developmental standpoint. As such, I focused on emerging adult disclosure recipients.

Current Study

The purpose of the current study was threefold: (1) to describe the experiences of emerging adults who have received an STI disclosure from a sexual partner, (2) to extend the research from the previous study by conducting confirmatory factor analyses of the theoretically-informed SDRM using a sample of emerging adults who have been to the recipient of an STI disclosure, and (3) to determine if and how relationship type, STI type, and gender differentiate their responses and outcomes, controlling for STI stigma. Specifically, I sought to answer the following research questions:

RQ1: How do emerging adult receivers describe their experiences with STI disclosure?

RQ2: Controlling for STI stigma, do relationship type, STI type, and participant gender differentiate emerging adults (a) feelings, (b) behaviors, (c) supportive responses, (d) reciprocal disclosures, (e) avoidant responses, (f) outcomes for themselves, and (f) outcomes for the relationship in response to an STI disclosure?

RQ3: Are there two-way interaction effects of (1) relationship type and STI type, (2) relationship type and gender, (3) STI type and gender, and a three-way interaction effect of relationship type, STI type, and gender on the outcome variables (a-f)?

Methods

Procedures

This study was approved by the university's IRB. As in Study 1, participants were recruiting through Prolific. Participants who indicated in their Prolific profile that they were between the ages of 18 and 29, residing in the U.S., and English was their first language were invited to take a screening survey (see Appendix 2) to determine their eligibility for this study. Participants who had received an STI disclosure from a sexual partner that was not HIV/AIDS

were invited to participate in the current study. Those who chose to participate in the current study were informed of its purpose. After giving informed consent, participants completed a restricted access online survey in Qualtrics. Participants were compensated \$3.25 USD for completing the 30-minute survey, consistent with Prolific's compensation policy.

Participants

Data were collected in October and November of 2020. Based on sample size suggestions for conducting Confirmatory Factor Analyses (CFAs; Thompson, 2004) and a priori power analyses, my minimum target sample size was $N = 150$. A total of 975 Prolific participants completed the screening survey, and 149 were eligible for the current study. Of the 149 invited to participate, 88 completed the study. Most participants (61.4%) reported their gender as woman ($n = 54$), followed by man ($n = 29$; 33%), and non-binary ($n = 5$; 5.7%). Ages ranged from 18 to 29, $M = 25.05$ ($SD = 3.18$). Most (69.3%) were White/Caucasian and heterosexual (64.8%). Most participants had completed some college (36.4%) or had a bachelor's degree (31.8%). Most participants (69.3%) were not currently enrolled in any school. At the time of data collection, most participants reported that their current or most recent relationship was a committed romantic relationship (89.8%). Specifically, 48.9% were in committed dating relationships, 18.2% were cohabiting, 3.4% were engaged, 18.2% were married, and one participant was in a committed polyamorous relationship (1.1%). Six participants (6.8%) identified currently being in a non-committed, casual sex relationship, and $n = 3$ indicated they were currently dating/talking to someone (3.4%). Complete demographic characteristics can be found in Table 30 (all tables and figures for Chapter 4 can be found in Appendix 5).

Measures

Outcome Variables

I used the scale developed in the previous study (SDRM; Appendix 4) in the current study, but I modified the items to assess actual disclosure reactions as opposed to the anticipated reactions assessed previously (see Appendix 6).

Disclosure Assessment

After completing a series of demographic items, participants were given the following prompt:

Think back to the question we asked you in the screener survey. As a reminder, here is the question we asked: [*screening scenario presented*]. Considering the same partner and STI disclosure from this question, please answer the following questions about yourself, your partner, and the STI disclosure. If more than one partner has told you they have an STI, please respond to all remaining survey items for the **most recent** disclosure experience.

I asked participants a series of questions first about the context of the disclosure, including their age at disclosure, their partner's gender, type of relationship with the discloser, STI(s) disclosed, behaviors engaged in, disclosure timing, discloser and receiver STI status, the discloser's communication strategy, the outcome of the relationship, and the participant's STI testing activities since the disclosure (see Table 31).

Independent Variables

Modeled after the previous study, I examined how relationship type, STI type, and gender differentiated participants' responses.

Relationship type. I provided participants with a definition of “committed romantic relationship” (see Appendix 6) and asked them to indicate if they had been in one with the discloser at the time of the disclosure. Participants who selected “yes” were asked to specify the type of committed relationship with the discloser (*committed dating relationship, cohabiting/living together, engaged, married/domestic partnership, other*). Participants who selected “no” were asked to specify the type of non-committed relationship (*casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup), casually dating/talking, other*). Based on the previous analyses and the cell sizes in the current study, I coded relationship dichotomously (0 = *non-committed relationship*, 1 = *committed relationship*). At the time of disclosure, fifty-two participants (59.1%) were in committed relationships, and 36 (40.9%) were in non-committed relationships with the discloser.

STI Type. Participants were asked, “Which STI(s) did your partner disclose to you? (check all that apply).” Options were *chlamydia, gonorrhea, syphilis, human papillomavirus (HPV), herpes, I don’t remember, and other (please specify)*. Participants who selected chlamydia, gonorrhea, or syphilis were coded as 0 = *bacterial STI*, and participants who selected HPV or herpes were coded as 1 = *viral STI*. Two participants selected “other” and specified *molluscum contagiosum virus (MCV)* and *pubic lice* (“crabs”). The MCV participant was coded as 1 = *viral STI*, and the pubic lice participant was coded as 0 = *bacterial STI*. Four of the 88 participants identified that their partner disclosed more than one STI. Specifically, one identified both chlamydia and gonorrhea (coded once as 0), two HPV and herpes (coded once as 1), and one both gonorrhea and HPV (coded once as 1). Participants who selected “I don’t remember” ($n = 9$) were randomly assigned to either the bacterial or viral category, due to low cell size. Thus, $n = 48$ were coded as viral and $n = 40$ were coded as bacterial.

Gender. Based on cell sizes, I coded gender as dichotomous, where cisgender men ($n = 29$) were coded as 0 = *men*, and cisgender women ($n = 54$) and nonbinary individuals who were assigned “female” at birth ($n = 5$) were coded as 1 = *women* ($n = 59$). See Appendix 6 for the measure of gender.

Missing Data

I examined the patterns of missingness using Little’s MCAR test and found that the data were missing completely at random, $\chi^2(3828) = .00, p = 1.00$. To conduct the CFAs with bootstrap estimation, there had to be no missing data. When I examined the SDRM items, there were 10 items with one or two missing values. I used series mean imputation for these variables.

Analyses and Results

To address my research questions, I conducted both descriptive and inferential analyses. First, I conducted analyses to describe participants’ experiences with their partners’ disclosures. Second, I conducted a series of confirmatory factor analyses (CFAs) to confirm the factor structure of the SDRM found in Study 1. Third, if my data met necessary statistical assumptions, I conducted a series of ANCOVAs, ANOVAs, chi-square tests, and *t*-tests.

Disclosure Assessment

The mean age of participants at the time of disclosure was 21.9 ($SD = 3.20$, *range* = 16-28), suggesting the mean length of time between the study and experienced disclosure was $M = 3.12$. The most commonly reported disclosure ages were between 18 and 22 ($n = 49$). Most disclosers were identified as cisgender men ($n = 60$; 68.2%), followed by cisgender women ($n = 24$; 27.3%), and non-binary ($n = 4$; 4.5%). The most commonly disclosed STI was herpes ($n = 31$; 35.2%), followed by chlamydia ($n = 26$; 29.4%) and HPV ($n = 14$; 15.9%). Eight participants

(9.1%) reported a gonorrhea disclosure, two identified other STIs (*molluscum contagiosum virus* and *pubic lice*), and nine (10.2%) did not remember the STI disclosed.

Just under half of participants (46.6%) identified their relationship with the discloser as a committed dating relationship ($n = 41$). Approximately one-third of participants (37.5%) identified their relationship with the discloser as either a “casual sex relationship” ($n = 17$) or “casually dating/talking” ($n = 16$). Eight participants (9.1%) identified their relationship with the discloser as cohabiting, engaged, or married/domestic partnership. Participants were asked to indicate all sexual behaviors they had engaged in with this partner; 73.9% of participants had given their partner oral sex and had penile-vaginal intercourse with their partner; 68.2% had received oral sex from their partner. Less than half (35.2%) had engaged in tribadism (genital-to-genital rubbing) with their partner. Anal sexual behaviors were the lowest reported, with 20.5% reporting penile-anal intercourse and 12.5% reporting giving or receiving anilingus (oral sex performed on the anus).

The majority of participants (68.2%) reported that their partner disclosed to them after they first engaged in any sexual behaviors. Of these, 76.7% ($n = 46$) indicated their partner disclosed a month or more after they first engaged in sexual behaviors, 18.3% ($n = 11$) said between a week and a month after, and 5% ($n = 3$) said less than a week after. Participants indicated that their partner’s STI was either in remission at the time of disclosure (30.7%), active and contagious (28.4%), cured but active during the relationship (12.5%), and 28.4% were not sure of the STI’s transmissibility.

Most participants (67.0%) reported that their partner told them about their STI in-person, followed by text message (19.3%), over the phone (10.2%), and on a video call (3.4%). When asked how the conversation about their partner’s STI was broached, most (72.2%) reported that

the disclosure was voluntary. Ten participants (11.4%) reported asking their partner about their sexual health history/status. For the remainder of participants (with the exception of four who indicated “other”), circumstances prompted them to ask. Specifically, five (5.7%) asked because they tested positive for an STI, three (3.4%) asked because they discovered their partner’s infidelity, and two (2.3%) asked because they found paperwork/medication related to the STI.

When asked, “What happened to your relationship with this partner after they disclosed?” 59 participants (67.0%) answered “we continued our relationship;” 33% of participants answered “I ended the relationship.” Most participants (84.1%) got an STI test after the disclosure, and for most (95.5%), this was the only time they had received an STI disclosure. See Table 31 for complete disclosure assessment.

Confirmatory Factor Analyses

I conducted a series of confirmatory factor analyses (CFAs) using AMOS 17 to examine how items loaded onto their respective factors based on the exploratory factor analyses from the previous study. All CFAs were conducted using bootstrap estimation to accommodate for the small sample size. I used 200 bootstrap samples with a bootfactor of four. All CFA results should be interpreted with caution, as the sample size is not adequate without bootstrapping to conduct CFAs, and not all variables were normally distributed. I fixed one factor loading to 1.00 for each construct; the items with the highest factor loadings in the EFAs from the previous study were fixed to 1.00. Items with factor loadings below $|\cdot 30|$ were considered inadequate and not included in the subsequent analyses.

Acceptable model fit was determined by attending to five model fit statistics. First, I examined the chi-square test (p should be above .05), which assesses the overall fit of the model and discrepancy between sample and covariance matrices, and is sensitive to sample size

(Thompson, 2004). Next, I used the comparative fit index ($CFI \geq .90$) and Tucker Lewis index ($TLI \geq .90$). The TLI is also referred to as the non-normed-fit index (NNFI), which is preferable for small sample sizes and indicates how the model of interest improves the fit compared to the null model (Hooper et al., 2008). The CFI, revised from the normed-fit index (NFI), compares the fit of the target model to the fit of a null model (Hooper et al., 2008; Thompson, 2004). Next, I examined the root mean square error of approximation ($RMSEA < .08$), which tests for the most parsimonious model and estimates how well the model reproduces population covariances (Hooper et al., 2008; Thompson, 2004). Finally, I examined the standardized root mean square residual ($SRMR < .08$), which is the standardized value of the square root of the difference between sample covariance matrix residuals and the hypothesized covariance model (Hooper et al., 2008).

Although it is generally important to use these fit indices as a guide, Hooper et al. (2008) identify the importance of examining the model in the context of theory. When considering model fit only, one moves away from the theoretical purpose of conducting structural models (Hooper et al., 2008). As such, they suggest that strict adherence to the cutoff values for fit indices can lead to Type I error, or incorrectly rejecting an acceptable model (Hooper et al., 2008). Thus, when mixed-fitting model statistics emerged, I examined them within the context of the Study 1 factor structures and the DD-MM (Greene, 2009) to determine how to proceed.

Emotional Reactions: Feelings

The items from the negative, positive, anxious, and guilty emotional reactions factors were used in the current CFA. The “distressed” item, which was excluded based on the EFA in Study 1, was not included in this assessment. The initial feelings model showed poor model fit, $\chi^2(146) = 370.99, p < .001$; $CFI = .86$; $TLI = .84$; $RMSEA = .13$; $SRMR = .09$. I examined the

modification indices and allowed some error terms (see Figure 3) to covary. The chi-square (χ^2 (140) = 300.03, $p < .001$) and RMSEA (.11) suggested that the model fit significantly worse than a perfect-fitting model; however, the CFI (.90) and SRMR (.08) indicated acceptable fit, and the TLI (.88) indicated mediocre fit. Because three of the five tests indicated mediocre and acceptable fit, I chose to proceed with planned analyses. All standardized loadings were moderate-to-high, with only three loadings $\lambda < |.59|$. All unstandardized loadings were significant at $p < .001$ (see Figure 3 and Table 32).

Emotional Reactions: Behaviors

The items from the rejecting and accepting behavioral reactions factors were included in the current CFA. The initial behaviors model had poor model fit, $\chi^2(43) = 123.45$, $p < .001$; CFI = .90; TLI = .87; RMSEA = .15; SRMR = .13. The modification indices suggested that to improve model fit that the error variances of “accept” and “encourage” should covary. These adjustments improved the model fit. In the final model, the chi-square was significant, suggesting the model fit deviated significantly from a perfectly-fitting model ($\chi^2(42) = 105.11$, $p < .001$). The final model indicated unacceptable fit based on the SRMR (.15), mediocre fit based on the TLI (.89) and RMSEA (.10), and acceptable fit based on the CFI (.92). Because three of the five tests indicated mediocre and acceptable fit, I chose to proceed with planned analyses. All standardized factor loadings were moderate-to high, with three factor loadings $\lambda < |.58|$. “Violent” had a low loading of $\lambda = .29$. All of the factor loadings were significant at $p < .001$, except “violent,” which had a low loading and was significant at $p < .01$ (see Figure 4 and Table 33).

Support

The items from the providing support and unsupportive factors were included in this CFA. The initial support model had poor model fit, $\chi^2(76) = 305.22, p < .001$; CFI = .79; TLI = .75; RMSEA = .19; SRMR = .12. Based on the modification indices, I allowed some error terms to covary (see Figure 5). This improved model fit. In the final model, the chi-square was significant, suggesting the model fit deviated significantly from a perfectly-fitting model ($\chi^2(71) = 158.92, p < .001$). The final model indicated unacceptable fit based on the RMSEA (.12), mediocre fit based on the SRMR (.10), and acceptable fit based on the CFI (.92) and TLI (.90). Because three of the five tests indicated mediocre and acceptable fit, I chose to proceed with planned analyses. All standardized factor loadings were moderate-to-high, with the exception of three loadings that were low but still acceptable: “information” and “advice” loaded lowly ($\lambda = .41$) onto the Support construct, and “not serious” had a loading of $\lambda = .32$ onto the Unsupportive construct. All of the factor loadings were significant at $p < .001$, with the exception of “not serious,” which was significant at $p < .01$ (see Figure 5 and Table 34).

Avoidance

The four avoidance items were included in this CFA. The initial avoidance model had acceptable model fit, $\chi^2(2) = 2.72, p = .26$; CFI = .99; TLI = .96; RMSEA = .06; SRMR = .03, and I proceeded with planned analyses. The items had acceptable loadings between $\lambda = .56$ and $\lambda = .70$. The factor loadings were all significant at $p < .001$ (see Figure 6 and Table 35).

Reciprocity

As in Study 1, I used an adapted version of the Self-Disclosure Index (Miller et al., 1983) to measure reciprocity. The only adaptations made were to the prompt (“How much did you discuss the following topics with your partner immediately after they told you about their STI?”),

and the first item was changed from “My personal history” to “My personal sexual history.” Responses were measured on a five-point Likert scale (1 = *did not discuss at all* to 5 = *discussed fully and completely*). Cronbach’s alpha indicated acceptable reliability ($\alpha = .93$).

The reciprocity model fit indices indicated mixed model fit. In the final model, the chi-square was significant, suggesting the model fit deviated significantly from a perfectly-fitting model ($\chi^2(27) = 89.45, p < .001$). The RMSEA (.16) indicated unacceptable fit; however, the TLI (.87) indicated mediocre fit and the CFI (.91) and SRMR (.05), indicated acceptable model fit. The original, unmodified Self-Disclosure Index (Miller et al., 1983) items had high loadings between $\lambda = .76$ and $\lambda = .93$. The single modified sexual history disclosure item had a low, but still acceptable, loading, $\lambda = .44$. All standardized loadings were significant at $p < .001$ (see Figure 7 and Table 36). I proceeded with the interpretation of this model because three of five tests had mediocre and acceptable fit. For inferential analyses, I chose to use only the sexual health reciprocity item because the loading was lower than the other items.

Receiver Outcomes

The items generated in the EFAs measuring negative and positive receiver outcomes were used for this CFA. The “becoming more educated” item, which was excluded based on the EFA in Study 1, was not included in this assessment. The initial receiver outcomes model had mixed model fit. The chi-square, $\chi^2(26) = 87.46, p < .001$, RMSEA (.16), and SRMR (.12) indicated poor fit, the TLI (.89) indicated mediocre fit, and the CFI (.92) indicated acceptable fit. Based on the modification indices, I allowed the error terms of “negative emotional health” and “hurt feelings” and “cold” and “more affectionate” to covary, and “positive emotional health” to cross-load onto negative receiver outcomes. This final model had improved model fit. In the final model, the chi-square was significant, suggesting the model fit deviated significantly from a

perfectly-fitting model ($\chi^2(24) = 45.18, p = .006$). The final model indicated unacceptable fit based on the SRMR (.12), mediocre fit based on the RMSEA (.10), and acceptable fit based on the CFI (.97) and TLI (.96). Because three of five tests indicated mediocre and acceptable fit, I chose to proceed with planned analyses. All loadings were moderate-to-high, except for “positive emotional health,” which had a loading of $\lambda = .31$ on the positive receiver outcomes factor. All loadings were significant at $p < .001$, except for positive emotional health ($p < .01$; see Figure 8 and Table 37).

Relationship Outcomes

The items from the negative and positive relationship outcomes factors were included in this CFA. In the initial model, the chi-square was significant, suggesting the model fit deviated significantly from a perfectly-fitting model ($\chi^2(19) = 50.82, p < .001$). The RMSEA (.14) suggested unacceptable fit, but the CFI (.96), TLI (.95), and SRMR (.02) suggested acceptable fit. I consulted the modification indices but made no changes to the model. Because three of five tests indicated acceptable fit, I chose to proceed with planned analyses. The loadings were significant at $p < .001$ and all above $\lambda \geq .80$ (see Figure 9 and Table 38).

Descriptive Statistics and Bivariate Associations

A summary of the means, standard deviations, modes, and ranges of the outcome variables can be found in Table 39. The means for most of the variables were below 2, suggesting that participants reported relatively low levels of both positive and negative responses and outcomes, with a few exceptions. Participants reported moderate levels of negative ($M = 2.77, SD = 1.23$), anxious ($M = 3.17, SD = 1.29$), and guilty ($M = 2.72, SD = 1.05$) emotional reactions. Participants also reported moderate levels of providing support ($M = 2.44, SD = 1.14$),

negative receiver outcomes ($M = 2.50$, $SD = 1.43$), and negative relationship outcomes ($M = 2.38$, $SD = 1.50$).

I conducted bivariate correlations among the outcome variables and proposed control variables (Table 40). Social desirability, measured using the BIDR-16 (Hart et al., 2015), was significantly correlated with anxious and guilty emotional reactions only. When added to the ANCOVAs, this variable did not contribute to the results. Thus, I did not include social desirability as a covariate in the analyses. The STI stigma measure was correlated with all negatively valenced outcome variables, as well as accepting behaviors and providing support; it was not correlated with positive emotional reactions, receiver outcomes, or relationship outcomes. Thus, I planned to conduct ten three-way ANCOVAs, three three-way ANOVAs, and one binary logistic regression (reciprocity). Independent variables were STI type, relationship type, and gender.

Three-Way ANOVA and ANCOVA Assumptions

Before conducting the analyses, I used the same strategies as in Study 1 to ensure the ANCOVA assumptions were met. I examined the studentized residuals using the Shapiro-Wilk test for normality. If the dependent variable had normality violations in five or more of the cells (i.e., rejecting behavioral responses, unsupportive responses, avoidance, and negative relationship outcomes), I log-transformed the dependent variables and re-ran the ANCOVAs. As in Study 1, over 90% of respondents had scores of 1 (*not at all*) for positive emotional reactions. I conducted a separate *t*-test for this variable. After log-transforming these variables, the ANCOVAs either failed Levene's test for equality of variances, were still skewed, or both. Based on meaningful breaks in the data, I recoded these variables as binary and conducted chi-square tests to determine if they differed based on the independent variables. If significant, I then

conducted binary logistic regressions to determine how that independent variable and STI stigma predicted outcomes.

If the dependent variable had four or fewer (i.e., negative, anxious, and guilty emotional reactions, accepting behavioral responses, supportive responses, and negative receiver outcomes) violations of normality, I proceeded with analyses and examined Levene's test. There were three cases where Levene's test was violated (i.e., negative, guilty, and accepting reactions). In these instances, either none or only one cell violated Shapiro-Wilk's test. Thus, I chose to proceed with ANCOVAs, as they provide fairly robust estimates (Rutherford, 2011).

The ANOVA for the dependent variables (positive receiver and relationship outcomes) were fairly normally distributed. Specifically, the residuals were fairly linear, as determined by Q-Q plot. Skewness for positive receiver outcomes was 0.94 and kurtosis was -0.14. Skewness for positive relationship outcomes was 1.24 and kurtosis was 0.71. The skewness and kurtosis values were within the acceptable range proposed by West et al. (1996). Values of skewness should be less than $|2|$ and of kurtosis less than $|7|$. I conducted these ANOVAs with untransformed dependent variables. For all ANOVAs and ANCOVAs, I used Bonferroni confidence interval corrections to adjust for multiple comparisons.

Three-Way ANCOVA Results

In all of the ANCOVAs, STI stigma was a significant covariate (see Tables 41-45) and STI stigma approached significance for negative receiver outcomes ($p = .06$; Table 46). There were no significant main effects of gender (Table 47) or relationship type (Table 48). There were significant main effects of STI type on negative emotional reactions ($p < .01$), guilty emotional reactions ($p < .01$), accepting behavioral responses ($p < .05$), and negative receiver outcomes ($p < .05$; Table 49). STI type approached significance for anxious emotional reactions ($p = .06$;

Table 49). Specifically, the estimated marginal means (EMM) of negative, anxious, and guilty emotional reactions and negative receiver outcomes were higher for participants who had received a bacterial STI disclosure (Table 49). The EMMs for accepting behavioral responses were higher for participants who had received a viral STI disclosure (Table 49). In other words, participants who had received bacterial STI disclosures had higher levels of negative, anxious, and guilty reactions and negative outcomes and lower levels of accepting behavioral responses.

There were significant interaction effects of gender and STI type on negative ($p < .05$) and guilty ($p < .05$) emotional reactions (Table 50). Anxious emotional reactions approached significance ($p = .06$; Table 50). Specifically, men had higher negative, anxious, and guilty emotional reactions when the STI disclosed was bacterial and lower when viral. Women's reactions did not differ based on STI type (Table 50). There were no interaction effects of gender by relationship type (Table 51), STI type by relationship type (Table 52), nor three-way interaction effects (Table 53).

Three-Way ANOVA Results

For the two ANOVAs, the models were not significant. Specifically, there were no significant differences in positive receiver and relationship outcomes for any independent or interaction terms. In other words, gender, STI type, and relationship type did not differentiate participants' responses. This is consistent with the results for these two variables in Study 1. This suggests that emerging adults experienced lower levels of positive individual and relationship outcomes, and the context of the disclosure did not matter, nor did their gender.

Chi-Square Results

I examined the distribution of responses for rejecting behavioral responses, unsupportive, avoidance, and negative relationship outcomes and transformed these variables into binary

variables. Additionally, I transformed reciprocity into a binary variable. Because the modified personal sexual history reciprocation did not load highly onto the construct, I chose to examine this item independently.

Rejecting Behavioral Responses

After analyzing the distribution of responses and to maintain an adequate count in each cell, I chose to split the data at the response value 2 (*a little*). Participants who had rejecting behaviors scores between 1.00-1.80 ($n = 59$) were coded as 0 (*less rejection*), and 2.00-5.00 ($n = 29$) were coded as 1 (*more rejection*). Based on the chi-square tests, none of the independent variables were associated with rejecting behavioral responses. Rejecting behaviors was positively associated with STI stigma ($r = .26, p = .02$).

Unsupportive

After analyzing the distribution of responses and to maintain an adequate count in each cell, I chose to split the data at the response value 2 (*a little*). Participants who had unsupportive scores between 1.00-1.75 ($n = 56$) were coded as 0 (*less unsupportiveness*), and 2.00-5.00 ($n = 32$) were coded as 1 (*more unsupportiveness*). Based on the chi-square tests, none of the independent variables were associated with being unsupportive. Unsupportive was positively associated with STI stigma ($r = .25, p = .02$).

Avoidance

Participants who had avoidance scores between 1.00-1.25 ($n = 62$) were coded as 0 (*less avoidance*), and 1.50-4.25 ($n = 26$) as 1 (*more avoidance*). I selected this binary coding scheme based on the distribution of responses in the current study, to maintain adequate cell counts, and to be consistent with the binary coding of avoidance in Study 1. Based on the chi-square tests,

none of the independent variables were associated with avoidance. STI stigma was positively associated with avoidance ($r = .38, p < .001$).

Negative Relationship Outcomes

After analyzing the distribution of responses and to maintain an adequate count in each cell, I chose to split the data at the response value 2. Participants who had negative relationship outcome scores between 1.00-1.75 ($n = 47$) were coded as 0 (*fewer negative relationship outcomes*), and 2.00-5.00 ($n = 41$) were coded as 1 (*more negative relationship outcomes*). Based on the chi-square tests, none of the independent variables were associated with negative relationship outcomes. STI stigma was positively associated with negative relationship outcomes ($r = .26, p = .02$).

Sexual Health Reciprocity

I examined the distribution of responses to the reciprocation item, “My personal sexual history.” Twenty-nine participants said they did not discuss this at all in response to their partner’s disclosure, 21 participants discussed “a little bit,” 12 “moderately discussed,” 17 discussed “quite a bit,” and 8 discussed “fully and completely.” These were dichotomously coded as 0 = *no sexual health reciprocation* ($n = 29$) and 1 = *sexual health reciprocation* ($n = 59$). Based on the chi-square tests, none of the independent variables were associated with reciprocity. The preliminary bivariate correlations examined the association between binary reciprocity with STI stigma and found no correlation ($r = .07, p = .51$).

Positive Emotional Reactions

Over 90% of participants said they did not have any positive emotional reactions, and this variable was not correlated with STI stigma, I ran *t*-tests. For relationship type and gender, Levene’s test was not violated, so I assumed equal variances for interpretation. There were no

differences in participants' mean positive emotional reactions for relationship type ($t = -.95, p = .34$) nor gender ($t = .77, p = .44$). Levene's test was violated for STI type ($F = 21.12, p < .001$), so I assumed the variances were not equal for interpretation. The results suggested that participants had slightly higher positive emotional reactions to a viral STI disclosure ($M = 1.43, SD = .91$) than a bacterial STI disclosure ($M = 1.04, SD = .14; t = -2.90, p = .006$). A mean difference of .38 in positive emotional reactions, although significant, is not particularly meaningful, especially when 90% of the sample said they had no positive emotional reactions whatsoever.

Discussion

The purposes of this study were to (a) describe the experiences of emerging adults who have received an STI disclosure from a sexual partner, (b) extend Study 1 research by confirming the factor structure of the STI Disclosure Reactions Measure (SDRM), and (c) determine whether relationship type, STI type, and gender differentiated these responses and outcomes, controlling for STI stigma. Despite the limited sample size, I was able to confirm the factor structure of some of the SDRM subscales with acceptable fit. The ANCOVA results suggested that STI stigma was an important covariate across analyses, and that STI type differentiated participants' responses and outcomes. Given the limited research on receivers of disclosure, the novelty of these descriptive analyses, and inferential analytic limitations, I focus primarily on discussing the disclosure experiences of participants, while still addressing the inferential analyses and their contribution.

Measuring Actual Disclosure Reactions

For empirical transparency, I reported all CFA findings, regardless of model fit. There is much controversy about using and interpreting various CFA fit statistics (Barrett, 2007; Hooper et al., 2008). Some scholars suggest that mediocre-fitting models should be rejected, but in the

case of new measures or small sample sizes due to population characteristics, these models *may* be interpreted on theoretical grounds (Barrett., 2007; Hooper et al., 2008). Because I examined a newly-developed measure with a difficult-to-reach population, I proceed with the interpretation of mediocre-fitting models, as well as the acceptable models.

The emotional reactions (feelings and behaviors) and support models had a mixture of poor, mediocre, and acceptable fit statistics. All of the models were specified based on the EFA findings from Study 1, but the responses that receivers experienced may load differently than the anticipated responses of participants in Study 1. It is possible, even, that these items may generate a factor structure similar to the expected structure in Study 1. For example, when examining the loading values for the support CFA (Figure 5), the items originally designed to assess emotional support load highly onto the construct, from $\lambda = .84$ to $.95$. The items designed to measure instrumental support load somewhat lower (help $\lambda = .74$; assist $\lambda = .62$). The informational support items loaded even lower (common $\lambda = .55$, advice $\lambda = .41$, information $\lambda = .41$). It is possible that these items, for actual receivers, are loading consistent with Magsamen-Conrad's (2014) discussion of support.

The reciprocity model had mixed fit statistics, with one or more acceptable fit statistic. The original Self-Disclosure Index items (Miller et al., 1983) I used had standardized loadings between $\lambda = .76$ and $\lambda = .93$, whereas the modified item ("My personal *sexual* history") had a lower, but still significant, loading ($\lambda = .44$). Disclosing personal sexual health information, whether initiating or reciprocating, is likely distinct from reciprocating other disclosures. The DD-MM (Greene, 2009) describes how reciprocity in health research is understudied but may be part of this process. Specifically, when deciding and planning to disclose, this process may be interrupted by the intended receiver's disclosure, whereby the individual proceeding through the

decision-making process decides to reciprocate (Greene, 2009). This description of reciprocity suggests that the intended receiver is not reciprocating but initially disclosing, and that the individual who was deciding to disclose (in this case, the person with the STI) is a reciprocal discloser. In contrast, Magsamen-Conrad (2014) explains that when considering anticipated responses, potential disclosers may anticipate reciprocity from the intended receiver, influencing their decision to disclose. In other words, Greene (2009) conceptualized the discloser as reciprocator, whereas Magsamen-Conrad (2014) conceptualized the receiver as reciprocator. In the context of STI disclosure, the literature does not generally suggest that people anticipate their partner will reciprocate an STI disclosure, but rather use partners' disclosures as vehicles to disclose their own STIs (Lee & Craft, 2002; Swanson & Chenitz, 1993; see Table 5). Future research is needed to examine how reciprocity manifests in receivers' experiences. This research can be used to determine if a measure for STI disclosure reciprocity is necessary and, if so, to develop a measure that more effectively captures this experience.

The receiver and relationship outcome models had mixed fit statistics, the majority of which were acceptable. The loadings (with the exception of positive emotional health in the receiver model [see Table 37 and Figure 8]) were high. Additionally, the avoidance model had acceptable model fit across all fit indices, suggesting these items are effectively capturing the construct in this population. The combination of these close fit statistics and high loadings suggests that these models may be effectively capturing these constructs among receivers, but as with the other CFAs, these results should be interpreted in light of the sample size and distribution limitations.

STI Stigma and Type

Similar to Study 1, STI stigma was an important correlate. Receivers with higher stigmatizing beliefs tended to report higher negative and lower positive responses. Across both studies, STI stigma was clearly an important construct. Among emerging adults, STI stigma is highly prevalent (Hirschler et al., 2015) and affects disclosure intentions (e.g., Coffelt et al., 2021; Emmers-Sommer et al., 2010). Clearly, having stigmatizing attitudes toward those with STIs influences emerging adults' reactions to disclosures, which could have detrimental effects on the discloser (Nack, 2000).

Distinct from the previous study, there were important main effects of STI type and interaction effects of STI type and gender. Receivers of bacterial STI disclosures reported more negative, anxious, and guilty emotional reactions, and negative receiver outcomes than receivers of viral STI disclosures. STI type may have implications for how individuals are perceived by others, beyond what had been revealed in the disclosure literature. While previous research suggests that viral STIs are more highly stigmatized due to their incurable nature (Lee & Craft, 2002; Nack, 2000), the current study suggests that bacterial STIs elicit negative responses. Receivers may have more negative responses *because* the STI could have been more easily prevented. Routine sexual health screenings to detect bacterial infection and using prophylaxis consistently to prevent infection may have been an expectation for these participants, and upon disclosure, this expectation was violated. It is also possible that this explanation is insufficient, as emerging adults often have inaccurate beliefs about STIs (Ethier et al., 2003; Hirschler et al., 2015). Regarding viral STIs, sometimes the source of the infection is important in tempering reactions (Coffelt et al., 2021; McCaffery et al., 2006; Perrin et al., 2006). For example, participants were more accepting when a viral STI was disclosed. It is possible that the discloser

emphasized that they either did not know about their STI, or they contracted the STI from a previous partner who did not disclose (Coffelt et al., 2021; McCaffery et al., 2006; Perrin et al., 2006). In this way, these disclosers may have generated more sympathy.

Men reported more negative, anxious, and guilty emotional reactions when the STI was bacterial, whereas women's reactions did not differ by STI type. This once again highlights the salience of gender norms in relation to STIs. Because the responsibility for sexual health is often placed on women (East et al., 2010), it is possible that the women in this study were socialized to react in certain ways, regardless of the type of STI. The disclosure of a bacterial STI may have generated an increased sense of urgency or panic in men for a variety of reasons, including the often-asymptomatic nature of bacterial STIs (the disclosure may have caught them off guard).

Receiver Experiences with Disclosure

An important contribution of this study is the examination of the experiences of disclosure recipients. Results from the systematic literature review (Chapter 2) revealed that of the included studies, only three examined receivers; two of these examined hypothetical disclosure scenarios and anticipated reactions (Emmers-Sommer et al., 2010; Smith et al., 2014), and one examined actual receivers' experiences (Coffelt et al., 2021). Using a college student convenience sample, Emmers-Sommer et al. (2010) examined perceptions of STI disclosure and asked participants to specify possible reactions a receiver might have. Smith et al. (2014) also used a college student convenience sample to examine how young adults would disclose an HPV diagnosis, or respond to an HPV disclosure, to/from a trusted confidant. Most identified the hypothetical discloser or receiver as a friend or parent (86%); few identified significant others (11%) or sexual partners (10%). These two studies contribute to our understanding of young adults' anticipated experiences with disclosure but do not reflect actual experiences.

The Coffelt et al. (2021) study had not yet been published when the studies for this dissertation were conducted. Both the Coffelt et al. (2021) study and the current study sought to examine the experiences of receivers and investigated similar research questions. Coffelt et al. (2021) collected data from 161 disclosers and 130 receivers (total $N = 517$), and these participants were slightly older ($M = 31.7$, no SD reported) than the participants in the current study ($M = 25.05$, $SD = 3.18$). They examined whether (non) disclosers' decisions varied by STI type (viral vs. bacterial) and gender (men vs. women) but found no significant results. Their study did not examine whether there were any differences based on these variables for receivers (Coffelt et al., 2021). They did describe the receivers' reports of the quality, timing, and delivery method of disclosures, as well as desire to dissolve the relationship, similar to the current study. The overlap between the current study and Coffelt et al.'s (2021) study highlight some of the important gaps in the STI disclosure literature. A unique contribution of the current study is the exclusive focus on disclosure recipients and detailed assessment of the disclosure experience and their reactions.

Disclosure in Emerging Adulthood

This dissertation used the period of emerging adulthood (Arnett, 2015) as a guiding framework. It is important to note that emerging adulthood and its associated opportunities may only be applicable to those with the privilege to engage in sexual exploration and experimentation, which is often those who are able to attend college (Arnett, 2015). I did not examine differences between college and non-college emerging adults in the current study, but findings suggest that disclosure experiences may be informed by differences in college experience. I found that most participants reported receiving the disclosure between the ages of 18 and 22 (55.7%). Further, 77.3% of participants reported having either some college

experience or a two- or four-year degree. Being diagnosed with STIs and receiving disclosures are not unique to college students, but research suggests that college students may be at greater risk for STI contraction than non-college emerging adults. Specifically, the college hookup culture (Garcia et al., 2012), college drinking culture (Olmstead et al., 2019), and inadequate sexual health education (Fields et al., 2015) may contribute to this increased risk (Arnett, 2015; Turchik & Garske, 2009). Future research should investigate how the experiences of both STI disclosers and receivers may be informed by or vary as a function of college experience.

Sexual Relationships and Behaviors

The STI disclosure literature suggests that disclosure is more likely to occur in committed romantic relationships than non-committed or casual sex relationships (e.g., Bickford et al., 2007; Green et al., 2003; Myers et al., 2016). Most participants (59.1%) reported being in a committed relationship with the discloser and 40.9% were in a non-committed relationship with the discloser. Although most were in committed relationships, about one-third of the sample received disclosures from non-committed partners. Although not generalizable, these data suggest that disclosures to non-committed partners may be more common than previous research suggests.

Consistent with Bickford et al.'s (2007) research, most participants (68.2%) in this study reported that disclosure occurred after first sexual engagement. To prevent the spread of STIs, the CDC (2020b) recommends that STI disclosure should occur before sexual activity occurs, and that individuals and couples should pursue regular STI testing prior to having sex. I did not ask participants why (from their perspective) the disclosure happened before or after, which is a limitation of this study. It is possible that the disclosers did not know about their STI prior to having sex, which would highlight the need for routine STI testing when initiating sexual

relationships. Results from the systematic literature review (Chapter 2) highlight numerous reasons why disclosers may have withheld disclosure, including fear of rejection (e.g., Arima et al., 2012; Myers et al., 2016; Swanson & Chenitz, 1993). This research has not examined the associations between disclosure motivations and timing. I am not able to specify why (from the receivers' perspectives) most disclosures occurred after first sex, but these findings are consistent with the published research on STI disclosure timing (Bickford et al., 2007; Myers, 2020).

Despite most disclosures occurring after the possibility of transmission, most receivers reported that their partners voluntarily told them about the STI (72.7%), whereas only 11.4% reported asking about their partner's sexual history without external prompt (e.g., finding out about infidelity). The responsibility for initiating sexual health discussions tends to fall on the partner with an STI (Myers et al., 2016). STIs are stigmatized (East et al., 2010; Hirschler et al., 2015; Lee & Craft, 2002; Lo et al., 2009) and initiating those conversations may be uncomfortable for partners who do not have STIs, or they have no perceived need to ask (i.e., placing the responsibility to tell on the person who *has* something to tell; Myers et al., 2016). It is important that all parties involved in a relationship take individual responsibility for their sexual health by getting regular STI testing and communicating with one another about STI status and sexual health prior to engaging in any behaviors that could transmit the infection (CDC, 2020b; Myers et al., 2016). Placing the responsibility on disclosers alone emphasizes that sexual health is their responsibility only and further stigmatizes people with STIs and the disclosure process.

Research suggests that some people with STIs are fearful of being broken up with if they disclose and thus withhold the information (Arima et al., 2012; Coffelt et al., 2021; Keller et al., 2000). Findings from the current study revealed that most participants (67%) continued the

relationship with the discloser, rather than dissolving the relationship. I conducted a post-hoc chi-square test to determine if relationship continuation or dissolution differed based on relationship type (committed or non-committed) and found no differences ($\chi^2(1) = 0.27, p = .60$). A post-hoc chi-square test of STI type revealed differences in dissolution. Of the 40 participants who received a bacterial STI disclosure, 20 (50%) ended the relationship and 20 (50%) continued the relationship, whereas 39 (81.3%) of the 48 viral disclosure receivers continued the relationship and only 9 (18.8%) ended the relationship ($\chi^2(1) = 9.64, p = .002$). I cannot conclude that STI type alone is responsible for participants' decisions to continue or dissolve the relationship, but these findings are consistent with results from the inferential analyses in this study: receivers of bacterial disclosures reported more negative, anxious, and guilty reactions and negative outcomes. The circumstances in which the partner contracted the STI may influence receivers' rejection or acceptance of the partner (Emmers-Sommer et al., 2010), which could explain these results. Future research is needed to investigate why some receivers choose to dissolve the relationship post-disclosure and others continue the relationship.

Limitations

One important limitation of this study is the inadequate sample size. Larger sample sizes are recommended for conducting CFAs, but smaller sample sizes may be acceptable when the population is difficult to access (Barrett, 2007; Hooper et al., 2008). Although I used bootstrap estimation, the majority of models had mixed model fit. To determine if the SDRM is applicable to both anticipated and actual reactions, future research is needed. Specifically, obtaining a large enough sample of receivers is an obvious next step. In a similar vein, my decision to conduct subsequent analyses after the CFAs, despite mixed model fit, should be taken into consideration. Although many of the models had acceptable CFI, TLI, and SRMR fit, they violated other fit

statistics (usually chi-square and RMSEA indices). Rather than rely solely on fit statistics, I also considered how the models fit within the context of the DD-MM (Greene, 2009).

The responses to and outcomes of disclosures for actual receivers may be, and likely are, conceptually different from the anticipated reactions of emerging adults. The avoidance, receiver outcomes, and relationship outcomes had overall acceptable model fit, suggesting that these constructs may be consistent across hypothetical and actual disclosure experiences. The other models, including the emotional reactions and support models, suggest that these constructs (as specified based on Study 1 EFAs) may not translate across these experiences. A more fitting approach may have been to conduct EFAs for this study, to determine the factor structure among this sample of actual receivers of an STI disclosure.

Another important limitation to consider is that the receivers' responses were likely biased by time. This study asked participants to reflect back on their reactions. With time, their reactions may have changed and influenced their perception of future reactions. This is one reason that couple-research is an important future direction. Studying the disclosure-interaction processes among couples in real time would greatly illuminate these processes.

Similar to Study 1, the majority of participants were White/Caucasian and heterosexual. Thus, the results do not necessarily capture the unique experiences of racial and sexual minorities (Feinstein et al., 2018; Lichtenstein, 2003). Another limitation is the failure to meet some analytic assumptions. Skewed distributions and inequality of variances made some of the planned analyses impossible. One possible reason for this is the small sample size.

Implications

Despite these limitations, the current study has important implications. First, emerging adults (or any developmental stage) who have received an STI disclosure from a sexual partner is

notably a difficult population to sample. Thus, a strength of this study is the acquisition of a sample of 88 emerging adults who received STI disclosures. Despite the limited ability to conduct analyses with sufficient power, I was able to provide meaningful and important descriptive information about this population. As my systematic literature review revealed, very few studies have considered the perspectives of receivers, let alone described the processes and mechanisms of the disclosure, from the receiver's perspective. From this study, we have begun to understand the relational and behavioral aspects of these relationships and disclosure experiences.

For example, these results reveal that almost 70% of participants were not disclosed to until *after* they engaged in sexual activities with their partner, which has implications for public health. The CDC recommends that one of the most effective methods for reducing the spread of STIs is through disclosure (2020b). Yet, both the STI disclosure research (e.g., Arima et al., 2012; Bickford et al., 2007; Coffelt et al., 2021; Myers, 2020; Swanson & Chenitz, 1993) and the results from this study suggest that over half of individuals with STIs waited until after engaging in sexual behaviors to disclose their STI. Curbing the spread of STIs seems a daunting task, if disclosure is not happening until after transmissible behaviors occur.

Pros and Cons of Disclosure

Disclosure is an emotionally complex issue, and there is not a one-size-fits-all approach. Although disclosure is recommended to reduce the spread of STIs and allow receivers to make informed decisions about engaging in sexual activity (CDC, 2020b), there are circumstances where it may not be beneficial or safe to disclose. Some individuals have expressed fear of violent retaliation as a direct response to disclosure (Cunningham et al., 2007; Decker et al., 2011), and some in fact do experience violent reactions (Decker et al., 2011). In circumstances

such as these, we cannot expect individuals to disclose an STI, if violence will result. In the current study, 97.7% of participants indicated that they did not become physically violent with their partner in response to the disclosure. However, one participant indicated they became “a little” physically violent, and another indicated they became “quite a bit” violent. These statistics, despite the low percentage, are concerning and highlight the risk that many individuals with STIs take when deciding to disclose.

Regarding the less severe reactions, participants in the study still reported experiencing negative responses and outcomes. Being informed of potential STI exposure is not likely to elicit positive responses. Receivers should not be shamed for experiencing negative feelings in response to a disclosure. However, it is also important that we strive to change cultural attitudes about STIs and those with them. Instead of stigmatizing the individual, we should move toward a culture that actively and collectively takes responsibility for sexual health. Just as the CDC encourages mask-wearing, social distancing, and vaccination to curb the spread of COVID-19 (2021c), the CDC encourages the use of condoms and dental dams, HPV and hepatitis B vaccinations, and preventative disclosure to curb the spread of STIs (CDC, 2020b). Yet, we know that many emerging adults do not consistently use condoms (Turchik & Garske, 2009), do not get the HPV vaccine (Allen et al., 2009), and do not disclose prior to having sex (e.g., Arima et al., 2012; Coffelt et al., 2021; Myers, 2020).

Sexual Health and Relationship Education

Collectively, these results highlight the need to improve sexual health education for U.S. youth. Whether disclosure does not occur out of fear, belief that disclosure is unnecessary, or lack of accurate sexual health knowledge, disclosure often does not occur. Sexual education programs are encouraged to begin incorporating information about disclosure, including

individuals' experiences with disclosure, possible outcomes, and strategies to effectively communicate and receive the information. Further, as discussed in the previous study, broad, socio-cultural shifts in attitudes toward sexual health may help facilitate changes that will increase disclosure rates and ultimately decrease STI rates. Encouraging parents to have active, ongoing conversations with their children, making policy changes toward more comprehensive and inclusive sexual health education, and changing the cultural messages portrayed about those with STIs are all lofty but important directions.

Further, working to improve the individual and relational experiences in the context of disclosure is another important step. For example, in the current study, 67% of participants continued their relationship with the discloser, despite experiencing unpleasant reactions. For couples who have experienced a disclosure, counseling for coping with the information and engaging with one another could further improve relationship outcomes. For individuals who have not yet disclosed, counseling interventions could provide strategies to improve disclosure efficacy, or even safe settings within which to disclose. In this way, partners could also work toward building efficacy and receiving the information empathetically, while also being validated for their reactions.

CHAPTER 5:

Conclusion

Research on the disclosure of sexually transmitted infections has blossomed over the last two decades, but the research does provide insight into these processes among emerging adults and recipients of disclosures. As the highest-risk population for STI contraction (Kirzinger et al., 2020), it is important to understand the processes of STI disclosure among this population. Further, disclosers are only one part of a dyadic process. In order to understand the disclosure process, we must also understand the experiences of receivers. Finally, the field has generally lacked theoretical guidance, which is important for postulating future hypotheses and applying research in real-world contexts. This three-part dissertation informed the STI disclosure literature in three ways: (a) systematically and critically reviewing the STI disclosure literature, (b) examining emerging adults' anticipated and (c) actual reactions to STI disclosures and the effects of relationship type, STI type, gender, and STI stigma, all couched within the context of the Health Disclosure Decision-Making Model (Greene, 2009).

The first manuscript synthesized and critiqued the extant STI disclosure literature in order to provide guidance for future research, education, and interventions. Findings from the review suggest that much of the STI disclosure research has not explicitly used guiding frameworks or a developmental lens, has not used or established consistent operationalizations for measurement, and varies in the strength of the methodological approach. Further, findings reveal that individuals with STIs experience a variety of feelings and emotions related to the prospect of disclosure, including anxiety, anger, guilt, and fear. There are various reasons for and against disclosure, most of which are central to the intended receiver. Feelings of moral obligation, love for partner, and desire for support are some of the most important reasons for disclosure. Fears about partner's reaction and response, fears of being rejected or broken up with, and beliefs about the lack of obligation were the most salient reasons to withhold disclosure.

The review revealed that disclosers enact various strategies, including the use of priming messages, framing, and direct disclosure. Non-disclosers use strategies to pass as uninfected (i.e., passing), withdraw from relationships, and the timing of outbreaks as strategies for non-disclosure. The review also revealed that, generally, only 50% or fewer individuals disclose prior to engaging in sexual activity. The findings indicate that by-and-large, relationship-related factors were important predictors of disclosure, including the type of relationship, length, quality, and closeness of the relationship, and the level of commitment between partners. Finally, the review suggests that some individuals do experience negative partner responses, whereas others experience positive partner responses and relationship outcomes. In the review of this literature, the experiences of receivers of STI disclosures was not well-represented.

The second and third manuscripts addressed limitations in understanding the perspectives and experiences of emerging adults as disclosure recipients. Specifically, these manuscripts examined emerging adults' anticipated (manuscript two) and actual (manuscript three) reactions to STI disclosures and how relationship type, STI type, gender, and STI stigma differentiated these responses. The findings suggest that STI stigma is associated with both anticipated and actual negative responses and outcomes. These findings mirror the research on disclosers' experiences with STI stigma. Specifically, perceiving STI stigma is not only harmful for the sexual self but is also associated with motivations to withhold disclosure, as are anticipated negative reactions (e.g., East et al., 2010; Lee & Craft, 2002; Myers et al., 2016; Nack, 2000; Newton & McCabe, 2005).

Findings from these studies also highlight the important role of receiver gender. In the second manuscript, I found that women tended to anticipate more negative, anxious, and guilty emotional reactions than men. Further, women who were assigned hypothetical disclosure

scenarios in which the discloser was a non-committed, casual sex partner had greater anticipated anxious and guilty reactions. These results highlight the pervasiveness of the Sexual Double Standard (Conley et al., 2013; Petersen & Hyde, 2010) and how women are often blamed for the transmission of STIs (East et al., 2010; Nack, 2000). In the third manuscript, I found that women's negative, anxious, and guilty reactions to the disclosure they received did not differ by STI type, whereas men reported higher levels when the STI was bacterial. These results again emphasize the salience of gender norms in relation to STIs. Women's emotional reactions may not have differed by type, because regardless of type, they are held responsible (East et al., 2010).

Results from these studies also reveal that STI type differentiated responses. In manuscript two, participants anticipated more unsupportive responses in the context of a bacterial STI disclosure. I found that similarly, in the third manuscript, negative, anxious, and guilty emotional reactions and negative receiver outcomes were higher for participants who received a bacterial STI disclosure. Although the literature is inconclusive about the relationship between disclosure and STI type, the results from this study suggest that bacterial STIs elicited more negative responses than viral STIs. Although research suggests that viral STIs are more highly stigmatized due to their incurability (Lee & Craft, 2002; Nack, 2000), it is possible that emerging adults stigmatize bacterial STIs more because they are easily prevented and treated, or they are less likely to be long-term infections.

In conclusion, the examination of STI disclosure and receivers of such to date has been limited. This three-part dissertation addressed some of the limitations and highlighted important areas for future research, education, and intervention. The systematic review shows that relationship factors are salient predictors of disclosure, and that individuals have a variety of

different reasons for and against disclosure. The findings from the two studies highlight the salience of STI stigma and gender in differentiating reactions to disclosures. Despite the other independent variables, STI stigma was an important predictor. Further, many of the results highlight the salience of the Sexual Double Standard in the context of STI disclosure. The concerns and fears of disclosers are valid. Negative reactions are possible and do occur, but these studies showed that reactions may depend on the relational context, type of STI, and gender of the receiver.

These manuscripts hold important implications for future research, education, and intervention. First, one of the primary goals of the two studies was to develop the theoretically-informed STI Disclosure Reactions Measure (SDRM). Future research should expand upon the results from the current study and continue to investigate the factor structure and validity of this measure, using sufficient sample sizes and across populations. Second, these manuscripts highlight the need to include receiver perspectives and experiences in the STI disclosure research. Future research should continue to investigate the experiences of receivers, as well as move toward a dyadic approach, examining disclosure processes among couples, not just disclosers and receivers separately. These processes do not happen in a vacuum, and it is important to consider the couple-context when conducting this research.

These manuscripts highlight the pervasiveness of STI stigma and its place in the disclosure process. I have called for broad, socio-cultural change in the ways we think and learn about STIs. Specifically, sexual health education programs should make strides toward incorporating curricula that address the harmful effects of STI stigma on disclosers and its effect on receivers' reactions. Further, continuous efforts should be made to de-problematize STIs, focusing on prevention efforts and stigma reduction, rather than the use of fear and disgust

tactics (Fields et al., 2015). Finally, these manuscripts highlight the importance of context associated with disclosure. Relationship factors are important contributors to the disclosure process and outcomes, and as such, should be addressed in relationship education and intervention. Disclosers, receivers, and couples would benefit from programs designed to improve their efficacy at engaging in these discussions.

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APPENDICES

APPENDIX 1:

Chapter 2 Tables and Figures

Table 1. PsycINFO Search Strategy

1) STIs	
Key words:	("Sexual* transmitted infection*" OR STI OR STIs OR "sexual* transmitted disease*" OR "STD" OR "STDs" OR "Sexual* communicable disease*" OR "Sexual* communicable disease*" OR ("venereal disease" OR "venereal diseases") OR "venereal infection*" OR "genital herpes" OR herpes OR "herpes genitalis" OR "human papillomavirus" OR HPV OR Chlamydia OR Gonorrhea OR "Pubic lice" OR phthiriasis OR Phthirus OR "Crab lice" OR "pubic louse" OR "crab louse" OR Trichomoniasis OR Trichomonas)
Controlled vocabulary:	(MJMAINSUBJECT.EXACT("Sexually Transmitted Diseases") OR MAINSUBJECT.EXACT("Herpes Simplex") OR MAINSUBJECT.EXACT("Human Papillomavirus") OR MAINSUBJECT.EXACT("Gonorrhea") OR MAINSUBJECT.EXACT("Syphilis"))
AND	
2) Disclosure	
Key words:	("self disclosure") OR disclosur* OR notif* OR ("partner notification") OR "self-disclosure*")
Controlled vocabulary:	(MJMAINSUBJECT.EXACT("Self-Disclosure") OR MJMAINSUBJECT.EXACT("Interpersonal Communication") OR MJMAINSUBJECT.EXACT("Secrecy") OR MJMAINSUBJECT.EXACT("Privacy"))
NOT (added after first combined search)	
3) Exclusion Terms	
subt.exact("hiv" OR "hiv infections" OR "aids prevention" OR "hiv seropositivity" OR "aids" OR "hiv testing" OR "child" OR "pregnancy" OR "anti-hiv agents" OR "substance-related disorders" OR "aids serodiagnosis")	
Parameter Limitations: Limited to English, peer-reviewed, and searched “anywhere but full text” (NOFT)	
Search Steps	
<u>1. Controlled Vocabulary</u> Date of search: 10/1/2020 Total number of hits: 79	<u>3. Combined</u> Date of search: 10/1/2020 Total number of hits: 504
<u>2. Key Terms</u> Date of search: 10/1/2020 Total number of hits: 504	<u>4. Combined with “NOT” filters</u> Date of search: 10/1/2020 Total number of hits: 200

Table 2. PubMed Search Strategy

1) STIs	
MeSH Terms	("sexually transmitted diseases, bacterial"[MeSH Terms] OR "Sexually Transmitted Diseases"[MeSH Terms] OR "sexually transmitted diseases, viral"[MeSH Terms] OR "Syphilis"[MeSH Terms] OR "Gonorrhea"[MeSH Terms] OR "Chlamydia"[MeSH Terms] OR "Chlamydia Infections"[MeSH Terms] OR "Lymphogranuloma Venereum"[MeSH Terms] OR "Herpes Genitalis"[MeSH Terms] OR "Chancroid"[MeSH Terms] OR "Granuloma Inguinale"[MeSH Terms] OR "Human papillomavirus 16"[MeSH Terms] OR "Human papillomavirus 31"[MeSH Terms] OR "11 protein human papillomavirus type 6"[Supplementary Concept] OR "12 protein human papillomavirus type 18"[Supplementary Concept] OR "Phthirus"[MeSH Terms])
AND	
2) Disclosure	
MeSH Terms	("Self Disclosure"[MeSH Terms] OR "Truth Disclosure"[MeSH Terms] OR "Disclosure"[MeSH Terms] OR "Disease Notification"[MeSH Terms] OR "Confidentiality"[MeSH Terms] AND "Self Disclosure"[MeSH Terms] OR "Truth Disclosure"[MeSH Terms] OR "Disclosure"[MeSH Terms] OR "Disease Notification"[MeSH Terms] OR "Confidentiality"[MeSH Terms])
NOT	
3) Exclusion Terms	
(HIV OR AIDS)	
<u>Search Steps</u>	
<u>1. MeSH Search</u>	
Date of search: 10/6/2020	
Total number of hits: 53	

Table 3. *Title/Abstract Screening Form*

TITLE/ABSTRACT SCREENING QUESTIONS FOR DATABASES	NO	YES
1. Does the study introduce primary data?		
2. Does the study include participants ages 18-29?		
3. Does the study examine HIV/AIDS exclusively?		
4. Does the study examine self-disclosure of an STI?		
5. Does the study examine factors associated with disclosure or decision-making?		
<i>NOTE: If any answer falls into a “No” for Question 1-3, then the study will be excluded.</i>		

Table 4. *Summary of Included Studies, Sorted by Study Design*

Quantitative studies

Study #	Author & Year	Study Setting	Study Objective	Study Design	Theory	Sampling & Sample	Data Collection & Analysis	Key Findings	Quality
1	Arima et al. (2012)	United States Seattle (urban)	Determine factors associated with self-reported disclosure of incident high-risk HPV infection; determine whether disclosure is associated with discussion of pap test/HPV vaccine; determine whether disclosure is associated with a perceived change in relationship	Longitudinal	No theory	N=81, 264 analytic observations $M_{age} = 21.0$ (SD = 1.0, range = 18-21) Males/Men 79% White STIs: HPV (high-risk) Convenience sampling	Online survey Generalized linear model (binomial family, log-link)	Disclosure reported in 81 of 264 (31%) partnerships. 43 (51%) of disclosures immediately after diagnosis; 18 (22%) of disclosures within first week of diagnosis. Reasons for disclosure focused on honesty (90%), belief that disclosure was the right thing to do (89%)& caring for her (88%). The reasons against disclosure were diverse; the most commonly reported were thinking condoms were enough (35%), not being in a serious relationship with the partner (34%), not knowing what to say (31%), embarrassed (27%), & thinking disclosure was not important (25%). Only 8% reported fear of rejection as reason against disclosure. Disclosure was associated with main partner type (i.e., the partner was a committed/main partner as opposed to a casual sex partner), longer partnership length, & fewer sexual partner numbers. Disclosure was associated with increased likelihood of discussing pap smear/vaccine but not associated with relationship changes.	Moderate

Table 4. Continued...

2	Decker et al. (2011)	United States California (urbanicity not described)	Assess associations of IPV victimization with 1) fear of partner notification, 2) experiences of STI partner notification, and 3) partner response to notification.	Cross-sectional	No theory	N=1282 No M _{age} given (range = 16-29) Females/Women 30% Hispanic, 28% Black, 22% White STIs: Unspecified ("STD or HIV")	Audio Computer Assisted Survey Instrument (ACASI) in family planning clinics Not explicitly stated. Estimated adjusted risk ratios.	Half of the sample (53.3%) experienced IPV, and those who did were more likely to be afraid to notify partners (ARR: 1.46, CI 1.2-1.77). IPV history was not directly related to partner notification, but the partners of women exposed to IPV were less likely to seek testing after notification (ARR: 0.93, CI 0.86-0.99) and were more likely to respond by saying the STI was not from them or accuse the partner of cheating (ARR: 1.56, CI 1.24-1.98). A small percentage (5.4%) of the women experienced threat of or actual harm in response to disclosure.	Moderate
3	Mohammed et al. (2010)	United States New Orleans, LA (urban)	Determine the factors associated with disclosure of three treatable sexually transmitted diseases. Specifically, using partner referral (PR) as the reference group, to determine if patient delivered partner therapy (PDPT) or booklet enhanced partner referral (BEPR) increased disclosure to sexual partners in 1) urethritis infection in men caused by chlamydia or gonorrhea attending a public STD clinic and 2) trichomoniasis infection in women at public family planning clinic.	Randomized control trials	No theory	<u>Men</u> N = 977 No M _{age} given Median age = 24.2 (range = 16-44) 95.7% Black/African American STIs: Chlamydia & gonorrhea <u>Women</u> N = 463 No M _{age} given Median age = 23.7 (range = 16-44) 99.1% Black/African American STIs: trichomoniasis	ACASI at clinic at baseline and follow-up between 21-56 days crude and adjusted associations using generalized estimating equations regression	<u>Men and Women</u> Disclosure occurred to 57.8% (men) and 87.3% (women) of partners. Among men, disclosure more likely to occur if participants had only one sex partner (AOR: 1.54 [1.10, 2.16]), were in steady relationships (1.37 [1.08, 1.74]), were assigned to PDPT (2.71 [1.93, 3.82]), and were ≥24 years old (1.39 [1.07, 1.83]). Among women, disclosure more likely to occur in steady relationships (2.65 [1.24, 5.66]). No difference in disclosure based on treatment type. Both men and women less likely to disclose to casual partners.	High

Table 4. Continued

4	Myers (2020)	93.5% United States Urbanicity not described	"examining when in the sexual and romantic development of a relationship disclosure occurred with one's last sex partner"	Cross-sectional	No theory	N= 92, 66 in analytic sample $M_{age} = 39.2$ (SD = 13.5, range = 18-73) 79.6% Female 80.4% White STIs: genital herpes	Online survey Chi-square/Fisher's Exact tests	80.4% disclosed to last partner but after several milestones. Disclosure prior to oral sex was higher when participants received oral (58.9%) than performed oral (45.6%). Over half disclosed before vaginal and anal sex. Participants who disclosed were more likely to have engaged in romantic milestones than participants who did not disclose ($p = .03 - <.001$).	Moderate
5	Myers et al. (2016)	93.5% United States Urbanicity not described	"identify common reasons for disclosure and non-disclosure [of herpes] and determine which individual and partner characteristics are associated with disclosure	Cross-sectional	No theory	N= 93 $M_{age} = 39.2$ (SD = 13.5, range = 18-73) 79.6% Female 80.4% White STIs: genital herpes	Online survey Bivariate associations (t-tests, Chi-square/Fisher's Exact tests); Binary logistic regression	age only individual-level bivariate predictor that was significant ($t(90) = 2.78, p = .007$). Non-disclosers were younger ($M = 31.44, SD = 11.7$) than disclosers ($M = 40.93, SD = 13.32$) committed relationships more likely to disclose ($p = .003$); shorter relationships disclosed at lower rates than longer ($p = .024$). participants who did not disclose anticipated more negative reactions than those who did $p < .001$ binary logistic regression: anticipated reaction and partner type remained significant. for every 1-point increase in expectations of neg reaction, odds of disclosure decreased by 80%. comm relationships had 8.31 greater odds of disclosing. selected reasons for disclosure (honesty, protect from getting, right to know) non-disclosure (concerned partner react badly, ashamed, reject)	Moderate

Table 4. Continued...

6	Newton & McCabe (2008b)	Country not stated (most likely Australia, based on authors' other 2008 publication) Urbanicity not described	Does the sexual self-concept of people with herpes and HPV be different from those without STIs (control group)? Does sexual self-concept in those with STIs differ by relationship status/type? Among those in relationships, is the sexual self-concept of those who have not disclosed their STI different from those who have?	Cross-sectional	No theory	N= 274 Herpes (45 men, 72 women) $M_{age} = 36.54$; HPV (24 men, 58 women) $M_{age} = 27.66$; No STI (20 men, 55 women) $M_{age} = 31.5$ No Race Given STIs: genital herpes, HPV	Online surveys 3x3 MANOVA	Among those with herpes who were in a relationship, half disclosed. Most people with HPV in relationships did not disclose. Those who had not disclosed had more sexual anxiety, lower sexual esteem, were less sexually satisfied, and were more sexually depressed than those who had disclosed.	Moderate
7	Pfeiffer et al. (2016)	United States Urbanicity not described	Identify intra- and inter-personal predictors of willingness to disclose an STI among college-aged men.	Cross-sectional	No theory	N = 1064 $M_{age} = 20.1$ (SD = 1.3, range = 17-24) Males/Men No Race Given STIs: unspecified, asked about "STDs"	Online survey T-tests, Chi-square tests, binary logistic regression	80% said they would disclose. Partner type & masculinity remained significant predictors in multivariate analysis. Those whose last partner was casual, almost 40% less likely to disclose. For every 1 unit increase in masculinity scores, participants were 15% less likely to disclose.	Low

Table 4. Continued...

8	Scrivener et al. (2008)	London, England Urban (London)	To investigate psychological functioning, stigma perception, disclosure outcomes and regret about the disclosure decision in people being treated for anogenital warts, comparing disclosers and non-disclosers and evaluating the possible predictors of disclosure.	Cross-sectional	No theory	N = 54 (36 disclosed, 18 did not disclose) No M _{age} given Median age = 27 66.7% Men 57% White STIs: HPV (genital warts)	Survey T-tests, Chi-square tests, binary logistic regression	Relationship length & closeness greater for disclosers. Disclosers were less likely to categorize relationship as casual. Disclosure decision regret was higher in non-disclosers. All expected neutral responses to disclosure. Actual responses were better than expected. After disclosure, most participants reported no changes in their relationship closeness, but 12 said they became closer. 10 participants said their partner became more supportive. Most commonly reported reasons for disclosure (partner's right to know, want to be honest, did not want to infect). Most common non-disclosure reasons (embarrassed, might respond negatively).	Moderate
9	Yang & Pittman (2017)	United States Urbanicity not described	RQ1: Would STI framing and causal attribution framing moderate the impact of shame on disclosure intentions? RQ2: Would STI framing and causal attribution framing moderate the impact of stigma on disclosure intentions?	Quasi-experimental (cross-sectional)	Attribution Theory & Prospect Theory (message framing)	N = 359, 272 in analytic sample No M _{age} given Ages 18-50, only 6 participants >26 56.3% Men 55.4% White STIs: HPV (framed as STI or common infection)	Online survey Mixed ANOVAs	No significant results related to current review. Only disclosure to family was significant for shame and STI framing interaction. No sig findings for RQ2.	Moderate

Table 4. Continued...

Qualitative studies

Study #	Author & Year	Study Setting	Study Objective	Study Design	Theory	Sampling & Sample	Data Collection & Analysis	Key Findings	Quality
10	Cunningham et al. (2007)	United States, Baltimore, MD Urban (Baltimore)	"Qualitatively explore the decision-making process for disclosure of STI diagnoses to sex partners among adolescent females...explored young women's patterns of disclosure to their sex partner(s) and how a variety of psychosocial factors are navigated to influence partner-notification decisions."	Grounded Theory	No explicit theory used (grounded theory)	N = 21 M _{age} = 17.7 (14-19) Females/Women African American STIs: Chlamydia & Gonorrhea	Semi-structured interviews Grounded theory approach	Disclosure motivations focused on concern for partner's health & desire to stop the spread and/or re-infection. Participants acknowledged that disclosure is important but perceived stigma was a barrier to disclosure. Participants also discussed how STI type & stigma contributed to decisions about disclosure (indicating viral STIs have more stigma & therefore would be less likely to disclose these). Participants differed in discussion of prior disclosure/diagnosis experiences; for some, prior reactions made future disclosure less likely, & for others, it made it easier. Participants notified more "regular" partners than casual partners. Some were angry with the casual partners for giving it to them, so they didn't speak to them. (Major themes: motivation to disclose; factors influencing disclosure; disease type; past experience; partner type)	Moderate

Table 4. Continued...

11	Duncan et al. (2001)	Glasgow, Scotland Urban (Glasgow)	To use qualitative methodology to "explore women's experiences of diagnosis of [chlamydia] and identify salient issues before the implementation of the pilot screening [programs]"	Interpretive Phenomenology	No theory	N = 17 No M _{age} (18-29) Females/Women Race not given STIs: Chlamydia	Semi-structured interviews Interpretive phenomenological analysis	The authors found that the women tended to be worried or anxious about disclosure and reported fearing negative reactions by sexual partners. For women currently in relationships, the prospect of disclosure did not seem to threaten the relationship itself, but they still feared their partner's reaction. Women reported that disclosing to a former partner would be difficult, particularly if the relationship ended badly. Some participants decided not to inform former partners. The authors conclude that the decision to withhold disclosure could have "psychological costs" for women, like feeling guilty.	Moderate
12	Feinstein et al. (2018)	United States, Atlanta, GA; Chicago, IL; New York City, NY; Other Urban	To explore the experiences of young men who have sex with men (YMSM) who tested positive for an STI with diagnosis, treatment, and reinfection. Specifically, to explore their emotional reactions to testing positive, experiences with treatment, disclosure to partners, and the extent to which testing positive influenced their thinking and behavior.	No explicit methodology stated. "Deductive and inductive coding"	No theory	N = 17 M _{age} = 24.06 (SD = 3.38, range = 18-29) (Cis)Males/Men 6 Hispanic, 5 Black/African American, 3 White, 3 Other STIs: Urethral and/or rectal chlamydia and/or gonorrhea	Semi-structured interviews Began with a priori codes (deductive) and used constant comparison method to identify emergent themes (inductive)	Most reported disclosure at time 1 (73.3%, 11/15) and time 2 (83.3%, 5/6) to at least one partner. Partners reported surprise and claimed they didn't have an STI. Various reasons for non-disclosure, including not remembering partners or not being in contact, feeling betrayed. One didn't tell because he was asymptomatic and didn't believe he had an STI (denial).	Low

Table 4. Continued...

13	Kosenko et al. (2012)	United States Urbanicity not described	What are the sources of uncertainty experienced by women living with HPV?	Grounded theory	Theory of Uncertainty in Chronic Illness	N = 25 M _{age} = 28.84 (SD = 8.56, range = 19-56) Females/women 52% White STIs: HPV	Interviews Constant comparative and latent analytic methods	Uncertainty about how/where HPV was acquired caused confusion and anxiety and contributed to disclosure difficulties. Disclosure was a chief concern; women felt obligated to inform current and future partners but were uncertain about how to approach disclosure (lack of efficacy) and fearful of potential responses.	Strong
14	Lee & Craft (2002)	United States Urban	Among individuals with genital herpes: (1) What does having genital herpes mean to them?(2) How do they react emotionally and socially to having genital herpes?(3) Why do they tell others that they have genital herpes?(4) To whom disclose?(5) What happens to their relationships and self-concepts after they tell others about their stigma?	No explicit methodology stated. Guided by Identity Theory	Identity Theory and Goffman's Stigma theory/research	N = 20 M _{age} = 30.16 (SD = 5.27, range = 21-38) 55% Women Race not given STIs: Herpes	Interviews, Interviewer notes Content analysis	Findings consistent with their expectations and demonstrate respondents experienced and managed stigma consistent with stigma research. Respondents withhold disclosure by passing (as uninfected) and withdrawing so they do not face rejection, but disclose to resist losing involvement in relationships and the stigma of herpes (i.e. disclose to receive pre-disease identity confirmation).	Moderate
15	McCaffery et al. (2006)	England Urbanicity not described	Examine the social and psychological impact of HPV testing in the context of cervical cancer screening	No explicit methodology stated.	No theory	N = 74 No M _{age} given Ages 20-64 (mostly 20-39) Females/women 41 White British, 17 South Asian, 16 African Caribbean STIs: HPV	Interviews Framework analysis	Findings suggest that women who tested positive experienced social and psychological consequences, as well as relational. Women were worried about disclosing to partners and what that would look like (fear of rejection). Reported anxiety about telling, fear of infecting, feeling guilty, uncertainty of origin of infection. Some did not disclose based on practitioner advice or to avoid rejection.	Low

Table 4. Continued...

16	Melville et al. (2003)	United States, Seattle, WA Urban	Assess emotional and psychosocial responses to a diagnosis of HSV-2 [genital herpes] infection based on results of a serological [blood] test in asymptomatic individuals and to provide a framework for counselling delivered in clinical settings.	Grounded Theory	No explicit theory used (grounded theory)	N = 24 M _{age} = 35 (range 19-55) 58% women 75% White STIs: HSV-2 (genital herpes); asymptomatic	Semi-structured interviews Constant comparative analysis	Initial reactions to diagnosis included anger with partner & distress. Most participants reported fears of telling partners, often associated with fear of rejection. Participants feared their partners would view them negatively, experienced feelings of guilt. Some participants discussed the decision-making process (if they tell vs don't, then what happens?). Concerns with telling future partners. Some participants discussed increased commitment as a result. Finding out that both have it encouraged participants to consider the cons of ending the relationship & having to disclose to someone new.	Moderate
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Table 4. Continued...

17	Nack (2000)	Unclear (most likely United States) Urbanicity not described	Explore how women diagnosed with incurable (viral) STIs managed the impact of stigma on how they saw themselves as sexual beings	Grounded Theory	Identity Theory and Goffman's Stigma theory/research	N = 28 No M _{age} given (range = 19-56) Females/women Mostly White STIs: Herpes and/or HPV	Unstructured interviews Constant comparative analysis	Findings & conclusions are couched within the emergent theory. The women went through a process of stigma management. Disclosure was a way to confront & manage the stigma they faced as women with STIs. Many women expressed anxiety & fear about disclosing, particularly fear of rejection. Disclosure was also motivated to prevent harm to their partners, or to solicit emotional support. Most of the women disclosed, but some put disclosure off for as long as possible. This motivation for delaying disclosure was rooted in fear of reaction/rejection. Some participants discussed being rejected, others discussed partners' relief. Still, even with positive reactions (e.g., seeking education), their sexual behaviors were still problematized. The main themes for disclosure found were disclosing as preventative &/or therapeutic, & a discussion of the consequences (outcomes) of disclosure.	Strong
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Table 4. Continued...

18	Newton & McCabe (2008a)	Australia Urbanicity not described	Extend research in the areas of stigma, sexuality, relationships, and disclosure associated with STIs.	No explicit methodology stated; “general inductive approach”	No theory	N = 60 M _{age} = 22 (range = 19-59) 50% Women 15 men with herpes, 15 men with HPV, 15 women with herpes, 15 women with HPV Race not given	Interviews “General inductive approach” revealed themes and codes.	Fear of rejection was salient. Many participants discussed slowing down the progression of the relationship or ending it altogether to avoid disclosing. Others said, regardless of circumstances, it was their duty to disclose to curb the spread. Most participants experienced anxiety and fear at the prospect of disclosure. Some discussed how the STI/disclosure affected communication in the relationship. Some discussed the disclosure altering their behaviors, where others reported that nothing changed. Several people discussed the fear of not being wanted, highlighting the salience of STI stigma.	Moderate
19	Perrin et al. (2006)	United States, Tampa, FL Urban	Identify women’s knowledge about HPV, their emotional responses to HPV diagnosis, and the extent of their disclosure of diagnosis to others.	No explicit methodology stated; appears deductive	No theory	N = 52 M _{age} = 24.3 (18-44) Females/women 75% White STI: HPV	Interviews “Independent, iterative coding”	Findings suggest most women disclosed to sexual partner (65%). Stigma may have been the driving force behind disclosure. Many of the women focused on cancer risk and used this as a way to elicit supportive responses instead of rejecting. Specifically, highlighting that they are at risk for cervical cancer instead of discussing HPV as an STI. Some women did discuss not disclosing whatsoever, or no plans to disclose if they were single going into a relationship.	Moderate

Table 4. Continued...

20	Shepherd (2010)	London, England Urban	Describe common themes and cognitive biases evident in the negative thoughts of women referred for psychological therapy for distress related to recurrent genital herpes. Aimed at helping clinicians recognize the negative thoughts and cognitive biases of patients who present with psychological distress related to recurrent genital herpes	No explicit methodology stated	No theory	N = 5 (one participant used for case study) M _{age} = 35.8 (range = 31-44) Females/Women White British STIs: herpes	Therapy notes/psychological assessment Simple content theme analysis	Women reported concerns about disclosure: being rejected & telling others (the actual process of disclosure). All discussed fear of rejection. Only one experienced rejection. The other four had not experienced negative reactions - two experienced neutral or positive reactions, & the other two had not disclosed. One woman was used as a case study, & the author discusses how her partner became very angry & ended the relationship. After many CBT sessions, they engaged in role play which improved her confidence in (efficacy) her ability to disclose & handle possible reactions (positive, negative, neutral). After therapy, she told therapist she'd started dating & hadn't disclosed to her current partner. She indicated she planned to disclose once she felt the relationship was developing.	Moderate
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Table 4. Continued...

21	Smith et al. (2014)	United States Urbanicity not described	RQ1: What do college students say to a close loved one, while imagining that they have received an unexpected positive test result for HPV? RQ2: What do college students say when they imagine that someone they care about has received an unexpected positive test result for HPV?	No explicit methodology stated; “inductive”	Health Disclosure Decision-Making Model	N = 151 M _{age} = 20.01 (SD = 1.14, range = 18-26) 54% Females 87% White STIs: HPV (hypothetical)	Audio recorded hypothetical voicemails Constant comparative analysis	Few participants categorized their discloser or confidant as sexual partners (only 10%). The findings are discussed as they overlap with the DD-MM. Authors found that disclosers sought reassurance & identity-confirming messages, & confidants delivered these. Most were in the context of disclosure to a friend or family member. Disclosers brought up concerns with telling partners. Several confidants emphasized that who they disclosed to was up to them, but they were obligated to tell partners. A discloser also echoed this.	Low
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Table 4. Continued...

22	Swanson & Chenitz (1993)	United States, San Francisco, CA Urban	Describe the psychosocial process that young adults use in adapting to living with genital herpes.	Grounded theory	Symbolic interaction & stigma	N = 70 M _{age} = 28.7 (SD = 4.7) 59% Females 79% White STIs: herpes	Semi-structured interviews Constant comparative analysis	Three-stage model for "regaining a valued self." Stage 1: protecting oneself, 2: renewing oneself, 3: preserving oneself. Stage 1: Reactions to own diagnosis included anger at infecting partner. Many reactions were dependent on several factors, including whether or not they had a supportive partner. Stage 2: Seek self-renewal by gaining information & support but balanced by the need to avoid rejection. Managing risks. Disclosure risked rejection but non-disclosure risked transmission. Used gauging (assessing the receiver), telling, & avoiding as risk management. Gauging: assessing the receiver's personality & predisposition to accept them, use of priming messages. Telling was either voluntary or forced. Some used partner's disclosure as opportunity to reciprocate; some using timing of the relationship/commitment to tell. Told to protect from physical harm. Avoiders tended to use timing of outbreaks to manage sexual engagement. Stage 3: Those who told & were accepted were encouraged to disclose further/to others. Revealers: almost always told before sex. In maintained relationships. Conditionals: not as comfortable with themselves were less likely to disclose. Used outbreaks & relationship type as litmus test for disclosure. Single & actively dating. Avoiders: always avoided it. Mix of partnered, married, & single.	Moderate
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Table 4. Continued...

23	Temple-Smith et al. (2010)	Australia Both urban and rural	Determine what supports would be most useful to improve partner notification. Initial reactions to chlamydia diagnosis, views about sharing diagnosis with sexual partner and about whether taking antibiotics to their sexual partner (PDPT) would be helpful.	No explicit methodology stated	No theory	N = 40 No M _{age} given (range = 18-60; 65% 18-25) 62% females Race not given STIs: Chlamydia	Telephone semi-structured interview “Coded for emerging themes”	The authors found that many participants saw disclosure as a social duty (moral obligation, right thing to do). Others talked about risk to partner's health, mainly the possibility of becoming infertile. Some women discussed disclosing as a way to confront infidelity. Reasons for not disclosing were fear of reaction. One woman felt that the 3 men that raped her didn't deserve to be told. One man talked about the emotional difficulty and speculated how people with more serious STIs would want to commit suicide. Some expressed guilt. Some experienced negative reactions including denial, anger, and ending the relationship; others experienced positive reactions that included emotional support and improved commitment.	Moderate
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Table 4. Continued...
Mixed-methods studies

Study #	Author & Year	Study Setting	Study Objective	Study Design	Theory	Sampling & Sample	Data Collection & Analysis	Key Findings	Quality
24	Bickford et al. (2007)	United Kingdom Urbanicity not described	Assess the nature and effect of stigma on disclosure of genital herpes diagnosis to sexual partners	Qualitative methods not specified	No theory	Qual. N = 6 3 Men ages 34, 38, 39; 3 Women ages 33, 40, 50	Interview and open-ended responses on surveys Thematic analysis	relationship type is important to determine who to disclose to (committed vs not) Rejection/fear of rejection associated with disclosure	Low (Not truly mixed methods; just a qual and quant study)
				Cross-sectional		Quant. N = 70 No M _{age} given 72.5% Women 91% White STIs: Genital herpes	Paper/pencil survey Descriptive statistics	<u>Disclosure to sexual partners</u> - All (33 (54%)) - some (23 (37%)) - none (6 (9%)) <u>Before or after first sex</u> -Always before (24 (44%)) - sometimes before (14 (25%)) - always after (17 (31%))	

Table 4. Continued...

25	Coffelt et al. (2021)	Unknown Urbanicity not described	What are the linkage rules for sexual health disclosures? How do disclosers and confidants perceive the quality of sexual health disclosures? What are the motivations to reveal and conceal sexual health information? Disclosures will differ between those with bacterial and viral diagnoses. What are the relational risks and benefits of revealing/concealing? Do men and women differ in their sexual health disclosures?	Qualitative method not specified	Communication privacy management theory	N = 291 (161 who had disclosed; 130 recipients) M _{age} = 31.7 (for full N = 517*), Median = 30, Mode = 28 55% Male* 72% White* STIs: Bacterial, viral (includes HIV), parasitic	Online survey via MTurk “descriptive coding approach”	Variations in timing of disclosure, most reported before sex. Topics covered in both disclosers & confidants accounts were how/where they got it, treatment, current status. Style of disclosure emerged; some used priming messages, most were direct, & some downplayed diagnosis. Face to face was most common, followed by phone & text. Motivation to not disclose: most said shame, followed by embarrassment & privacy. Possibility of breakup, not knowing about the STI, fear of rejection, & others reported by 5 or fewer.	Moderate
				Cross-sectional			Online Survey (MTurk) Frequencies MANOVAs	Disclosure did not vary by STI type (χ^2 (3) = 3.10, p = .38), sex (χ^2 (1) = .18, p = .68. Disclosers quality score (1-7) 6.23 (SD = .85). Receivers 6.03 (SD = 1.42).	

Table 4. Continued...

26	Emmers-Sommer et al. (2010)	Unknown Urbanicity not described	Assess college students' beliefs about disclosure. Appropriate time to disclose STI? Reasons why someone who knowingly has STI would not disclose it to a partner? How would participants respond to a partner's STI disclosure? Does how a participant's partner contracted the STI affect reaction to the disclosure?	Qualitative methodology not specified	Sexual script theory	N = 253 No age reported; "university students" 60% Women Race not given STIs: not specified; referred to as "STD status." 7.8% of the sample reported ever having an STI	Online survey with open-ended questions Analysis not specified "coded Responses; placed into categories"	Reported reasons for not disclosing: Ashamed, embarrassed, didn't know, no reason to tell, privacy, rejection by partner, selfish, transmission. Responses to partner's disclosure: shocked/surprised, negative emotions (angry, sad, upset), glad they told /respect honesty/be supportive, stop having sex, get tested/see a doctor, use protection, break up/leave partner, stay/feel the same about partner, learn more/ask questions, depends on STI/how they contracted it, depends on how much I like the person, not sure. Circumstances in which STI was acquired and tolerability. Not tolerable: cheating, gay sex, promiscuous/careless behavior, drugs/prostitution (risky/irresponsible). Tolerable: if they were lied to/situation was not their fault; if they got from a serious partner. (Positive receiver responses possible when STI was acquired from circumstances out of their control & if the relationship is committed)	Moderate, but not truly mixed-methods
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Table 4. Continued...

				Cross-sectional			Online survey Descriptive statistics	Most participants regardless of relationship type said disclosure should happen before they first have sex. Two participants said they would not be obligated to tell (one casually dating, one not in relationship). 20 participants said when they meet the partner.	
27	Green et al. (2003)	England Urban	Identify factors which determine whether and when patients will disclose infection with genital herpes to sexual partners	Qualitative methodology not specified	No theory	N = 50 No M _{age} given Median = 34 (19-68) 52% Female Race not given STIs: genital herpes	Semi-structured interviews Content analysis	Not obligated to tell casual partners and fear of reaction most reported reasons for non-disclosure. Others included fear of gossip, partner might accuse of cheating, and didn't believe they were putting partner at risk (belief that lack of symptoms = not transmissible, or on antivirals). Relationship factors most influential for disclosure: Moving in together symbolic of greater commitment and elicited disclosure; loving the partner. 22 participants reported good partner reactions & 5 reported adverse reactions	Moderate

Table 4. Continued...

				Cross-sectional		N = 50 (number of partners disclosed to used as N: 121)	Quantitative data generated from qualitative content analysis Logistic regression	Univariate: both relationship type ($p < .001$) & length ($p = .03$) were significant, but multivariate made length "borderline" $p = .08$, order became significant ($p = .04$), such that the most recent partner was less likely to be informed than the previous two. Partner type remained significant ($p = .003$). more likely to disclose to committed & longer than casual, shorter.	
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Table 4. Continued...

28	Keller et al. (2000)	United States Urban	People living with HPV for 6+ months, what are their beliefs about disclosure obligation? Does knowledge of transmission influence beliefs about the disclosure obligation and actual disclosure behavior? What percentage have disclosed the presence of HPV to their sexual partners. What are identified reasons for/against and how do they feel about decision?	Qualitative methodology not specified	No theory	N = 48 Descriptives based on full sample (92) $M_{age} = 23.1$ (SD = 6.0) 68% Female 89% White STIs: HPV	Paper survey with open-ended questions that were added later Content analysis	74% had disclosed to their sexual partner. Among those in the same relationship, 95% (18) had disclosed, & among those in new relationships, 45% (13) had disclosed (of those 45%, 4 of them told partner after sex, 9 disclosed before). Factors influencing decision to disclose: morally right; honesty important in relationship; partner might need treatment; partner already has warts; needed to explain condom use; cared about the partner; HPV is partner's fault. Factors influencing decision to not disclose: no intercourse yet; embarrassment; not a serious relationship; too personal; using condoms; fear of partner leaving; health provider said not necessary; might be stereotyped as promiscuous; not having recurrence. Those who disclosed reported good feelings about their decision. Many reported being happy or relieved. The only regrets were by the 4 who did not disclose prior to intercourse; wished they had been honest sooner. Most who did not disclose felt fine or good about their decisions, & 25% felt bad or guilty.	Low, not truly mixed-methods
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Table 4. Continued...

				Cross-sectional			Paper survey Frequencies MANOVAs	52% agreed they must tell all sexual partners about HPV prior to intercourse. 15% agreed that it was not necessary to tell casual partners. 58% said they must tell even if they had no obvious recurrence. As time passed, more participants believed they were less obligated to disclose. None of the MANOVAs were significant, suggesting that "knowledge about transmissibility of HPV did not influence beliefs about disclosure obligations."	
29	Niccolai et al. (2008)	United States, Connecticut Urbanicity not described	(1) to measure the frequencies of and association between intentions not to notify sex partners and not to continue sexual relationships after a chlamydia diagnosis; (2) to determine individual- and partnership-level correlates of the two outcomes; and (3) to describe reasons for these behavioral intentions.	Qualitative methodology not specified	No theory	N = 135 M _{age} = 20.9 (range = 15-37) Females/women 58% Black/African American STIs: Chlamydia	Open-ended questions in A-CASI "independently coded"	Reasons for intending not to notify: no perceived need, unwillingness to address issues, fear or discomfort with potential consequences, inability to locate partner.	Low
				Cross-sectional			A-CASI "Generalized estimating equations" to obtain odds ratios. "Significant covariates included in multivariate model"	Longer relationship (adjusted OR = 2.12 [1.08-4.14] and higher quality (3.39 [1.53-7.48] were associated with intentions to disclose.	

Table 5. Thematic Synthesis of Studies

STI Disclosure Construct	Sub-Theme	Explanation	Example	DD-MM Construct	Contributing Studies
Feelings/Emotions about Disclosure	Anger/Blame	Anger with the person who (they believe) transmitted the infection	"I'm not upset no more. I mean I was at first. I wanted to kill the girl actually—figure of speech you know. But I was that mad." 16	Assess the self	10 13 16 19 22 29
	Worry/anxiety/distress	Worry/anxiety/distress associated with various disclosure-related phenomena. Mostly about the disclosure process.	"I've infected him and this is the man I want to spend the rest of my life with...how am I going to tell him?" 15	Assess the self	11 13 15 16 17 18 19 20 21 24
	Guilt/Self-Blame	Guilt or self-blame for having the STI, for exposing partner	"I just felt very guilty. I felt very badly that I didn't know and that I affected somebody else's life that way." 16	Assess the self	11 12 15 16 19 23
	Fear of partner's reaction	Being afraid, worried, or concerned about the receiver reacting in a negative way	"...Hey, it's enough to have to handle the disease without Joe Blow over here having himself a little cardiac arrest you know. I don't need that reaction." 14	Assess receiver: anticipated response	1 2 5 11 14 17 23 27
	Fear of how partner will view them	Concerns with being viewed negatively or labeled by partner, or being viewed as promiscuous or dirty	"I think people's conception of me would change if I said I had herpes." 27	Assess info: stigma Assess receiver: anticipated outcome	8 16 17 19 27
	Fear of being rejected	Fears of being rejected. This could be rejection from a committed partner or being rejected for sex by a casual partner.	"Oh my gosh I'm positive and if I tell him he probably you know, might reject me for this." 16 "I do not believe anyone would want me." 18 "If I told men that I had it they might not want to have sex with me." 27	Assess receiver: anticipated response	1 2 8 10 13 16, 17 18 20 22 23 24 27 29

Table 5. Continued...

	Fear of relationship termination	Fear that if they disclose, their partner will end the relationship.	"I thought she was going to freak out and run away from me. Scared that she was going to run off and leave me forever." 16	Assess receiver: anticipated outcome	1 16 20 25 28
Reasons for Disclosure	Honesty	Being honest about the STI is the best policy. Especially prevalent in committed relationships.	Authors: Among persons in the same relationship, the most frequently reported influencing factors were that ... honesty in relationships is important" 28	Pre-diagnosis beliefs Assess info: relevance to others	1 4 8 28
	Morally Obligated	Disclosing the STI is the morally correct/right thing to do. People with STIs are obligated to disclose. It is their "social duty." They are obligated because it prevents transmission, and the partner has the right to know.	"...I don't look at sex as a moral issue at all. The only moral issue in herpes is that it is a disease, and you can harm someone else by not telling them, so morally you should be obligated to tell them." 22 (also applicable to concern for/protect partner's health) "I told him because it's just the right thing to do." 23	Pre-diagnosis beliefs Assess info: relevance to others	1 4 8 10 13 14 18 21 22 23 28
	Concern for/protect partner's health	Disclose out of concern for or to protect partner's health.	"And I was concerned for their health as well." 23 "I know that chlamydia [can cause infertility]. I want children and I know that my ex, he wants children." 23	Assess info: relevance to others	8 10 17 22 23 28
	Care about/love partner	Caring about and/or loving the partner motivates disclosure.	"Because I loved him" 27	Assess info: relevance to others Assess relationship: closeness	1 27 28

Table 5. Continued...

	Self-verify/combat STI stigma	Disclosure can be therapeutic and helps individuals engage in self-verification processes and/or address and combat the STI stigma they experience	Author: "The women disclosed for either preventive or therapeutic reasons. That is, they were either motivated to reveal their STD status to prevent harm to themselves or others or to gain the emotional support of confidants." 17	Assess info: stigma	14 17 19
	Resist the loss of romantic/sexual involvement	Disclosure brings the risk of rejection, but the decision to withhold disclosure means they must avoid sex and relationships. Disclosure serves to resist this potential loss.	Authors: "Respondents tell others that they have genital herpes to ... resist losing their involvement in relationships..." 14	Assess the self: sexual self	14
	Solicit partner support	Disclose to receive emotional support and identity confirmation from partner, to assist with coping with the STI.	Author: "Finally willing to risk criticism and shame, they hoped for positive outcomes: acceptance, empathy, sympathy—any form of nonjudgmental support." 17	Assess receiver: anticipated response	14 17 19 22
	Confront partner	Individuals unexpectedly diagnosed disclose to confront the partner, inquiring about possible infidelity or the partner's knowledge of the status	"I was wondering what was going on and why all of a sudden have I got it, after three years of being with him." 23	Assess relationship	8 23 28
	Explain symptoms/use of prophylaxis	Disclosure is not necessarily voluntary but forced by the need to explain the use of condoms (perhaps in a long-term relationship), the use of medication, or the presence of outbreaks.	Authors: "Forced telling occurred when cures were noted that created suspicion and the partner confronted the person with herpes...[including recurring lesions] and discoveries of medication for herpes." 22	Asking questions	1 8 22 28
Reasons against Disclosure	Fear of reaction	Anticipating a negative emotional reaction motivates individuals to withhold disclosure.	"I am worried about his reaction...he would probably be aggressive...put me down and think that he's superior. I'm sure he'd be the type of person to tell a lot of people as well." 23	Assess receiver: anticipated response	1 2 5 11 17 23 27

Table 5. Continued...

	Fear of response	Anticipating or fearing specific responses motivates non-disclosure, including being accused of cheating, the information being leaked, and even experiencing violence.	"He probably would have been mad. Probably tried to blame it all on me. It would be all in the wrong way, like a violent way, so that's also why I was like I ain't telling him nothing." 10	Assess receiver: anticipated response	1 2 8 10 13 17 23 27 29
	Fear of rejection	Rather than face the possibility of being rejected, individuals choose to withhold disclosure.	"And plus, no one wants to tell someone, 'Oh, I have something that you can't cure. Still want to have sex with me?'" 10	Assess receiver: anticipated response	1 5 10 14 15 18 20 22 26
	Fear of relationship termination	If an individual believes their partner may end the relationship in response to the disclosure, then they decide not to disclose	"Fear of ... loss of relationship" 1 Authors: "...in the same relationship as point of diagnosis did not disclose because of ... fear of rejection [authors coded as fear of "partner leaving" but discussed as rejection]." 28	Assess receiver: anticipated outcome Assess relationship: quality, commitment	1 25 28
	Not obligated to tell	The individual believes that they are not obligated to inform their partner. This is most often the case with casual sex or non-committed relationships. These individuals believe that the nature of the relationship does not necessitate disclosure.	"I haven't had regular partners since I got HSV and the few times I've had sex I've been with casual partners so I haven't told them." 18	Assess info: relevance to others, symptoms Assess relationship: type	1 8 18 19 22 26 27 28 29
	Ashamed/shame	Feelings of shame inhibit disclosure. Highlights the salience of STI stigma.	"Too ashamed to say anything" 26	Assess info: stigma	5 25 26
	Embarrassed	Being embarrassed of having an STI inhibits disclosure. Highlights STI stigma.	"It will be embarrassing and I won't be able to cope" 20	Assess info: stigma	1 8 20 25 26 28
	Logistical reasons	Individuals may not disclose for various logistical reasons, including not remembering the partner or not being able to get in contact with the partner.	"Didn't know her contact information" 1 Authors: "...such as not remembering partners and not being in contact with partners." 12 "I am not with him and he is nowhere to be found." 29		1 12 29

Table 5. Continued...

	Denial	Disclosure does not occur because the individual is in denial about having an STI.	“At the time, I was in denial about it. ... So, I just kind of told myself that it was hereditary. That was kinda funny because I asked the nurse that called if it could be hereditary, and she said ‘No, this is completely sexually transmitted’—I really didn’t accept it until a few months after my cryosurgery.” 17	Assess the self	12 17
	Lack of efficacy	Individuals do not know how to approach the disclosure situation, or do not know what to say. This highlights a lack of disclosure efficacy, or confidence in ability to disclose.	“...I don’t know who I’m supposed to tell, ‘cause none of them ever told me.” 13 “The thought of having it, deciding when to do it and how and what to say—it was extremely stressful.” 13	Assess disclosure efficacy	1 8 13
	Practitioner advice	Individuals were advised by their health practitioner that they did not need to disclose the STI. This was only found in the context of HPV.	“...her guilt was resolved during her last gynecological exam when the nurse practitioner confirmed that after years of ‘clean’ pap smear results Deborah was not being ‘medically unethical’ by not disclosing to her partners.” 17	Assess info: symptoms	15 17 28
	Anger/retaliation/betrayal	The individual is angry with/feels betrayed by the person that infected them and does not want to be in contact or is withholding disclosure in retaliation.	“...at that moment I had felt betrayed....If I give somebody my body like that, I would just think that you have enough respect for me and you” 12 “The other three men didn’t deserve to be told be-cause they are the ones who raped me...I don’t think I need to return the favor to them.” 23	Assess relationship	1 10 12 23 29
	Did not know	Individuals were not aware that they had an STI.	“Didn’t know at the time” 1 “Didn’t know they are infected” 26	(Not) Assess info	1 25 26

Table 5. Continued...

	Entitled to privacy	The information is personal and private, and it is their choice whether or not they want to disclose.	“Well I haven’t told anyone. I feel like it’s not really something I want to share with people at this point.” 19	Assess the self	19 25 26 28
	Beliefs about transmissibility	Individuals had false beliefs about the transmissibility of their infections, believing they did not need to disclose because the STI was not transmissible.	“It seemed easier and less stressful not to tell him and it was nothing that was going to affect him physically.” 15 “They might have an STD that cannot be transmitted to another” 26 “The way I see it is that if I am in control of the herpes and I can control it with my tables...then I don’t feel I have to tell” 27	Assess info: symptoms	8 15 26 27 28
	Condoms	Individuals believed that if condoms were being used, then disclosure was not required.	“It was a momentary fling using condoms, and I thought it was irrelevant” 27	Assess info: symptoms	1 8 27 28
	Not had sex yet	Sexual engagement had not occurred yet, so disclosure was viewed as not yet necessary.	“If they weren’t sexually active” 26 Authors: “For the participants in new relationships, the most common factor influencing nondisclosure was that they had not yet had intercourse.” 28	Assess info: relevance to others	1 26 28
Disclosure Strategies	Priming messages	Individuals may use priming messages to gauge/assess their partner’s potential reaction, not disclosing their STI initially, but initiating conversations about STIs generally.	Authors: “One woman talked about herpes in general and watched closely for her partner’s positive reaction before telling. Another strategy, reported by men in particular, was to joke about herpes and wait for a partner’s positive reaction to the joke before telling.” 22	Enact message strategies	22 25 27

Table 5. Continued...

	Framing	Individuals may frame their STI in certain ways to decrease the likelihood of a negative reaction.	"I have told my partner that they don't know where it comes from ... obviously because he'd look at me in a different light because ... he'd be like, have I got it or has she been with somebody else?" 15		15 19 25 27 (9 examines framing to increase disclosure intentions)
	Direct disclosure	Some individuals choose to enact direct disclosure strategies, being clear and direct about their STI status.	Authors: "[29% used a] direct, straightforward, blunt, or upfront approach... Another conversational attribute this study supports is the use of a direct and straightforward tone." 25	Enact message strategies	22 25
	Delivery method	Disclosers may use face-to-face disclosure, phone calls, text messages, and so on to deliver the disclosure.	Authors: "Channels used for disclosures included face-to-face (37%; n = 53), telephone (6%; n = 9), or email/text message (3%; n = 4)." 25		25
	Reciprocity	Some individuals used partners' disclosers (of STIs or other personal information) as opportunities to reciprocate.	"It was like she was telling me some things she'd been through. She's been through this divorce, and all this hell, you know. And then she goes: 'Have you ever been through anything like that?' you know. And we just started talking." 14 "One day I went to meet him and he had this big cold sore on his face. It was the perfect vehicle to start the discussion... I told him." 22	Reciprocity	14 22
Non-Disclosure Strategies	Passing	Individuals may "pass" as uninfected persons to avoid disclosure. Because most STIs are typically not visible in daily interactions, individuals can pass as healthy and uninfected.	"It was a conscious effort to be the same old Thomas and to act the same way. And so I felt like I was just harboring a secret that no one was gonna get out of me. And no one was even having a reason to suspect that there was a problem." 14	(Not) enact message strategies	14

Table 5. Continued...

	Slow Down/Withdraw	Individuals may slow down the sexual progression of relationships to avoid disclosure, or withdraw from/end relationships altogether. Rather than face the potential for rejection, some decide to forgo pursuing sexual and romantic relationships.	"I just didn't want to have anything to do with it. A lot of it was not trusting people. When we broke up, I decided that I was not having sex... Then, I came to kind of a turning point in my life and realized that I didn't want to do the one-night-stand thing anymore. It just wasn't worth it. It wasn't fun." 17 "I have been trying to avoid sexual situations even though I like this person very much both emotion- ally and physically. I would like to be more intimate with this person but I don't want to tell her about what I have." 18		14 16 17 18
	Timing of Outbreaks	Some individuals may time their sexual encounters based on the timing of outbreaks. Individuals abstain from sex when experiencing an outbreak and thus avoid disclosing.	Authors: "timing of sexual encounters was of critical importance in controlling transmission and preventing the partner's noticing the herpes symptoms." 22 "I knew that I didn't have an episode, didn't have any herpes at all..." 27		22 27
Disclosure Timing	Before or after sexual engagement	Individuals without STIs tend to believe that disclosure should always occur before any sexual engagement, but across studies, only around 50% of individuals disclose before.	"...She had not disclosed about having genital herpes to this new partner as she felt that it was her right to keep this information private. However, she planned to disclose once she felt that the relationship was developing." 20	Assess info: relevance Assess relationship: type	1 4 20 22 24 25 26 28
	Uncertainty about best time	Individuals are not sure when the best time to disclose is.	"It was just, 'When do I tell him?' Because I don't want it to be like I was trying to deceive him or something, and I didn't want to say it too late or early. So, it was very much like, 'What's the best timing?'" 13	Assess relationship: milestones Assessing disclosure efficacy	13

Table 5. Continued...

Relationship Factors	Relationship type	The type of relationship contributes to the decision-making process. Typically, disclosure is more likely to occur within committed relationships than non-committed, casual sex relationships.	“If I would have a one-night-stand type of situation, I wouldn’t tell. If I were having an ongoing relationship I would tell them but expect them to get upset...” 22	Assess relationship: type	1 3 5 7 10 11 22 24 25 27 28
	Relationship length	Disclosure is more likely in longer relationships.	Authors: “Disclosure was significantly more likely in closer and longer-lasting relationships.” 8	Assess relationship: length	1 3 5 8 29
	Relationship closeness	Disclosure is more likely when partners/relationships are closer.		Assess relationship: closeness	8 25
	Relationship quality	Disclosure is more likely when relationships are higher quality.	Authors: “Factors associated with intentions to notify a sex partner included...higher relationship quality” 29	Assess relationship: quality	29
	Commitment level/relationship milestones	Changes in relationships may elicit disclosure. Increases in commitment are associated with increased likelihood of disclosure.	“I would just say ‘there is something I have to tell you, and I think you need to know before we get married...’” 27	Assess relationship: commitment	4 22 27
Individual-level factors	Sexual partner number	The number of sexual partners may be associated with disclosure likelihood. People with fewer sexual partners were more likely to disclose their STI.	Authors: “disclosure was more likely to occur in those reporting only one sex partner [prior to baseline interview]” 3		1 3
	Gender	Gender may be an important component of disclosure, particularly in the context of the Sexual Double Standard. No study findings to suggest gender differentiated disclosure, but women tend to experience more STI stigma than men.	“They wouldn’t say nothing to the guy. It would all be on the girl. The girl would just be called a freak...She burning, she dirty, she a freak.” 10	Assess info: stigma	3 7 10 11 25
	Age/Development	Developmental stage may differentiate disclosure. Younger participants are less likely to disclose than older participants.	Authors: “there were significant adjusted associations between disclosure and older age” 3 Authors: “The mean age for individuals who reported not disclosing at last sex was 31.44 years (SD=11.70), whereas the mean age for individuals who did disclose was 40.93 years (SD = 13.32).” 5		3 5

Table 5. Continued...

	STI type	Similar to gender, STI type may differentiate disclosure, but the findings are not clear. Disclosure of viral STIs may be more difficult, because they are more highly stigmatized and not curable.	“[disclosing chlamydia] had to be done, but it was really hard to do. I’ve thought about it...and I can see how someone would commit suicide for that reason. They’d rather just kill themselves than tell the other partner. Not necessarily chlamydia, but with a serious or half serious one, you know.” 23	Assess info: symptoms	6 10 23 25
	IPV exposure	Prior IPV exposure may increase fear of reactions, inhibiting disclosure.	Authors: “Those exposed to IPV were more likely to report being afraid to notify partners of an STI...A relatively small portion (5.4%) experienced threats of harm or actual harm in response to STI notification.” 2	Assess receiver: anticipated responses	2
Responses to & Outcomes of Disclosure	Negative partner responses	Some disclosers report their partner reacting negatively, rejecting them, breaking up with them, denying the STI, and threatening or becoming violent.	“I did talk to them. And everyone said that it wasn’t them or that they also got tested and they’re clean...” 12 “I told him it doesn’t feel right. ‘You’d better check.’ And, so he checked, and he just jumped off me and screamed, ‘Oh fuck!’ And, I just thought, oh no, here we go. He just freaked and went to the bathroom and washed his penis with soap. I just felt so dirty.” 17	Responses	1 2 12 17 20 23 26 27
	Positive partner responses	Some disclosers report their partner reacting positively, providing emotional support, asking questions and seeking knowledge. Some partners were even relieved, believing the disclosure was going to be something worse.	“He was really supportive about it. It was me saying to him it’s because I’ve been stupid and blah blah ... and he was saying well maybe it’s not, how do you know?” 15 “...when it happened it was a positive experience because I told him and he was very calm about it and he gave me a hug.” 23	Responses	1 8 15 17 20 22 23 26 27

Table 5. Continued...

	IPV exposure	Prior IPV exposure may increase fear of reactions, inhibiting disclosure.	Authors: "Those exposed to IPV were more likely to report being afraid to notify partners of an STI...A relatively small portion (5.4%) experienced threats of harm or actual harm in response to STI notification." 2	Assess receiver: anticipated responses	2
Responses to & Outcomes of Disclosure	Negative partner responses	Some disclosers report their partner reacting negatively, rejecting them, breaking up with them, denying the STI, and threatening or becoming violent.	"I did talk to them. And everyone said that it wasn't them or that they also got tested and they're clean..." 12 "I told him it doesn't feel right. 'You'd better check.' And, so he checked, and he just jumped off me and screamed, 'Oh fuck!' And, I just thought, oh no, here we go. He just freaked and went to the bathroom and washed his penis with soap. I just felt so dirty." 17	Responses	1 2 12 17 20 23 26 27
	Relationship outcomes	Some disclosers report that as a result of the disclosure, they experienced increases in commitment, communication, and closeness with their partner.	"Nothing changed. He still accepts me and respects me regardless of HPV. Since I ultimately passed this virus onto him, I was afraid that he would start to resent me and our relationship. But just the opposite happened. We became closer and our love grew in leaps and bounds." 18 "I guess it's brought us closer together...just because we have been through something pretty bad together." 23	Outcomes: relationship	8 16 18 23
Outcomes of Non-Disclosure	Non-discloser outcomes	Non-disclosers may have higher levels of anxiety and depression and lower levels of sexual-esteem and satisfaction than disclosers. They may also express guilt and regret about their decision to not disclose.	"I had some thoughts about [non-disclosure], that it was indeed dishonest. That's a bit of a conflict in me." 22	Outcomes: discloser	6 8 11 22 28

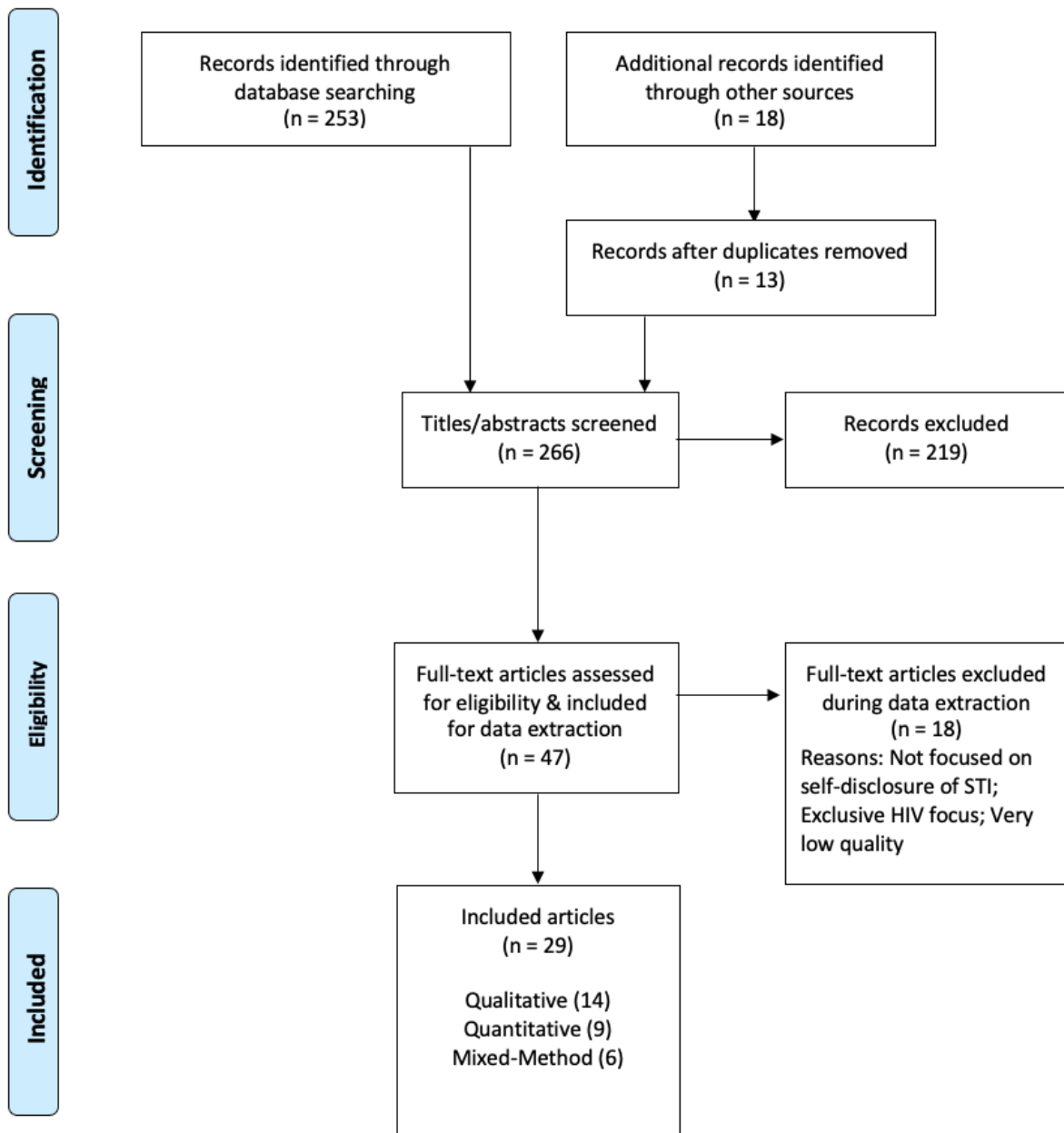
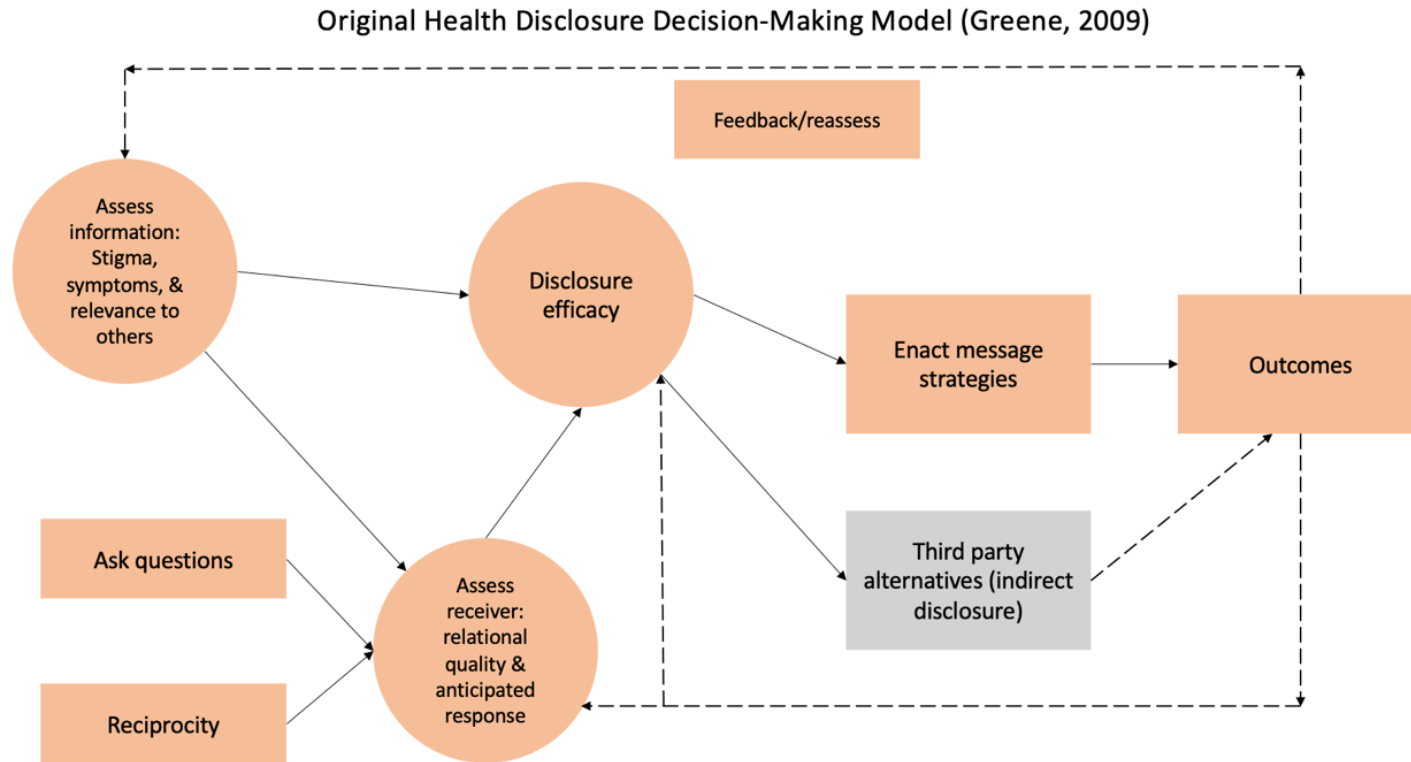
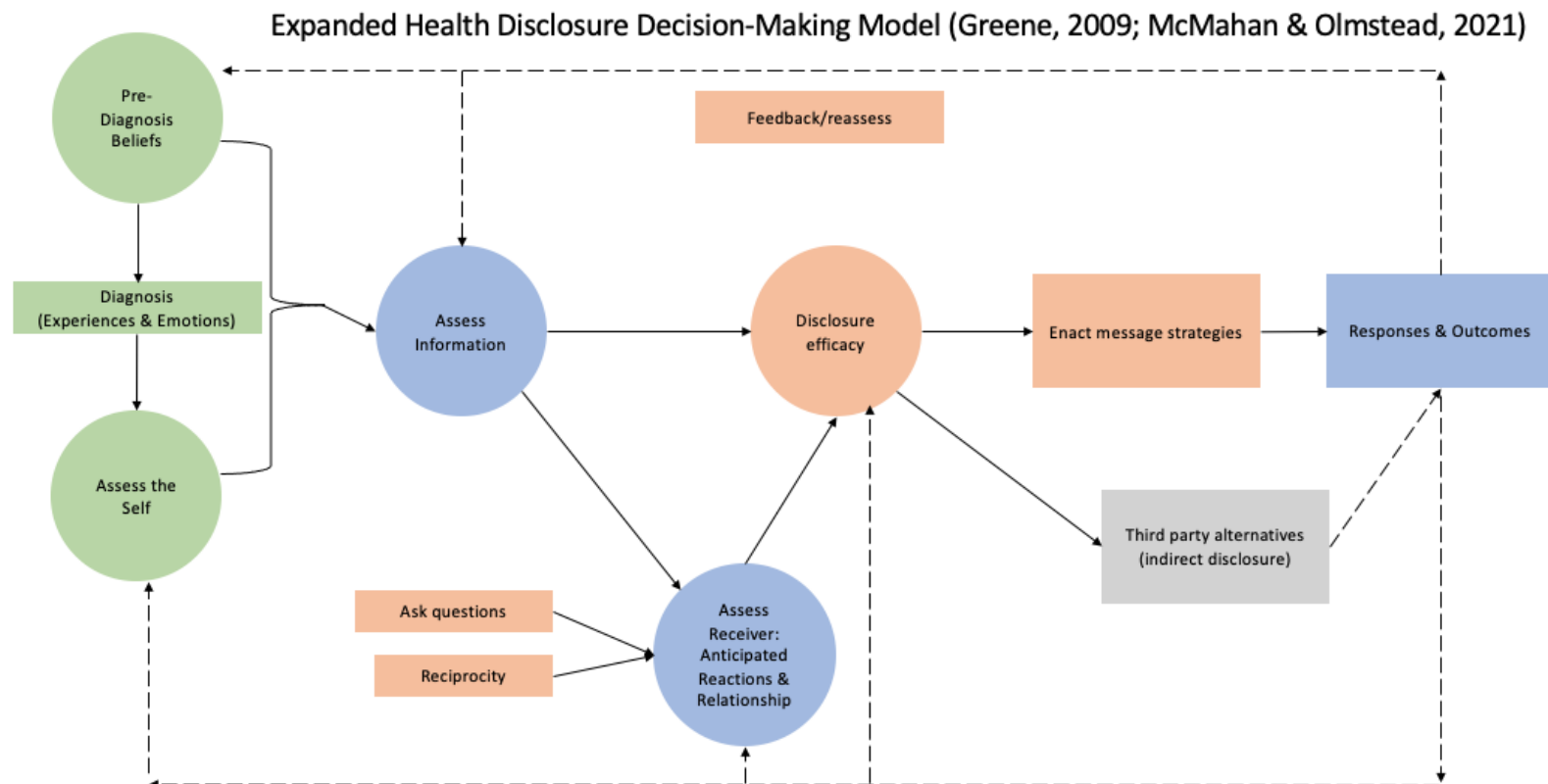


Figure 1. *PRISMA Article Screening Flow Diagram*



Orange shapes represent theoretical components included in the review; the grey box represents the component not included in the review (the purpose of the review was to assess the research on direct disclosure to partners, not indirect (e.g., via gossip).

Figure 2. *Original and Expanded Health Disclosure Decision-Making Models*



Orange shapes represent original theoretical components included and found in the review; the grey box represents the component not included in the review (the purpose of the review was to assess the research on direct disclosure to partners, not indirect (e.g., via gossip). Green shapes represent proposed additions to the model, based on the findings from the review. Blue shapes represent original theoretical components with proposed expansions.

Figure 2. *Continued...*

APPENDIX 2:

Screening Items

1. We are interested in knowing if a consensual sexual partner (committed or non-committed partner who you have had oral, vaginal, and/or anal sex with) has ever directly told you that they had a sexually transmitted infection/disease (STI/STD) while you were in a sexual relationship with them. This does not include ex-partners who told you about the STI after your relationship ended. This also does not include a doctor, anonymous text or email, or other person who told you about possible STI exposure.

Based on this description, have you ever experienced this?

- a. Yes, a sexual partner has directly told me about their STI while we were together.
- b. No, a sexual partner has never told me about an STI while we were together.
- c. I have never had oral, vaginal, and/or anal sex with anyone.

If (a) was selected, potential participants may be qualified for Study 2 (Chapter 4), and were presented with a second screening question to determine eligibility:

2. Did this partner tell you that they had HIV/AIDS? (If you have experienced multiple STI disclosures, answer for the most recent disclosure).
 - i. Yes, my partner told me they had HIV/AIDS.
 - ii. No, my partner did not tell me they had HIV/AIDS, but a different STI.

If (i) was selected, they did not qualify Study 2. They were redirected to a page containing a thank-you message, informing them that they did not qualify for the study. They were redirected back to Prolific, where they received \$0.25 for completing the screening survey.

If (ii) was selected, they qualified for Study 2. They were redirected to a thank-you message, informing them that they qualified for the study and would be contacted through Prolific to take the survey. They were redirected back to Prolific, where they received \$0.25 for completing the screening survey.

If (b) was selected, potential participants were qualified for Study 1 (Chapter 3). They were redirected to a thank-you message, informing them that were qualified for Study 1 and would be contacted through Prolific to take the survey. They were redirected back to Prolific, where they received \$0.25 for completing the screening survey.

If (c) was selected, potential participants were not qualified for either study. They were redirected to a page containing a thank-you message, informing them that they did not qualify for the studies. They were redirected back to Prolific, where they received \$0.25 for completing the screening survey.

APPENDIX 3:

Chapter 3 Tables

Table 6. *Chapter 3 Demographic Characteristics (N = 243)*

	<i>n</i>	<i>M(SD)/%</i>
Gender		
Women	127	52.3
Men	100	41.2
Non-binary	10	4.1
Transmen	3	1.2
Transwomen	3	1.2
Age (18-29)		23.93 (3.22)
Race/Ethnicity		
White/Caucasian	163	67.1
Bi/multiracial	26	10.7
Asian American	25	10.3
Black/African American	15	6.2
Latinx/Hispanic	11	4.5
Native Hawaiian/Pacific Islander	2	0.8
Native American/American Indian or Alaskan Native	1	0.4
Sexual Orientation		
Heterosexual	160	65.8
Bisexual	54	22.2
Pansexual	13	5.3
Lesbian	8	3.3
Queer	5	2.1
Gay	1	0.4
Asexual	1	0.4
Unsure	1	0.4
Educational Attainment		
Secondary/high school	23	9.5
GED	5	2.1
Some college	74	30.5
Two-year degree (e.g., Associate's)	28	11.5
Four-year degree (e.g., Bachelor's)	83	34.2
Master's degree	25	10.3
Doctorate degree (e.g., M.D., Ph.D.)	5	2.1
Current College Enrollment		
Not enrolled	150	61.7

Table 6. Continued...

Two-year college	15	6.2
Four-year university	77	31.7
Trade school	1	0.4
Most Recent Relationship Type		
Committed dating relationship	93	38.3
Cohabiting/living together	52	21.4
Engaged	10	4.1
Married/domestic partnership	46	18.9
Polyamorous triad, married to one partner	1	0.4
Casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup)	24	9.9
Casually dating/talking	16	6.6
Other	1	0.4

Table 7. Vignette Scenario Summary

	Label	N (%)
Relationship Type		
Casually dating/talking to someone	CDT	16 (6.6)
In a casual sex relationship	CSR	25 (10.3)
In a committed dating relationship	CMR	93 (38.3)
Living with a partner	COH	52 (21.4)
Engaged to someone	ENG	11 (4.5)
Married to someone	MAR	46 (18.9)
STI Type		
Chlamydia	B	122 (50.2)
Genital Herpes	V	121 (49.8)
Original Vignette Number		
1	CDT x B	5 (2.1)
2	CDT x V	11 (4.5)
3	CSR x B	12 (4.9)
4	CSR x V	13 (5.3)
5	CMR x B	47 (19.3)
6	CMR x V	46 (18.9)
7	COH x B	26 (10.7)
8	COH x V	26 (10.7)
9	ENG x B	6 (2.5)
10	ENG x V	5 (2.1)
11	MAR x B	26 (10.7)
12	MAR x V	20 (8.2)

Table 8. *Bivariate Correlations for Chapter 3 (N = 243)*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. STI Stigma	-															
2. BIDR-16	-.18*	-														
3. Negative Emotional Reactions	.23	-.11	-													
4. Positive Emotional Reactions	.19*	-.08	.02	-												
5. Anxious Emotional Reactions	.17*	-.07	.46	.05	-											
6. Guilty Emotional Reactions	.42	-.10	.42	.11	.43	-										
7. Rejecting Behavioral Responses	.28	-.08	.75	.16 ^a	.34	.31	-									
8. Accepting Behavioral Responses	-.09	-.04	-.57	.19*	-.19*	-.19*	-.51	-								
9. Providing Support	-.12	-.11	-.63	.06	-.15 ^a	-.16 ^a	-.58	.76	-							
10. Unsupportive	.24	-.02	.62	.23	.23	.26	.75	-.35	-.48	-						
11. Avoidance	.13 ^a	.03	.32	.31	.25	.20*	.39	-.15 ^a	-.22	.52	-					
12. Reciprocity	.09	-.02	.02	.10	.17*	.18*	.04	.15 ^a	.24	.05	.09	-				
13. Negative Receiver Outcomes	.23	-.08	.75	.08	.40	.34	.77	-.57	-.63	.70	.39	.02	-			
14. Positive Receiver Outcomes	.05	.05	-.36	.25	-.09	-.07	-.27	.51	.53	-.18*	-.00	.29	-.42	-		
15. Negative Relationship Outcomes	.22	-.08	.68	.04	.36	.29	.71	-.57	-.66	.65	.33	-.08	.83	-.43	-	
16. Positive Relationship Outcomes	-.08	-.03	-.30	.18*	-.09	-.08	-.23	.52	.45	-.09	.08	.21	-.40	.64	-.40	-

^a $p < .05$, * $p \leq .01$, $p \leq .001$

Tables 9 - 14: Exploratory Factor Analyses (EFA) Results

Note: All extracted factors are bolded.

Table 9. *EFA Results for Emotional Reactions: Feelings*

Item	F1: Negative Emotional Reactions	F2: Positive Emotional Reactions	F3: Anxious Emotional Reactions	F4: Guilty Emotional Reactions
Eigenvalue	6.74	2.80	1.67	1.05
Angry	.87	.13	.10	-.07
Unsympathetic	.84	.14	-.17	-.02
Irritated	.77	.05	.20	-.17
Suspicious	.77	-.04	-.02	-.06
Hostile	.77	.07	.14	-.02
Sympathetic	-.75	.16	.36	-.02
Disgusted	.73	.09	.09	.11
Trusting	-.70	.15	-.00	.15
Disappointed	.70	-.08	.04	.09
Upset	.65	-.09	.17	.18
Pleased	.10	.89	-.17	.08
Relief	-.06	.88	.09	-.06
Proud	-.06	.75	.23	-.21
Happy	.04	.66	-.35	.21
Nervous	.05	-.14	.83	.11
Scared	.07	.02	.81	.11
Guilty	-.28	.11	.16	.79
Calm	-.10	.24	.00	-.64
Ashamed	.24	.15	.16	.52

Table 10. *EFA Results for Emotional Responses: Behaviors*

Item	F1: Rejecting Behavioral Responses	F2: Accepting Behavioral Responses
Eigenvalue	5.02	1.88
Insult my partner	.92	.19
Yell at my partner	.85	.06
Reject my partner	.84	-.08
Criticize my partner	.83	-.00
Withdraw from my partner	.75	-.18
Become physically violent with my partner	.62	.31
Compliment my partner	.35	.78
Praise my partner	.28	.73
Hug my partner	-.26	.69
Encourage my partner	-.19	.69
Accept my partner	-.35	.64

Table 11. *Principle Component Analysis^a Results for Avoidance*

Item	F1: Avoidant Responses
Eigenvalue	2.11
I would ignore my partner.	.82
I would refuse to discuss the disclosure with my partner.	.75
I would immediately change the subject.	.73
I would be silent.	.57

^aBecause only one factor was being extracted, principle components analysis was used

Table 12. *EFA Results for Support*

Item	F1: Providing Support	F2: Unsupportive
Eigenvalue	8.00	1.56
I would let my partner know that many other people also have STIs.	.89	.21
I would offer to help my partner with whatever they needed.	.87	-.02
I would behave warmly toward my partner.	.87	.02
I would try to make my partner feel comfortable about themselves and their disclosure.	.86	-.04
I would give my partner useful information about STIs.	.85	.13
I would let my partner know that I was there for them.	.85	-.04
I would be supportive of my partner.	.83	-.11
I would offer to assist my partner, such as driving them to the doctor or giving them money for treatment.	.82	-.08
I would be sensitive to my partner's disclosure.	.81	-.05
I would offer my partner practical advice.	.80	.09
I would be indifferent to my partner's needs.	.01	.80
I would not take my partner's disclosure seriously.	.41	.72
I would cut off support for my partner.	-.25	.68
I would be rude and abrupt in my response.	-.29	.64

Table 13. *EFA Results for Receiver Outcomes*

Item	F1: Negative Receiver Outcomes	F2: Positive Receiver Outcomes
Eigenvalue	4.97	1.79
I would become cold toward my partner.	.95	.09
I would become distant from my partner.	.94	.03
I would become less affectionate toward my partner.	.93	.04
My emotional health would be negatively affected.	.79	-.04
My feelings would be hurt.	.77	-.10
I would become more affectionate toward my partner.	-.10	.83
I would become closer to my partner.	-.18	.80
My emotional health would be positively affected.	.48	.79
I would become more empathetic toward my partner.	-.36	.66

Table 14. *EFA Results for Relationship Outcomes*

Item	F1: Negative Relationship Outcomes	F2: Positive Relationship Outcomes
Eigenvalue	4.36	1.85
Our relationship would not be as strong as it was before the disclosure.	.92	.03
Our relationship would not be as good as it was before the disclosure.	.92	-.07
Our relationship would not be as secure as it was before the disclosure.	.90	-.06
I would no longer like my partner after receiving their disclosure.	.88	.10
Our relationship would be better than it was before the disclosure.	.04	.94
Our relationship would be more secure than it was before the disclosure.	-.01	.89
Our relationship would be stronger than it was before the disclosure.	-.05	.86
I would like my partner more after receiving their disclosure.	.04	.70

Table 15. Means, Modes, and Ranges of Outcome Variables, N = 243

Outcome Variable	Mean (SD)	Mode	Actual Range
Negative Emotional Reactions	3.51 (0.91)	4.40	1.30 – 5.00
Positive Emotional Reactions	1.07 (0.31)	1.00	1.00 – 3.75
Anxious Emotional Reactions	3.92 (0.92)	4.00, 5.00	1.00 – 5.00
Guilty Emotional Reactions	2.92 (0.78)	2.67	1.33 – 5.00
Rejecting Behavioral Reactions	2.08 (0.95)	1.17	1.00 – 4.67
Accepting Behavioral Reactions	1.66 (0.68)	1.00	1.00 – 4.20
Providing Support	2.63 (1.09)	1.00	1.00 – 5.00
Unsupportive	1.81 (0.85)	1.00	1.00 – 4.25
Avoidance	1.48 (0.58)	1.00	1.00 – 3.50
Reciprocity	2.36 (1.05)	1.00	1.00 – 5.00
Negative Receiver Outcomes	3.04 (1.15)	2.00	1.00 – 5.00
Positive Receiver Outcomes	1.78 (0.78)	1.00	1.00 – 4.25
Negative Relationship Outcomes	2.68 (1.30)	1.00	1.00 – 5.00
Positive Relationship Outcomes	1.64 (0.81)	1.00	1.00 – 5.00

Tables 16 - 29. Analyses of Covariance Results and Main, Two-Way, and Three-Way Interaction

Effects Based on the Estimated Marginal Means (EMM)

Note: All significant effects are bolded (effects that approach significance are also bolded).

Table 16. Negative Emotional Reactions ANCOVA (N = 243)

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	242.40	.000	.51
STI Stigma	13.31	.000	.05
Gender	4.34	.04	.02
STI Type	0.15	.70	.001
Rel Type	0.05	.83	.000
Gender x STI Type	0.01	.92	.000
Gender x Rel Type	3.02	.08	.013
STI Type x Rel Type	0.05	.82	.000
Gender x STI Type x Rel Type	0.02	.88	.000

$R^2 = .07$, Adjusted $R^2 = .04$

Table 17. *Anxious Emotional Reactions ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	357.49	.000	.60
STI Stigma	6.53	.01	.03
Gender	13.72	.000	.05
STI Type	2.67	.10	.01
Rel Type	0.14	.70	.001
Gender x STI Type	0.84	.36	.004
Gender x Rel Type	4.39	.04	.02
STI Type x Rel Type	1.99	.16	.01
Gender x STI Type x Rel Type	0.03	.86	.000

$R^2 = .10$, *Adjusted R*² = .07

Table 18. *Guilty Emotional Reactions ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	196.81	.000	.46
STI Stigma	46.46	.000	.17
Gender	8.63	.004	.04
STI Type	0.01	.92	.000
Rel Type	1.50	.22	.01
Gender x STI Type	0.88	.35	.004
Gender x Rel Type	3.73	.05	.02
STI Type x Rel Type	0.64	.42	.003
Gender x STI Type x Rel Type	0.97	.33	.004

$R^2 = .21$, *Adjusted R*² = .18

Table 19. *Rejecting Behavioral Responses ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	48.91	.000	.17
STI Stigma	18.05	.000	.07
Gender	0.38	.54	.002
STI Type	0.02	.88	.000
Rel Type	0.20	.65	.001
Gender x STI Type	0.09	.76	.000
Gender x Rel Type	0.24	.63	.001
STI Type x Rel Type	0.00	.99	.000
Gender x STI Type x Rel Type	0.01	.93	.000

$R^2 = .07$, *Adjusted* $R^2 = .04$

Table 20. *Log10 Transformed Unsupportive Responses ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	92.18	.000	.28
STI Stigma	12.54	.000	.05
Gender	2.05	.15	.01
STI Type	0.90	.34	.004
Rel Type	0.01	.90	.000
Gender x STI Type	0.10	.75	.000
Gender x Rel Type	0.37	.54	.002
STI Type x Rel Type	1.08	.30	.005
Gender x STI Type x Rel Type	0.70	.40	.003

$R^2 = .07$, *Adjusted* $R^2 = .04$

Table 21. *Negative Receiver Outcomes ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	8.01	.005	.03
STI Stigma	11.93	.000	.05
Gender	1.16	.28	.005
STI Type	3.37	.06	.01
Rel Type	0.56	.45	.002
Gender x STI Type	0.64	.42	.003
Gender x Rel Type	0.30	.58	.001
STI Type x Rel Type	2.04	.15	.01
Gender x STI Type x Rel Type	0.43	.51	.002

$R^2 = .07$, *Adjusted R*² = .04

Table 22. *Negative Relationship Outcomes ANCOVA (N = 243)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	52.35	.000	.18
STI Stigma	11.42	.000	.05
Gender	0.75	.39	.003
STI Type	0.07	.80	.000
Rel Type	1.20	.27	.005
Gender x STI Type	0.07	.79	.000
Gender x Rel Type	1.59	.21	.01
STI Type x Rel Type	0.15	.70	.001
Gender x STI Type x Rel Type	0.01	.91	.000

$R^2 = .06$, *Adjusted R*² = .03

Table 23. Main Effect of Gender

Variable	<i>M (SE)</i>		$\Delta M (SE)$	<i>p</i>
	Men	Women		
Negative Emotional Reactions	3.34 (.11)	3.66 (.11)	.32 (.15)	.04
Anxious Emotional Reactions	3.64 (.11)	4.21 (.11)	.57 (.15)	.000
Guilty Emotional Reactions	2.79 (.09)	3.15 (.08)	.36 (.12)	.004
Rejecting Behavioral Responses	2.06 (.12)	2.16 (.11)	.10 (.16)	.54
Log10 Unsupportive	0.24 (.02)	.21 (.02)	.03 (.03)	.28
Negative Receiver Outcomes	2.88 (.14)	3.16 (.14)	.28 (.20)	.15
Negative Relationship Outcomes	2.67 (.16)	2.87 (.16)	.20 (.22)	.39

Table 24. Main Effect of Relationship Type (Non-Committed [NC] vs. Committed [C])

Variable	<i>M (SE)</i>		$\Delta M (SE)$	<i>p</i>
	NC	C		
Negative Emotional Reactions	3.48 (.14)	3.52 (.06)	.04 (.15)	.83
Anxious Emotional Reactions	3.95 (.14)	3.90 (.06)	.05 (.15)	.70
Guilty Emotional Reactions	3.04 (.11)	2.89 (.05)	.15 (.12)	.22
Rejecting Behavioral Responses	2.14 (.15)	2.07 (.07)	.07 (.16)	.65
Log10 Unsupportive	.24 (.03)	.22 (.01)	.02 (.03)	.45
Negative Receiver Outcomes	3.01 (.18)	3.03 (.08)	.02 (.20)	.90
Negative Relationship Outcomes	2.89 (.20)	2.65 (.09)	.24 (.22)	.27

Table 25. Main Effect of STI Type (Bacterial [B] vs. Viral [V])

Variable	<i>M (SE)</i>		$\Delta M (SE)$	<i>p</i>
	B	V		
Negative Emotional Reactions	3.47 (.12)	3.53 (.10)	.06 (.15)	.70
Anxious Emotional Reactions	3.80 (.12)	4.05 (.10)	.25 (.15)	.10
Guilty Emotional Reactions	2.97 (.09)	2.96 (.08)	.01 (.12)	.92
Rejecting Behavioral Responses	2.09 (.12)	2.12 (.11)	.03 (.16)	.88
Log10 Unsupportive	.26 (.02)	.20 (.02)	.06 (.03)	.06
Negative Receiver Outcomes	3.11 (.15)	2.93 (.13)	.18 (.20)	.34
Negative Relationship Outcomes	2.80 (.17)	2.74 (.15)	.06 (.22)	.80

Table 26. *Interaction effect of gender x STI type*

Variable	<i>M (SE)</i>				<i>p</i>
	Men		Women		
	B	V	B	V	
Negative Emotional Reactions	3.32 (.17)	3.36 (.14)	3.63 (.16)	3.70 (.15)	.92
Anxious Emotional Reactions	3.58 (.17)	3.70 (.14)	4.01 (.15)	4.41 (.15)	.36
Guilty Emotional Reactions	2.85 (.13)	2.72 (.11)	3.10 (.12)	3.20 (.11)	.35
Rejecting Behavioral Responses	2.02 (.18)	2.09 (.15)	2.17 (.16)	2.14 (.15)	.76
Log10 Unsupportive	.29 (.04)	.20 (.03)	.23 (.03)	.19 (.03)	.42
Negative Receiver Outcomes	3.00 (.22)	2.75 (.18)	3.22 (.20)	3.10 (.19)	.75
Negative Relationship Outcomes	2.67 (.25)	2.67 (.20)	2.93 (.23)	2.81 (.21)	.79

Table 27. *Interaction effect of gender x relationship type*

Variable	<i>M (SE)</i>				<i>p</i>
	Men		Women		
	NC	C	NC	C	
Negative Emotional Reactions	3.19 (.20)	3.49 (.10)	3.78 (.20)	3.55 (.08)	.08
Anxious Emotional Reactions	3.51 (.20)	3.77 (.10)	4.40 (.20)	4.02 (.08)	.04
Guilty Emotional Reactions	2.75 (.16)	2.83 (.08)	3.34 (.16)	2.96 (.06)	.05
Rejecting Behavioral Responses	2.05 (.21)	2.06 (.10)	2.32 (.21)	2.08 (.09)	.63
Log10 Unsupportive	.27 (.04)	.22 (.02)	.21 (.04)	.21 (.02)	.58
Negative Receiver Outcomes	2.81 (.25)	2.95 (.12)	3.21 (.25)	3.11 (.10)	.54
Negative Relationship Outcomes	2.65 (.29)	2.69 (.14)	3.13 (.29)	2.60 (.12)	.21

Table 28. *Interaction effect of STI type x relationship type*

Variable	<i>M (SE)</i>				<i>p</i>
	NC		C		
	B	V	B	V	
Negative Emotional Reactions	3.47 (.22)	3.50 (.18)	3.47 (.09)	3.57 (.09)	.82
Anxious Emotional Reactions	3.72 (.21)	4.19 (.18)	3.88 (.09)	3.91 (.09)	.16
Guilty Emotional Reactions	3.10 (.17)	2.99 (.14)	2.85 (.07)	2.94 (.07)	.42
Rejecting Behavioral Responses	2.13 (.23)	2.15 (.19)	2.06 (.09)	2.08 (.09)	.99
Log10 Unsupportive	.29 (.04)	.19 (.04)	.22 (.02)	.21 (.02)	.15
Negative Receiver Outcomes	3.20 (.27)	2.81 (.23)	3.02 (.11)	3.04 (.11)	.30
Negative Relationship Outcomes	2.96 (.31)	2.82 (.26)	2.63 (.13)	2.66 (.13)	.70

Table 29. *Three-way interaction effect of gender x relationship type x STI type*

Variable	<i>M (SE)</i>								<i>p</i>
	Men				Women				
	NC		C		NC		C		
	B	V	B	V	B	V	B	V	
Negative Emotional Reactions	3.17 (.31)	3.21 (.25)	3.46 (.15)	3.52 (.13)	3.77 (.30)	3.79 (.27)	3.48 (.11)	3.61 (.12)	.88
Anxious Emotional Reactions	3.36 (.31)	3.66 (.24)	3.81 (.14)	3.73 (.13)	4.08 (.29)	4.72 (.27)	3.95 (.11)	4.09 (.12)	.86
Guilty Emotional Reactions	2.92 (.25)	2.57 (.19)	2.79 (.12)	2.88 (.10)	3.28 (.23)	3.41 (.21)	2.91 (.08)	3.00 (.10)	.35
Rejecting Behavioral Responses	2.01 (.33)	2.10 (.26)	2.03 (.15)	2.09 (.14)	2.25 (.31)	2.21 (.28)	2.09 (.11)	2.07 (.13)	.93
Log10 Unsupportive Negative Receiver Outcomes	.34 (.06)	.19 (.05)	.23 (.03)	.21 (.03)	.24 (.06)	.18 (.05)	.21 (.02)	.20 (.03)	.51
Negative Relationship Outcomes	3.12 (.40)	2.50 (.31)	2.89 (.18)	3.01 (.17)	3.29 (.38)	3.13 (.34)	3.16 (.14)	3.07 (.16)	.40
Negative Relationship Outcomes	2.68 (.45)	2.62 (.36)	2.66 (.21)	2.72 (.19)	3.25 (.43)	3.01 (.39)	2.60 (.16)	2.60 (.18)	.91

APPENDIX 4:

Chapter 3 Measures

[Variable Label]

Demographic Items

1. [Gender]

How would you describe your gender identity?

1. Male/Man
2. Female/Woman
3. Trans male/Trans man
4. Trans female/Trans woman
5. Non-binary
6. Intersex
7. Gender identity not listed (please specify): _____

2. [SAAB]

What sex were you assigned at birth, on your original birth certificate?

1. Male
2. Female

3. [Age]

What is your age (in years)?

1. Dropdown 18-29

4. [Race]

How would you describe your race/ethnicity? Mark all that apply.

1. White/Caucasian
2. Black/African American
3. Asian American
4. Native Hawaiian or other Pacific Islander
5. Latinx or Hispanic
6. Native American/American Indian or Alaskan Native
7. Race/Ethnicity not listed (please specify): _____

5. [SO]

How would you describe your sexual orientation?

1. Heterosexual/Straight
2. Gay
3. Lesbian
4. Bisexual
5. Pansexual
6. Queer
7. Asexual

8. Unsure
9. Sexual Orientation not listed (please specify): _____

6. **[RelType]**

Would you describe your *most recent* sexual relationship as “a committed romantic relationship?” By “committed romantic relationship,” we mean a relationship where you and your partner depend on one another and are a team, view the relationship as long-term, are willing to make sacrifices for one another, and would find it difficult to end the relationship.

1. Yes
 - i. (If yes): Which of the following options best describes your relationship with this sexual partner? **[C_Rel]**
 1. Committed dating relationship
 2. Cohabiting/living together
 3. Engaged
 4. Married/Domestic Partnership
 5. Other (please specify): _____ **[C_Rel_Oth]**
2. No
 - i. (If no): Which of the following options best describes your relationship with this sexual partner? **[NC_Rel]**
 1. Casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup)
 2. Casually dating/talking
 3. Other (please specify): _____ **[NC_Rel_Oth]**

7. **[College]**

Are you currently enrolled in postsecondary education (i.e., college or trade school)?

1. No, I am not enrolled in postsecondary education
2. I am enrolled at a two-year college
3. I am enrolled at a four-year university
4. I am enrolled in trade school

8. **[Educ]**

What is your highest level of education attainment?

1. Primary/elementary school
2. Junior high/middle school
3. Secondary/high school
4. GED
5. Some college
6. Two-year degree (e.g., Associate’s)
7. Four-year degree (e.g., Bachelor’s)
8. Master’s degree
9. Doctorate degree

Control Items

[STI Stigma (Fortenberry et al., 2002)]

Using the following scale, please indicate your level of agreement with the following statements.

1 = Strongly disagree, 2 = Disagree, 3 = Neither agree nor disagree, 4 = Agree, 5 = Strongly agree

1. I would feel dirty if a doctor examined me for sexually transmitted infections. [STigma_1]
2. Getting a sexually transmitted infection would make me feel lonely. [STigma_2]
3. Getting examined for a sexually transmitted infection makes people think I have poor morals. ...
4. Most people I know think that a sexually transmitted infection is a sign of a weak character.
5. Getting a sexually transmitted infection means I have poor morals.

[Social Desirability: BIDR-16 (Hart et al., 2015)]

Using the scale below, mark a number beside each statement to indicate how true it is.

1 = not at all true, 4 = somewhat, 7 = very true

1. I have not always been honest with myself. (R) [BIDR_1]
2. I always know why I like things. [BIDR_2]
3. It's hard for me to shut off a disturbing thought. (R) [BIDR_3]
4. I never regret my decisions. ...
5. I sometimes lose out on things because I can't make up my mind soon enough. (R)
6. I am a completely rational person.
7. I am very confident of my judgments.
8. I have sometimes doubted my ability as a lover. (R)
9. I sometimes tell lies if I have to. (R)
10. I never cover up my mistakes.
11. There have been occasions when I have taken advantage of someone. (R)
12. I sometimes try to get even rather than forgive and forget. (R)
13. I have said something bad about a friend behind his/her back.
14. When I hear people talking privately, I avoid listening.
15. I never take things that don't belong to me.
16. I don't gossip about other people's business.

STI Disclosure Reactions Measure

Receiver Anticipated Response

We are interested in how you think you would respond in this scenario. By response, we mean what you think you would first feel, say, and/or do, right after the partner in this scenario told you about their sexually transmitted infection.

This scale consists of a number of words, phrases, and statements that describe different feelings, emotions, and behaviors. Please use the following scale to mark what you think you would feel, say, and do right after your partner in the above scenario told you about their STI. Read each item, and then mark the appropriate answer. Use the following scale to record your answers:

1 = not at all; 2 = a little; 3 = moderately; 4 = quite a bit; 5 = extremely

[Emotional Response – Feelings]

As soon as my partner told me about their STI, I would feel:

1. Scared **[ER_Scared]**
2. Nervous **[ER_Nervous]**
3. Happy ...
4. Irritated
5. Hostile
6. Guilty
7. Calm
8. Trusting
9. Ashamed
10. Upset
11. Distressed
12. Proud
13. Sympathetic
14. Angry
15. Disgusted
16. Suspicious
17. Disappointed
18. Unsympathetic
19. Relief
20. Pleased

[Emotional Response – Behaviors]

As soon as my partner told me about their STI, I would:

1. Withdraw from my partner **[BR_Withdraw]**
2. Hug my partner **[BR_Hug]**
3. Criticize my partner **[BR_Criticize]**
4. Praise my partner **[BR_Praise]**
5. Insult my partner **[BR_Insult]**
6. Compliment my partner **[BR_Compliment]**
7. Reject my partner **[BR_Reject]**
8. Accept my partner **[BR_Accept]**
9. Yell at my partner **[BR_Yell]**
10. Become physically violent with my partner **[BR_Violent]**
11. Encourage my partner **[BR_Encourage]**

We are interested in how you think you would respond in this scenario. By response, we mean what you think you would first feel, say, and/or do, right after the partner in this scenario told you about their sexually transmitted infection.

This scale consists of a number of words, phrases, and statements that describe different feelings, emotions, and behaviors. Please use the following scale to mark what you think you would feel, say, and do right after your partner in the above scenario told you about their STI. Read each item, and then mark the appropriate answer. Use the following scale to record your answers:

1 = not at all; 2 = a little; 3 = moderately; 4 = quite a bit; 5 = completely

[Support]

As soon as my partner told me about their STI:

1. I would let my partner know that I was there for them. **[SP_ThereFor]**
2. I would behave warmly toward my partner. **[SP_BehaveWarmly]**
3. I would be rude and abrupt in my response. **[SP_Rude]**
4. I would try to make my partner feel comfortable about themselves and their disclosure. **[SP_Comfortable]**
5. I would be sensitive to my partner's disclosure. **[SP_Sensitive]**
6. I would not take my partner's disclosure seriously. **[SP_NotSerious]**
7. I would be supportive of my partner. **[SP_Supportive]**
8. I would offer my partner practical advice. **[SP_Advice]**
9. I would let my partner know that many other people also have STIs. **[SP_Common]**
10. I would be indifferent to my partner's needs. **[SP_Indifferent]**
11. I would give my partner useful information about STIs. **[SP_Info]**
12. I would offer to assist my partner, such as driving them to the doctor or giving them money for treatment. **[SP_Assist]**
13. I would offer to help my partner with whatever they needed. **[SP_Help]**
14. I would cut off support for my partner. **[SP_CutOff]**

[Avoidance]

1. I would refuse to discuss the disclosure with my partner. **[AV_RefusetoDiscuss]**
2. I would immediately change the subject. **[AV_ChangeSubj]**
3. I would be silent. **[AV_Silent]**
4. I would ignore my partner. **[AV_Ignore]**

[Reciprocation: Measured using an adapted version of the Self-Disclosure Index (Miller et al., 1983)]

How much do you think you would discuss the following topics with your partner immediately after they told you about their STI?

1 = Would not discuss at all; 2 = Would discuss a little bit; 3 = Would moderately discuss; 4 = Would discuss quite a bit; 5 = Would discuss fully and completely

[RR]

1. My personal sexual history **[RR_1]**
2. Things I have done which I feel guilty about **[RR_2]**
3. Things I wouldn't do in public ...
4. My deepest feelings
5. What I like and dislike about myself
6. What makes me the person I am
7. My worst fears
8. Things I have done which I am proud of
9. My close relationships with other people

Receiver Outcomes

We are also interested in what you think the outcomes of this STI disclosure would be. Thinking about the same scenario, now consider what you think would happen as a result of your partner's disclosure. What do you think the outcomes would be for you? What do you think the outcomes would be for the relationship?

This scale consists of a number of words, phrases, and statements that describe different outcomes. Read each item, and then mark the appropriate answer. Use the following scale to record your answers:

1 = not at all; 2 = a little; 3 = moderately; 4 = quite a bit; 5 = extremely

[Negative Receiver Outcome] [Receiver Outcomes (RcO)]

1. My emotional health would be negatively affected. [RcO_neghealth]
2. My feelings would be hurt. [RcO_hurtfeel]
3. I would become distant from my partner. [RcO_distant]
4. I would become cold toward my partner. [RcO_cold]
5. I would become less affectionate toward my partner. [RcO_lessaffect]

[Positive Receiver Outcome]

6. I would become more educated about sexually transmitted infections. [RcO_moreeduc]
7. My emotional health would be positively affected. [RcO_poshealth]
8. I would become closer to my partner. [RcO_closer]
9. I would become more empathetic toward my partner. [RcO_empathy]
10. I would become more affectionate toward my partner. [RcO_moreaffect]

[Negative Relationship Outcome] [Relationship Outcomes (RO)]

1. Our relationship would not be as strong as it was before the disclosure. [RO_notstrong]
2. Our relationship would not be as secure as it was before the disclosure. [RO_notsecure]
3. Our relationship would not be as good as it was before the disclosure. [RO_notgood]
4. I would no longer like my partner after receiving their disclosure. [RO_notlike]

[Positive Relationship Outcome]

5. Our relationship would be stronger than it was before the disclosure. [RO_stronger]
6. Our relationship would be more secure than it was before the disclosure. [RO_moresecure]
7. Our relationship would be better than it was before the disclosure. [RO_better]
8. I would like my partner more after receiving their disclosure. [RO_likemore]

[RelOutcome] What do you think would happen to your relationship with this partner after they disclosed?

1. I would end the relationship
2. I would continue the relationship

APPENDIX 5:

Chapter 4 Tables and Figures

Table 30. *Chapter 4 Participant Demographic Characteristics (N = 88)*

	<i>n</i>	<i>M(SD)/%</i>
Gender		
Women	54	61.4
Men	29	33.0
Non-binary	5	5.7
Age (18-29)		25.05 (3.18)
Race/Ethnicity		
White/Caucasian	61	69.3
Black/African American	12	13.6
Asian American	6	6.8
Latinx/Hispanic	4	4.5
Bi/multiracial	4	4.5
Native Hawaiian/Pacific Islander	1	1.1
Sexual Orientation		
Heterosexual	57	64.8
Bisexual	16	18.2
Pansexual	4	4.5
Gay	4	4.5
Lesbian	4	4.5
Queer	1	1.1
Asexual	1	1.1
Unsure	1	1.1
Educational Attainment		
Secondary/high school	9	10.2
GED	1	1.1
Some college	32	36.4
Two-year degree (e.g., Associate's)	8	9.1
Four-year degree (e.g., Bachelor's)	28	31.8
Master's degree	7	8.0
Doctorate degree (e.g., M.D., Ph.D.)	3	3.4
Current College Enrollment		
Not enrolled	61	69.3
Two-year college	2	2.3
Four-year university	24	27.3
Trade school	1	1.1

Table 30. Continued...

Most Recent Relationship Type		
Committed dating relationship	43	48.9
Cohabiting/living together	16	18.2
Engaged	3	3.4
Married/domestic partnership	16	18.2
Committed polyamorous relationship	1	1.1
Casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup)	6	6.8
Casually dating/talking	3	3.4

Table 31. Disclosure Assessment

	<i>n</i>	<i>M(SD)/%</i>
Participant's age at disclosure		21.93 (3.20)
16	2	2.3
17	3	3.4
18	8	9.1
19	11	12.5
20	9	10.2
21	10	11.4
22	11	12.5
23	6	6.8
24	5	5.7
25	7	8.0
26	7	8.0
27	5	5.7
28	4	4.5
Discloser's gender		
Male/man	60	68.2
Female/woman	24	27.3
Non-binary	4	4.5
STI type disclosed		
Chlamydia	26	29.5
Gonorrhea	8	9.1
Syphilis	2	2.3
Human papillomavirus (HPV)	14	15.9
Herpes	31	35.2
Other	2	2.3
Molluscum contagiosum virus (MCV)	1	1.1
Pubic lice ("crabs")	1	1.1
Don't remember	9	10.2

Table 31. Continued...

Relationship type with discloser		
Committed dating relationship	41	46.6
Cohabiting/living together	3	3.4
Engaged	2	2.3
Married/domestic partnership	3	3.4
Casual sex relationship	17	19.3
Casually dating/talking	16	18.2
Other	6	6.8
Behaviors engaged in		
I gave them oral sex	65	73.9
I received oral sex from them	60	68.2
I gave them analingus (oral sex on anus)	11	12.5
I received analingus (oral sex on anus)	11	12.5
Tribadism (genital-to-genital rubbing)	31	35.2
Penile-vaginal intercourse	65	73.9
Penile-anal intercourse	18	20.5
Disclosure timing		
Before first sexual engagement	28	31.8
After first sexual engagement	60	68.2
Discloser's STI status at time of disclosure		
Their STI was in remission (not active or contagious)	27	30.7
Their STI was active and contagious	25	28.4
Their STI was cured, but it was active during our relationship	11	12.5
I am not sure	25	28.4
Participant's STI status at time of disclosure		
I did not have an STI when my partner disclosed	66	75.0
I had an STI when my partner disclosed	13	14.8
I am not sure	9	10.2
Did you suspect that your partner gave you the STI?		
Yes	39	44.3
No	49	55.7
Did your partner suspect that you gave them the STI?		
Yes	13	14.8
No	75	85.2

Table 31. *Continued...*

How did your partner tell you about their STI?		
In-person	59	67.0
In a text message	17	19.3
On the phone	9	10.2
On a video chat	3	3.4
How did the conversation about your partner's STI come up?		
They voluntarily told me	64	72.7
I asked my partner about their sexual history/if they had an STI	10	11.4
I tested positive for an STI, prompting me to ask	5	5.7
I found out that my partner had sex with someone else during our relationship, prompting me to ask	3	3.4
I found medical paperwork/medication for an STI, prompting me to ask	2	2.3
Other	4	4.5
Relationship outcome		
I ended the relationship	29	33.0
We continued our relationship	59	67.0
Since your partner disclosed their STI to you, have you gotten an STI test?		
Yes	74	84.1
No	14	15.9
Was this the only time you have experienced an STI disclosure?		
Yes	84	95.5
No	4	4.5

Tables 32 - 38: Confirmatory Factor Analyses (CFAs) Results

Note: All CFAs were conducted using 200 bootstrap samples with a bootfactor of 4. All factor loadings are significant at $p \leq .001$ unless otherwise noted.

Table 32. *CFA Loading Results for Emotional Reactions: Feelings (N = 88)*

Item	Negative ER		Positive ER		Anxious ER		Guilty ER	
	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β
Angry	1.00 (--)	.95						
Unsympath.	.77 (.07)	.80						
Disappoint.	.78 (.06)	.82						
Suspicious	.60 (.07)	.67						
Disgusted	.91 (.05)	.91						
Sympathetic	-.51 (.08)	-.57						
Upset	.94 (.06)	.92						
Trusting	-.50 (.08)	-.59						
Hostile	.89 (.06)	.90						
Irritated	.89 (.06)	.89						
Pleased			1.00 (--)	.94				
Happy			1.05 (.07)	.93				
Proud			.99 (.08)	.86				
Relief			.80 (.09)	.74				
Nervous					1.00 (--)	.86		
Scared					1.19 (.11)	.96		
Guilty							1.00 (--)	.51
Calm							-1.36 (.30)	-.65
Ashamed							2.02 (.32)	.78

Table 33. *CFA Loading Results for Emotional Reactions: Behaviors (N = 88)*

Item	Rejecting Behavioral Reactions		Accepting Behavioral Reactions	
	B (SE)	β	B (SE)	β
Insult	1.00 (--)	.91		
Withdraw	1.08 (.08)	.87		
Criticize	1.16 (.09)	.87		
Reject	1.25 (.07)	.99		
Yell	.79 (.09)	.75		
Violent ^a	.09 (.03)	.29		
Compliment			1.00 (--)	.93
Praise			1.04 (.08)	.91
Hug			.64 (.13)	.49
Accept			.90 (.15)	.58
Encourage			1.04 (.11)	.78

^a $p \leq .01$ **Table 34.** *CFA Loading Results for Support (N = 88)*

Item	Providing Support		Unsupportive	
	B (SE)	β	B (SE)	β
Common	1.00 (--)	.55		
Help	1.25 (.24)	.74		
Assist	.85 (.18)	.62		
Information	.58 (.17)	.41		
Advice	.60 (.18)	.41		
Supportive	1.66 (.25)	.93		
Sensitive	1.37 (.25)	.84		
Comfortable	1.67 (.28)	.94		
Behave Warmly	1.65 (.28)	.95		
There For	1.67 (.29)	.91		
Indifferent			1.00 (--)	.61
Rude			1.91 (.29)	1.01
Not Serious ^a			.33 (.11)	.32
Cut Off			1.47 (.23)	.81

^a $p \leq .01$

Table 35. CFA Loading Results for Avoidance (N = 88)

Item	Avoidance	
	B (SE)	β
Ignore	1.00 (--)	.56
Silent	1.06 (.29)	.57
Change Subject	.91 (.24)	.66
Refuse to Discuss	1.27 (.33)	.70

Table 36. CFA Loading Results for Reciprocity (N = 88)

Item	Reciprocity ^a	
	B (SE)	β
My personal sexual history	.66 (.16)	.44
Things I have done which I feel guilty about	1.00 (--)	.77
Things I wouldn't do in public	.93 (.11)	.79
My deepest feelings	1.14 (.15)	.76
What I dislike about myself	1.25 (.13)	.88
What makes me the person I am	1.30 (.13)	.93
My worst fears	1.12 (.13)	.81
Things I have done which I am proud of	1.18 (.12)	.90
My close relationships with other people	1.02 (.13)	.77

^aMeasured using an adapted version of the Self-Disclosure Index (Miller et al., 1983). All items were the same as the original, except the first item: the word "sexual" was added.

Table 37. CFA Loading Results for Receiver Outcomes (N = 88)

Item	Negative Receiver Outcomes		Positive Receiver Outcomes	
	B (SE)	β	B (SE)	β
Cold toward partner	1.00 (--)	.95		
Negative emotional health	.75 (.07)	.77		
Hurt feelings	.92 (.06)	.88		
Distant from partner	1.06 (.05)	.95		
Less affectionate	1.03 (.05)	.94		
More affectionate			1.00 (--)	.93
Positive emotional health ^a			.29 (.10)	.31
Closer to partner			.78 (.08)	.77
Empathetic toward partner			.99 (.07)	.92

^a $p \leq .01$

Table 38. *CFA Loading Results for Relationship Outcomes (N = 88)*

Item	Negative Relationship Outcomes		Positive Relationship Outcomes	
	B (SE)	β	B (SE)	β
Not as strong	1.00 (--)	.95		
Not as secure	1.05 (.04)	.98		
Not as good	1.04 (.04)	.95		
Not like partner	.77 (.07)	.80		
Better			1.00	.97
More secure			1.01 (.05)	.94
Like partner more			.92 (.07)	.85
Stronger			1.01 (.06)	.89

Table 39. *Means, Modes, and Ranges for Outcome Variables (N = 88)*

Outcome Variable	Mean (SD)	Mode	Actual Range
Negative Emotional Reactions	2.77 (1.23)	1.50	1.00 – 5.00
Positive Emotional Reactions	1.25 (0.70)	1.00	1.00 – 4.50
Anxious Emotional Reactions	3.17 (1.29)	4.00	1.00 – 5.00
Guilty Emotional Reactions	2.72 (1.05)	2.00, 2.33	1.00 – 5.00
Rejecting Behavioral Reactions	1.91 (1.23)	1.00	1.00 – 5.00
Accepting Behavioral Reactions	1.60 (0.99)	1.00	1.00 – 5.00
Providing Support	2.44 (1.14)	1.00	1.00 – 4.90
Unsupportive	1.67 (0.91)	1.00	1.00 – 5.00
Avoidance	1.47 (0.71)	1.00	1.00 – 4.25
Negative Receiver Outcomes	2.50 (1.43)	1.00	1.00 – 5.00
Positive Receiver Outcomes	1.91 (0.96)	1.00	1.00 – 4.50
Negative Relationship Outcomes	2.38 (1.50)	1.00	1.00 – 5.00
Positive Relationship Outcomes	1.91 (1.12)	1.00	1.00 – 5.00

Table 40. Bivariate Correlations (N = 88)

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. STI Stigma	-														
2. BIDR-16	-.03	-													
3. Negative Emotional Reactions	.42	-.12	-												
4. Positive Emotional Reactions	-.14	.13	-.25 ^a	-											
5. Anxious Emotional Reactions	.36	-.22 ^a	.70	-.17	-										
6. Guilty Emotional Reactions	.34	-.23 ^a	.80	-.16	.72	-									
7. Rejecting Behavioral Responses	.31*	.01	.84	.01	.51	.58	-								
8. Accepting Behavioral Responses	-.37	.17	-.69	.53	-.40	-.53	-.48	-							
9. Providing Support	-.30*	.05	-.66	.34	-.28*	-.40	-.54	.77	-						
10. Unsupportive	.22 ^a	-.05	.71	.16	.41	.55	.83	-.33*	-.38	-					
11. Avoidance	.30*	-.10	.60	.13	.42	.46	.61	-.34	-.34	.74	-				
12. Reciprocity ^b	.07	.15	-.13	.12	-.14	.01	-.14	.26 ^a	.19	-.01	-.06	-			
13. Negative Receiver Outcomes	.33*	-.08	.86	.09	.57	.70	.86	-.47	-.51	.82	.58	-.08	-		
14. Positive Receiver Outcomes	-.14	.11	-.44	.54	-.19	-.23 ^a	-.28*	.66	.60	-.14	-.05	.30*	-.23 ^a	-	
15. Negative Relationship Outcomes	.28*	-.08	.77	.08	.48	.63	.76	-.46	-.50	.74	.55	-.10	.91	-.24 ^a	-
16. Positive Relationship Outcomes	-.20	.07	-.45	.50	-.25 ^a	-.30*	-.29*	.66	-.18	-.13	.23 ^a	-.25 ^a	-.25 ^a	.72	-.30*

^a $p < .05$, * $p \leq .01$, **$p \leq .001$** ^bIncludes only a binary-coded version of the sexual health item (0 = no reciprocity 1 = any reciprocity)

Tables 41 - 53. Analyses of Covariance Results and Main, Two-Way, and Three-Way Interaction Effects Based on the Estimated Marginal Means (EMM)

Note: All significant effects are bolded (effects that approach significance are also bolded).

Table 41. *Negative Emotional Reactions ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	17.02	.000	.18
STI Stigma	8.45	.005	.10
Gender	.01	.91	.00
STI Type	9.35	.003	.11
Rel Type	0.98	.33	.01
Gender x STI Type	4.68	.03	.06
Gender x Rel Type	0.09	.76	.001
STI Type x Rel Type	0.01	.92	.000
Gender x STI Type x Rel Type	0.45	.50	.001

$R^2 = .28$, *Adjusted R*² = .21

Table 42. *Anxious Emotional Reactions ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	20.01	.000	.20
STI Stigma	6.92	.01	.08
Gender	0.98	.32	.01
STI Type	3.55	.06	.04
Rel Type	1.15	.29	.01
Gender x STI Type	3.72	.06	.05
Gender x Rel Type	0.03	.87	.000
STI Type x Rel Type	0.02	.88	.000
Gender x STI Type x Rel Type	0.11	.74	.001

$R^2 = .21$, *Adjusted R*² = .13

Table 43. *Guilty Emotional Reactions ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	31.23	.000	.28
STI Stigma	4.75	.03	.06
Gender	0.004	.95	.000
STI Type	9.50	.003	.11
Rel Type	0.40	.53	.005
Gender x STI Type	5.48	.02	.06
Gender x Rel Type	0.04	.83	.001
STI Type x Rel Type	1.01	.32	.01
Gender x STI Type x Rel Type	0.10	.75	.001

$R^2 = .23$, *Adjusted R*² = .16

Table 44. *Accepting Behavioral Responses ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	69.55	.000	.47
STI Stigma	9.46	.003	.12
Gender	0.02	.90	.000
STI Type	4.33	.04	.05
Rel Type	0.25	.62	.003
Gender x STI Type	0.02	.89	.000
Gender x Rel Type	0.63	.43	.01
STI Type x Rel Type	0.01	.93	.000
Gender x STI Type x Rel Type	0.51	.48	.01

$R^2 = .21$, *Adjusted R*² = .13

Table 45. *Providing Support ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	64.88	.000	.45
STI Stigma	5.08	.03	.06
Gender	.05	.82	.001
STI Type	1.88	.17	.02
Rel Type	1.95	.17	.02
Gender x STI Type	.16	.69	.002
Gender x Rel Type	2.79	.10	.03
STI Type x Rel Type	1.43	.27	.02
Gender x STI Type x Rel Type	.31	.26	.003

$R^2 = .18$, *Adjusted R*² = .09

Table 46. *Negative Receiver Outcomes ANCOVA (N = 88)*

Variable	<i>F Ratio</i>	<i>p</i>	η_p^2
Intercept	10.49	.002	.12
STI Stigma	3.73	.06	.04
Gender	0.35	.55	.004
STI Type	6.06	.02	.07
Rel Type	1.16	.28	.01
Gender x STI Type	3.29	.07	.04
Gender x Rel Type	0.03	.86	.000
STI Type x Rel Type	0.39	.53	.005
Gender x STI Type x Rel Type	0.49	.49	.01

$R^2 = .19$, *Adjusted R*² = .11

Table 47. *Main Effect of Gender on Outcome Variables*

Variable	<i>M (SE)</i>		<i>ΔM (SE)</i>	<i>p</i>
	Men	Women		
Negative Emotional Reactions	2.74 (.22)	2.77 (.15)	.03 (.27)	.91
Anxious Emotional Reactions	2.95 (.24)	3.24 (.16)	.29 (.29)	.32
Guilty Emotional Reactions	2.73 (.19)	2.71 (.13)	.02 (.24)	.95
Accepting Behavioral Responses	1.91 (.18)	1.88 (.12)	.03 (.23)	.90
Providing Support	2.43 (.22)	2.37 (.14)	.06 (.26)	.82
Negative Receiver Outcomes	2.62 (.27)	2.42 (.18)	.20 (.33)	.55

Table 48. *Main Effect of Relationship Type (Non-Committed [NC] vs. Committed [C])*

Variable	<i>M (SE)</i>		<i>ΔM (SE)</i>	<i>p</i>
	NC	C		
Negative Emotional Reactions	2.63 (.20)	2.88 (.16)	.25 (.26)	.33
Anxious Emotional Reactions	2.94 (.23)	3.25 (.17)	.31 (.28)	.29
Guilty Emotional Reactions	2.65 (.18)	2.79 (.14)	.14 (.23)	.53
Accepting Behavioral Responses	1.84 (.17)	1.95 (.13)	.11 (.22)	.62
Providing Support	2.22 (.20)	2.58 (.16)	.36 (.26)	.17
Negative Receiver Outcomes	2.35 (.25)	2.69 (.19)	.34 (.32)	.28

Table 49. *Main Effect of STI Type (Bacterial [B] vs. Viral [V])*

Variable	<i>M (SE)</i>		<i>ΔM (SE)</i>	<i>p</i>
	B	V		
Negative Emotional Reactions	3.16 (.19)	2.35 (.18)	.81 (.26)	.003
Anxious Emotional Reactions	3.37 (.21)	2.82 (.20)	.55 (.29)	.06
Guilty Emotional Reactions	3.08 (.17)	2.36 (.16)	.72 (.23)	.003
Accepting Behavioral Responses	1.66 (.16)	2.13 (.15)	.47 (.22)	.04
Providing Support	2.22 (.19)	2.58 (.18)	.36 (.26)	.17
Negative Receiver Outcomes	2.92 (.24)	2.12 (.22)	.80 (.33)	.02

Table 50. *Interaction Effect of Gender x STI Type*

Variable	<i>M (SE)</i>				<i>p</i>
	Men		Women		
	B	V	B	V	
Negative Emotional Reactions	3.44 (.33)	2.04 (.30)	2.88 (.22)	2.66 (.19)	.03
Anxious Emotional Reactions	3.52 (.36)	2.38 (.33)	3.22 (.24)	3.26 (.21)	.06
Guilty Emotional Reactions	3.37 (.29)	2.09 (.27)	2.79 (.19)	2.64 (.17)	.02
Accepting Behavioral Responses	1.66 (.28)	2.16 (.25)	1.66 (.19)	2.10 (.16)	.89
Providing Support	2.20 (.32)	2.67 (.30)	2.25 (.22)	2.50 (.19)	.69
Negative Receiver Outcomes	3.32 (.40)	1.91 (.37)	2.51 (.27)	2.33 (.24)	.07

Table 51. *Interaction Effect of Gender x Relationship Type*

Variable	<i>M (SE)</i>				<i>p</i>
	Men		Women		
	NC	C	NC	C	
Negative Emotional Reactions	2.65 (.35)	2.83 (.25)	2.60 (.22)	2.94 (.19)	.76
Anxious Emotional Reactions	2.77 (.39)	3.13 (.28)	3.11 (.25)	3.37 (.21)	.87
Guilty Emotional Reactions	2.68 (.31)	2.78 (.22)	2.62 (.20)	2.81 (.17)	.83
Accepting Behavioral Responses	1.76 (.30)	2.05 (.21)	1.91 (.19)	1.84 (.16)	.43
Providing Support	2.03 (.35)	2.83 (.25)	2.41 (.22)	2.33 (.19)	.10
Negative Receiver Outcomes	2.47 (.44)	2.76 (.31)	2.22 (.28)	2.62 (.24)	.86

Table 52. *Interaction Effect of STI Type x Relationship Type*

Variable	<i>M (SE)</i>				<i>p</i>
	NC		C		
	B	V	B	V	
Negative Emotional Reactions	3.04 (.30)	2.21 (.28)	3.27 (.23)	2.49 (.21)	.92
Anxious Emotional Reactions	3.24 (.33)	2.65 (.31)	3.50 (.26)	3.00 (.24)	.88
Guilty Emotional Reactions	3.12 (.26)	2.18 (.25)	3.04 (.20)	2.55 (.19)	.32
Accepting Behavioral Responses	1.62 (.25)	2.06 (.24)	1.71 (.20)	2.19 (.18)	.93
Providing Support	2.19 (.30)	2.26 (.28)	2.26 (.23)	2.90 (.21)	.27
Negative Receiver Outcomes	2.85 (.37)	1.84 (.35)	2.99 (.29)	2.39 (.27)	.53

Table 53. *Three-Way Interaction Effect of Gender x Relationship Type x STI Type*

Variable	<i>M (SE)</i>								<i>p</i>
	Men				Women				
	NC		C		NC		C		
	B	V	B	V	B	V	B	V	
Negative Emotional Reactions	3.45 (.53)	1.85 (.49)	3.42 (.36)	2.23 (.34)	2.63 (.34)	2.57 (.28)	3.12 (.28)	2.75 (.26)	.50
Anxious Emotional Reactions	3.41 (.58)	2.13 (.54)	3.62 (.40)	2.63 (.38)	3.07 (.38)	3.16 (.31)	3.38 (.31)	3.36 (.28)	.74
Guilty Emotional Reactions	3.48 (.47)	1.89 (.43)	3.27 (.32)	2.29 (.31)	2.77 (.30)	2.46 (.25)	2.81 (.25)	2.81 (.23)	.75
Accepting Behavioral Responses	1.61 (.45)	1.92 (.42)	1.71 (.31)	2.93 (.29)	1.63 (.29)	2.20 (.24)	1.70 (.24)	1.99 (.22)	.48
Providing Support	2.01 (.52)	2.06 (.49)	2.39 (.36)	3.27 (.34)	2.36 (.34)	2.47 (.28)	2.13 (.36)	2.53 (.25)	.61
Negative Receiver Outcomes	3.40 (.65)	1.55 (.61)	3.25 (.45)	2.27 (.43)	2.30 (.43)	2.14 (.35)	2.73 (.35)	2.51 (.32)	.49

Figures 3-9: Confirmatory Factor Analyses (CFA) Model

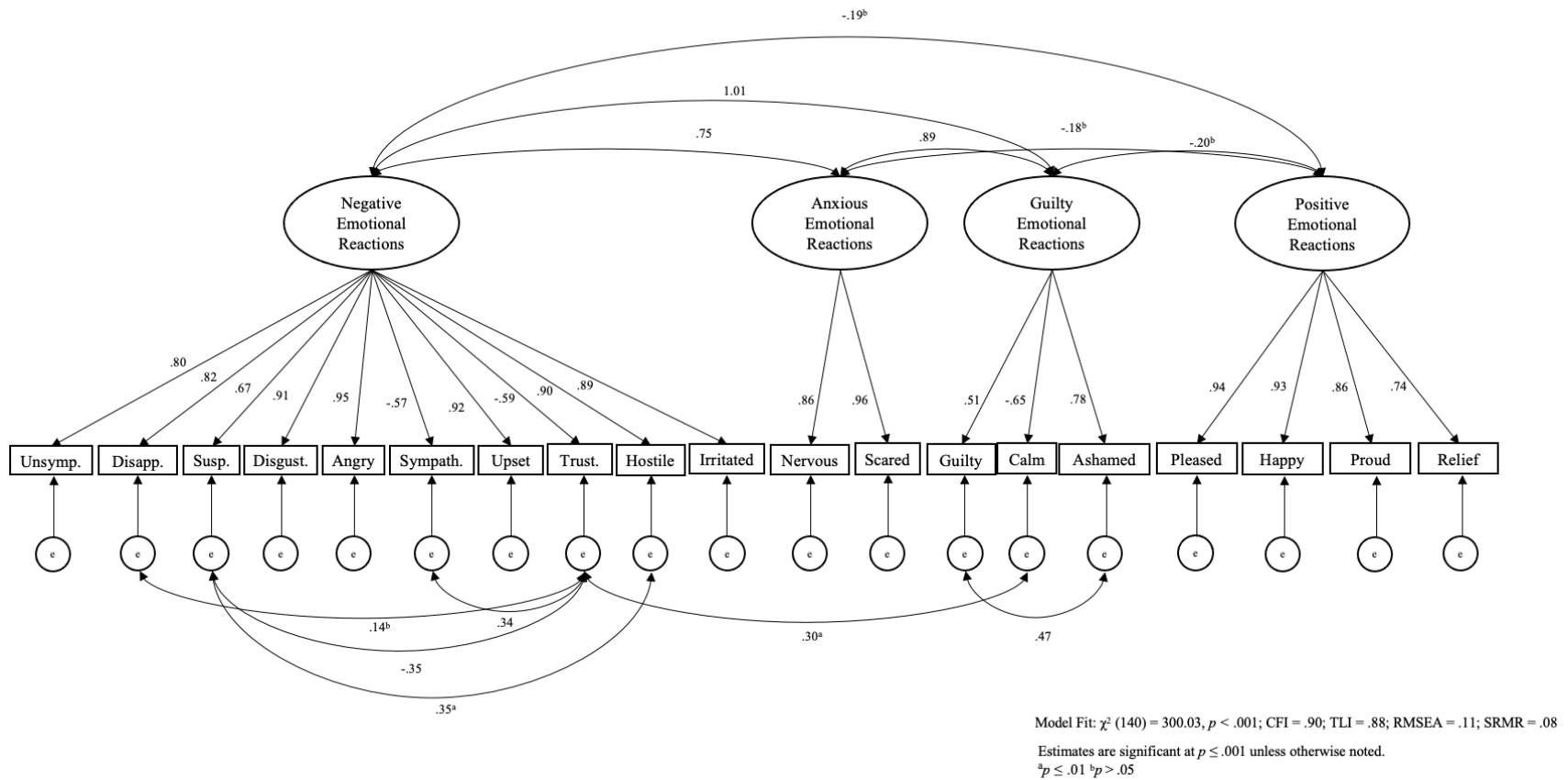
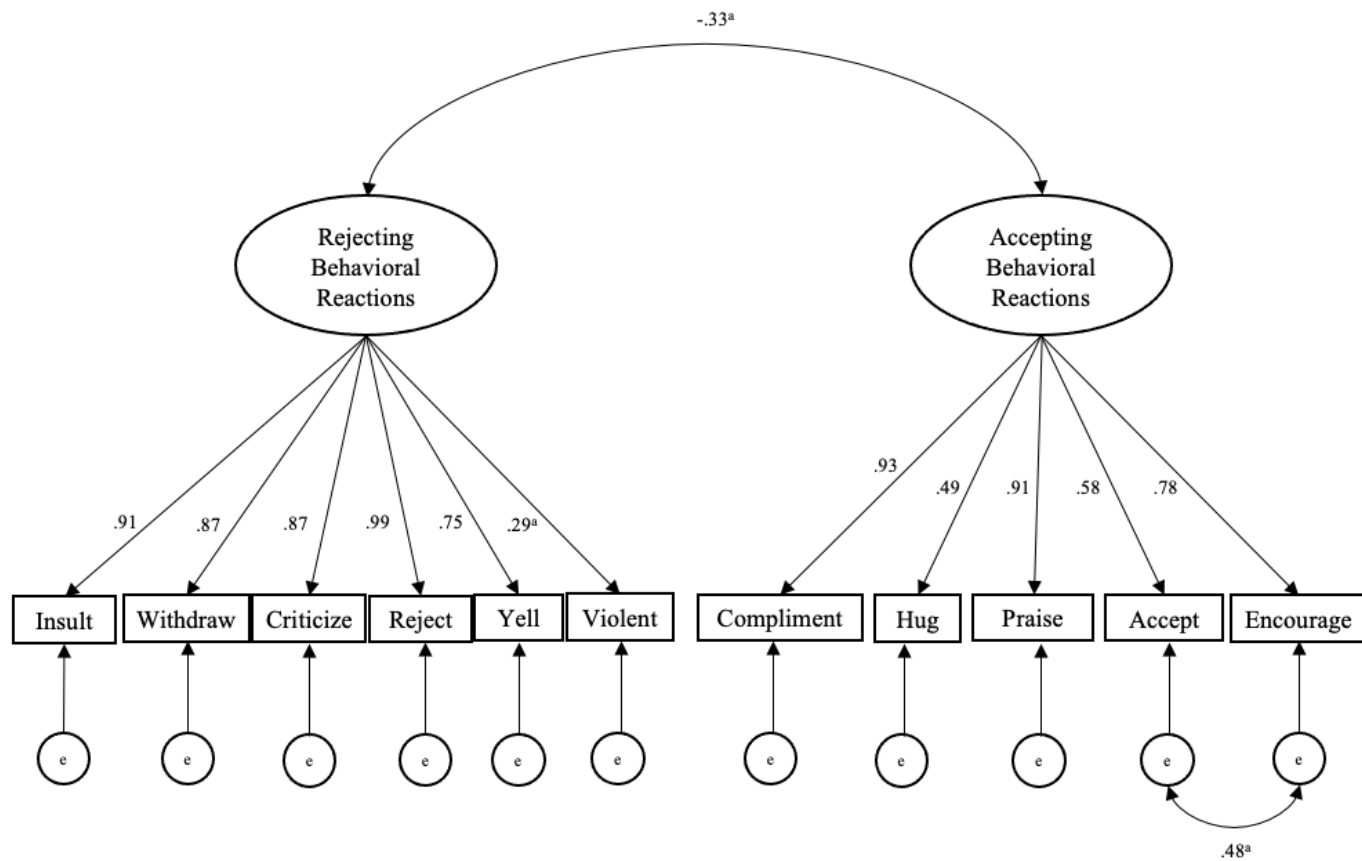


Figure 3. CFA Model for Emotional Reactions: Feelings



Model Fit: $\chi^2 (42) = 105.11, p < .001$; CFI = .92; TLI = .89; RMSEA = .10; SRMR = .15

Estimates are significant at $p \leq .001$ unless otherwise noted.

^a $p \leq .01$

Figure 4. CFA Model for Emotional Reactions: Behaviors

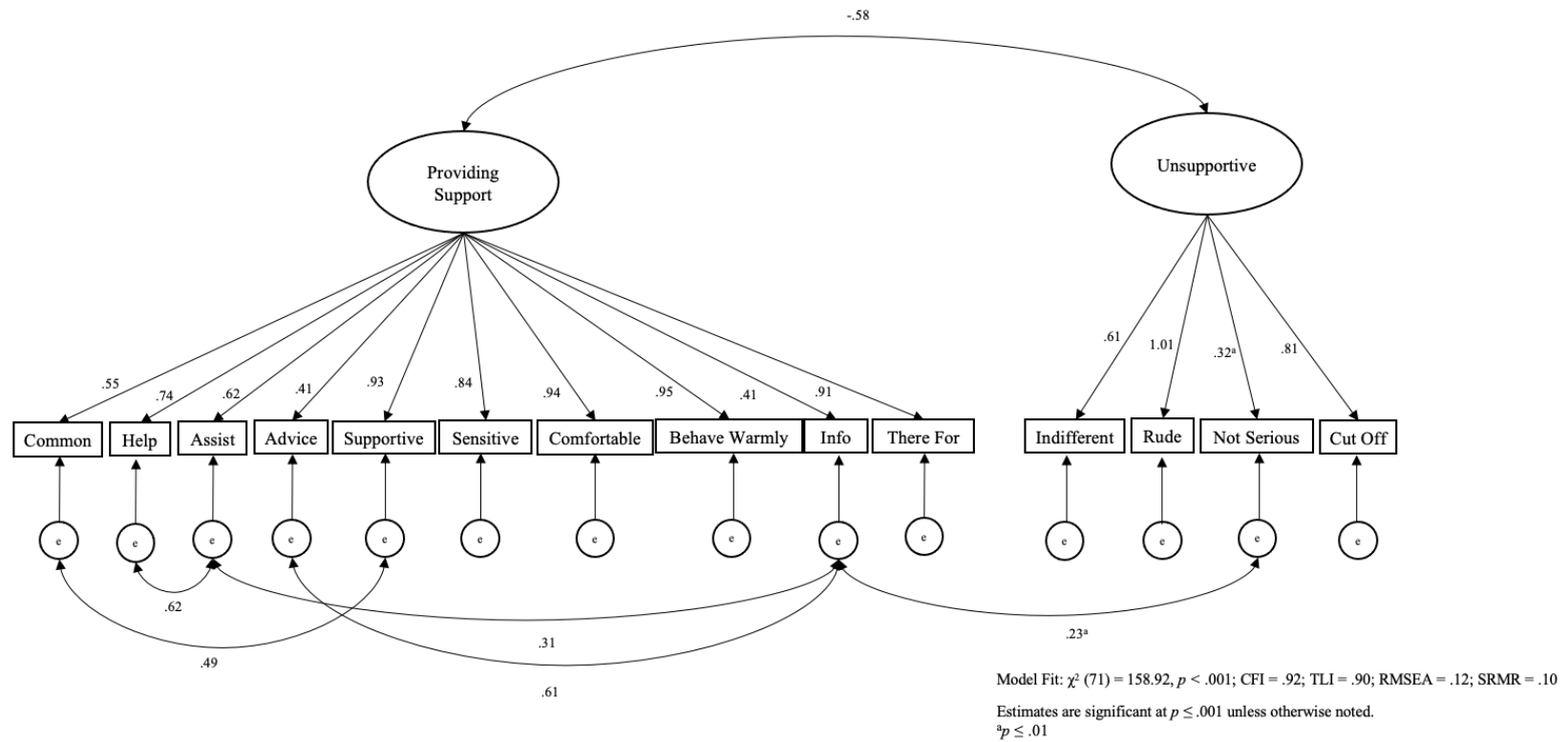
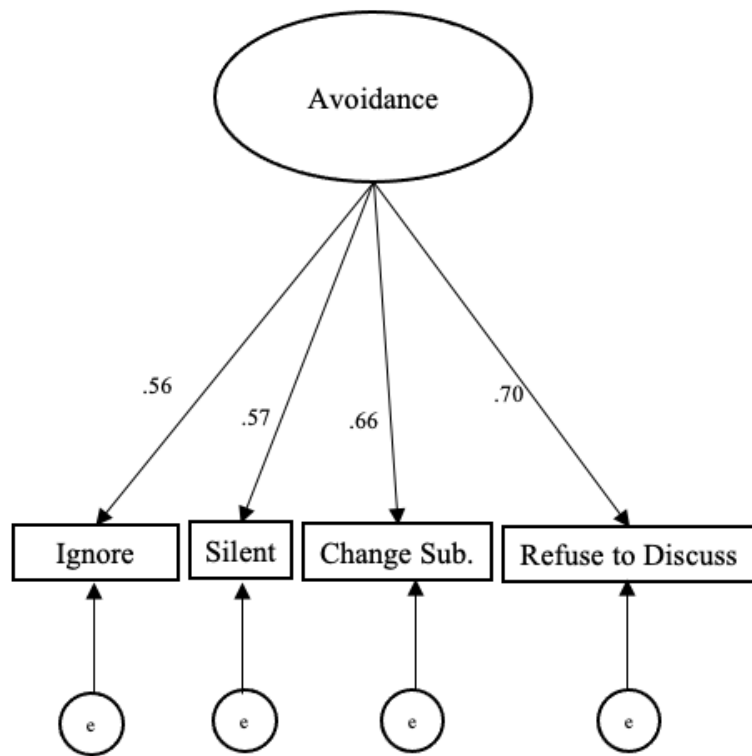


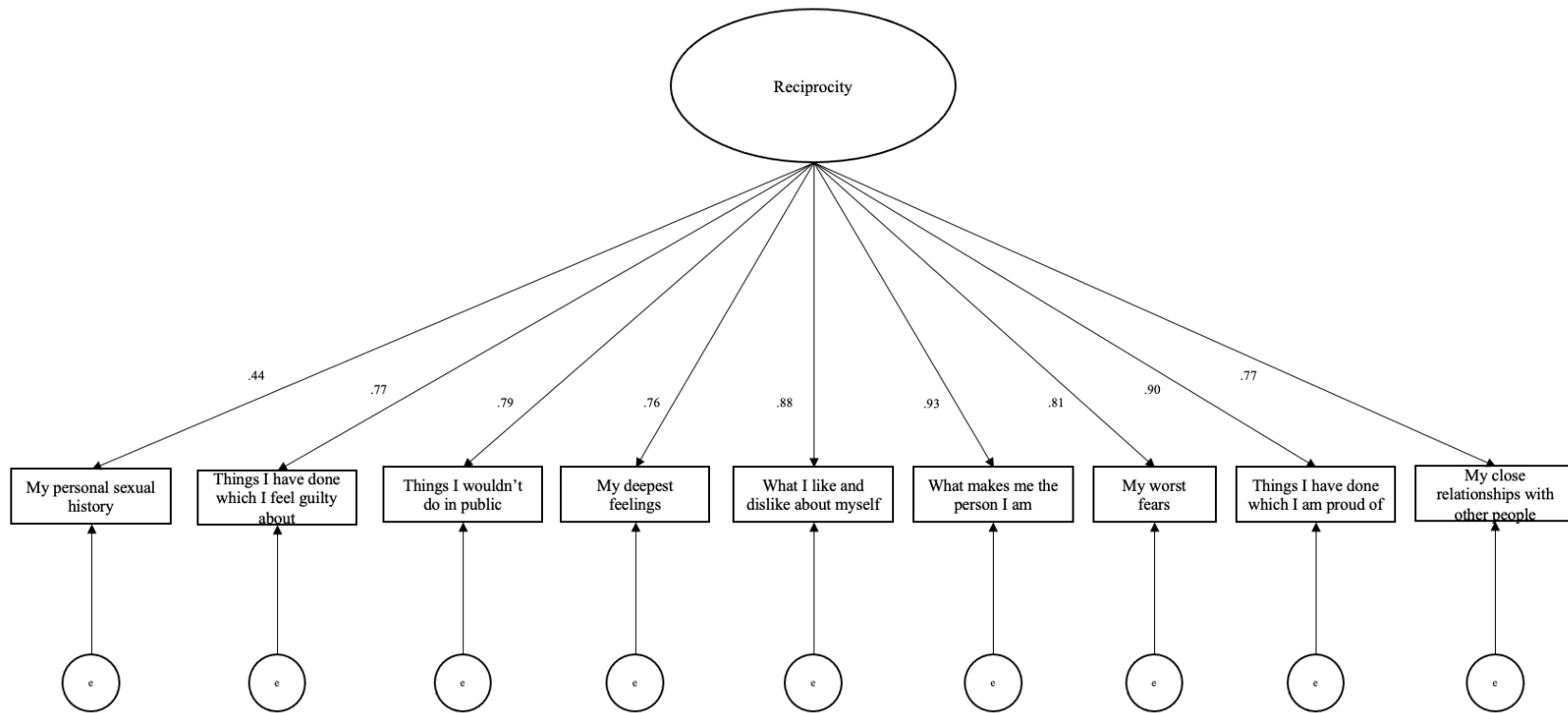
Figure 5. *CFA Model for Support*



Model Fit: $\chi^2 (2) = 2.72, p = .26$; CFI = .99; TLI = .96; RMSEA = .06; SRMR = .03

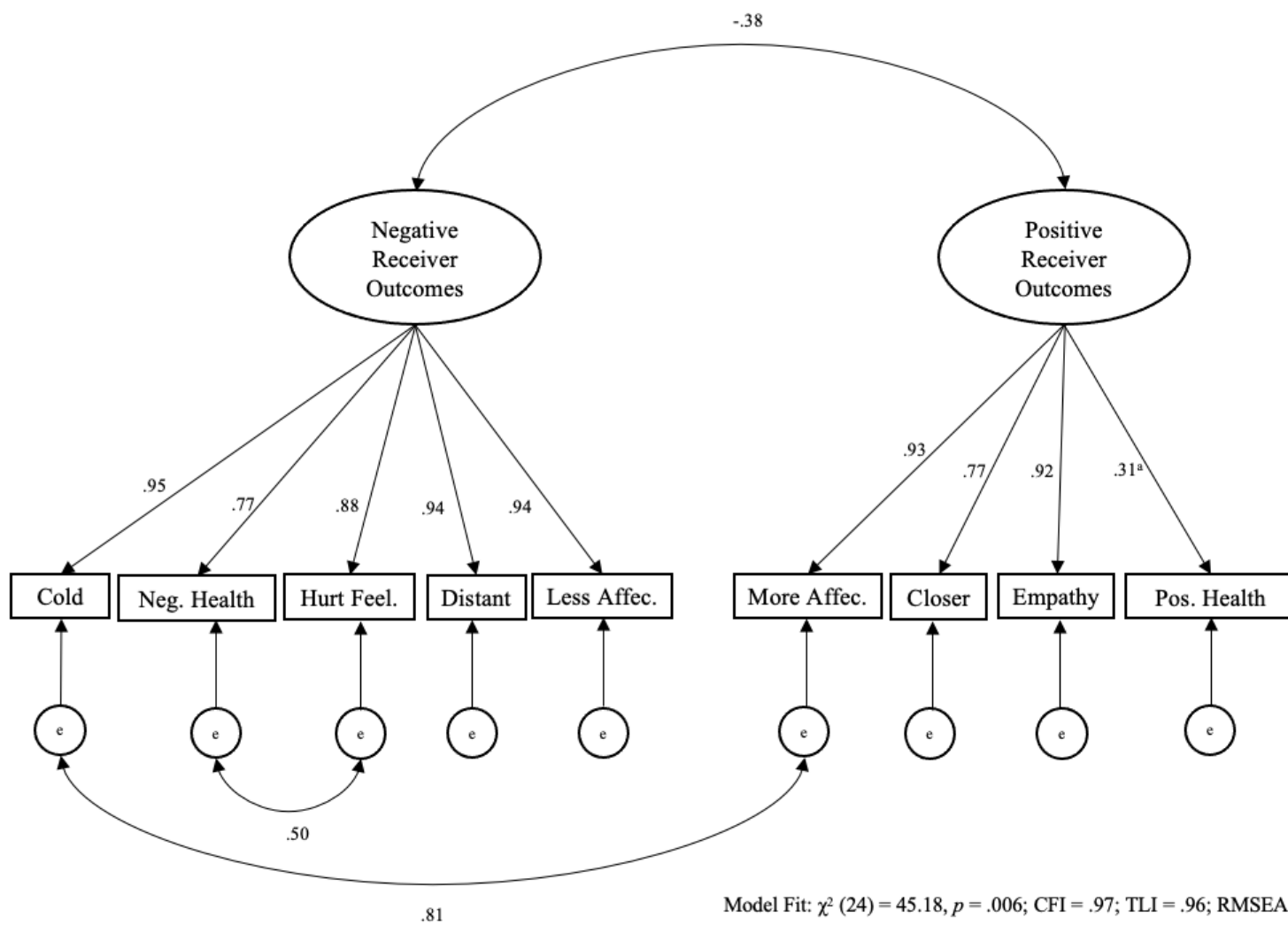
Estimates are significant at $p \leq .001$ unless otherwise noted.

Figure 6. CFA Model for Avoidance



Model Fit: $\chi^2 (27) = 89.45, p < .001$; CFI = .91; TLI = .87; RMSEA = .16; SRMR = .05
 Estimates are significant at $p \leq .001$ unless otherwise noted.

Figure 7. CFA Model for Reciprocity

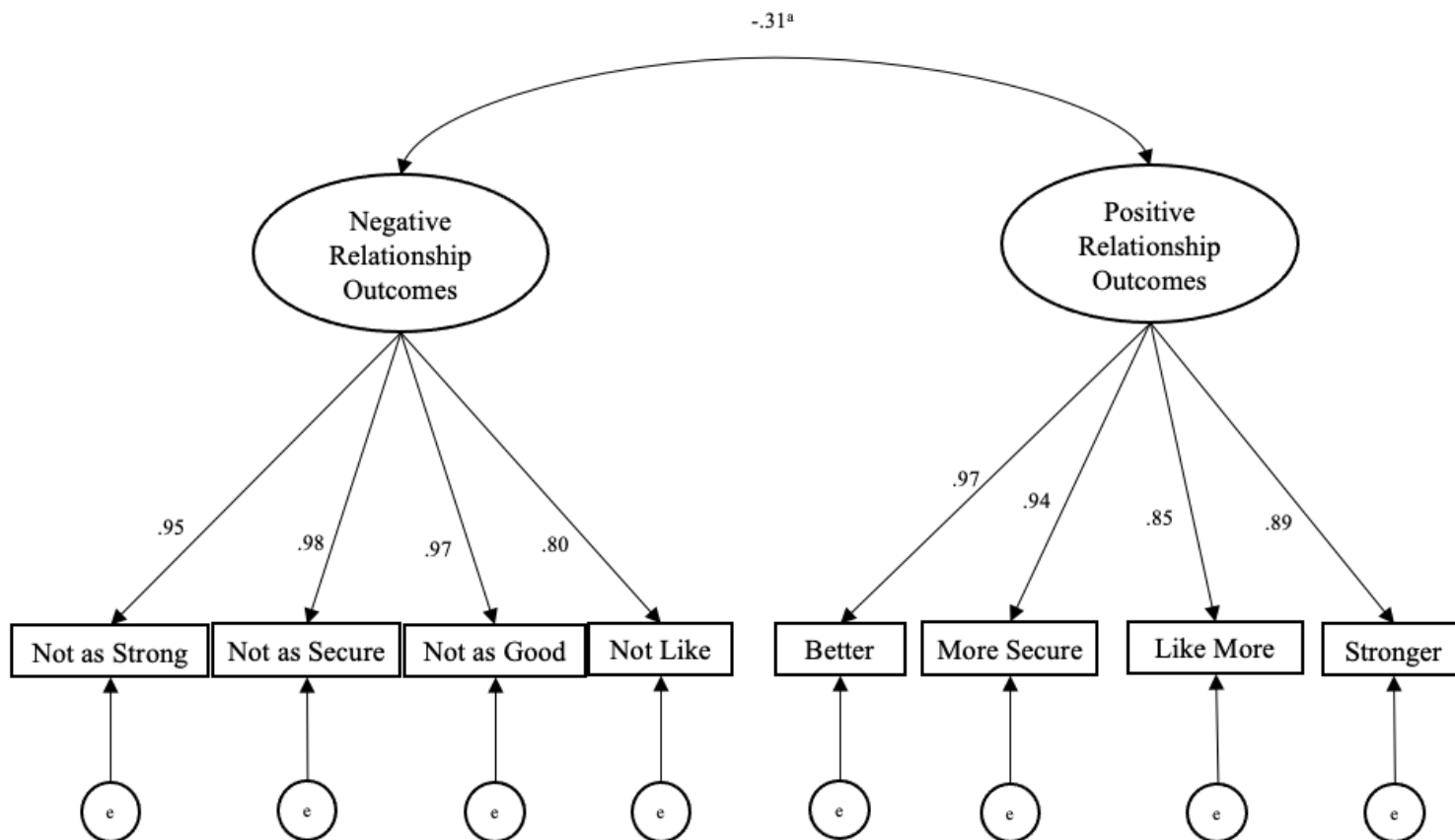


Model Fit: $\chi^2 (24) = 45.18, p = .006$; CFI = .97; TLI = .96; RMSEA = .10; SRMR = .12

Estimates are significant at $p \leq .001$ unless otherwise noted.

^a $p \leq .01$

Figure 8. CFA Model for Receiver Outcomes



Model Fit: $\chi^2 (19) = 50.82, p < .001$; CFI = .96; TLI = .95; RMSEA = .14; SRMR = .02

Estimates are significant at $p \leq .001$ unless otherwise noted.

^a $p \leq .01$

Figure 9. CFA Model for Relationship Outcomes

APPENDIX 6:

Chapter 4 Measures

Demographic and Control Items for Study 2 (Chapter 4) are the same as those for Study 1 (Chapter 3). See Appendix 4.

Disclosure Assessment

Think back to the question we asked you in the screener survey. As a reminder, here is the question we asked: [insert screening question]. Considering the same partner and STI disclosure from this question, please answer the following questions about yourself, your partner, and the STI disclosure. If more than one partner has told you they have an STI, please respond to all remaining survey items for the **most recent** disclosure experience.

1. What was your approximate age when you experienced this disclosure?
[Drop down]: 15 or younger, 16-29
2. How would you describe this partner's gender identity?
 - a. Male/Man
 - b. Female/Woman
 - c. Trans male/Trans man
 - d. Trans female/Trans woman
 - e. Non-binary
 - f. Intersex
 - g. Gender identity not listed (please specify): _____
3. Were you in a committed romantic relationship with this sexual partner *at the time they told you about their STI*? By "committed romantic relationship," we mean a relationship where you and your partner depend on one another and are a team, view the relationship as long-term, are willing to make sacrifices for one another, and would find it difficult to end the relationship.
 - a. Yes
 - i. (If yes): Which of the following options best describes your relationship with this sexual partner *at the time of their disclosure*?
 1. Committed dating relationship
 2. Cohabiting/living together
 3. Engaged
 4. Married/Domestic Partnership
 5. Other (please specify): _____
 - b. No
 - i. (If no): Which of the following options best describes your relationship with this sexual partner *at the time of their disclosure*?
 1. Casual sex relationship (e.g., friends-with-benefits, one-night-stand, hookup)

2. Casually dating/talking
3. Other (please specify): _____
4. Which STI(s) did your partner disclose to you? (check all that apply)
 - a. Chlamydia
 - b. Gonorrhea
 - c. Syphilis
 - d. Human papillomavirus (HPV)
 - e. Herpes
 - f. I don't remember
 - g. Other (please specify): _____
5. Please mark all of the following behaviors that you engaged in with this partner during your relationship.
 - a. I gave them oral sex
 - b. I received oral sex from them
 - c. I gave them analingus (oral sex on anus)
 - d. I received analingus (oral sex on anus)
 - e. Tribadism (genital-to-genital rubbing)
 - f. Penile-vaginal intercourse
 - g. Penile-anal intercourse
6. Did your partner disclose their STI(s) to you before or after you first engaged in any sexual behaviors with them?
 - a. Before
 - b. After
7. From the options listed, which best describes the nature of your partner's STI at the time of their disclosure?
 - a. Their STI was active and contagious.
 - b. Their STI was in remission (not active or contagious).
 - c. Their STI was cured, but it was active during our relationship.
 - d. I am not sure
8. What was your STI status at the time of the disclosure?
 - a. I had an STI when my partner disclosed
 - b. I did not have an STI when my partner disclosed
 - c. I am not sure
9. Did you suspect that your partner gave you the STI?
 - a. Yes
 - b. No
10. Did your partner suspect that you gave them the STI?
 - a. Yes
 - b. No

11. How did your partner tell you about their STI?
- a. In-person
 - b. In a text message
 - c. On the phone
 - d. On a video chat
 - e. Other (please specify): _____
12. How did the conversation about your partner's STI come up?
- a. They voluntarily told me
 - b. I asked my partner about their sexual history/if they had an STI
 - c. I tested positive for an STI, prompting me to ask
 - d. I found out that my partner had sex with someone else during our relationship, prompting me to ask
 - e. I found medical paperwork/medication for an STI, prompting me to ask
 - f. Other (please specify): _____
13. Since your partner disclosed their STI to you, have you gotten an STI test?
- a. Yes
 - b. No
14. Was this the only time you experienced an STI disclosure?
- a. Yes
 - b. No

STI Disclosure Reactions Measure

STI Disclosure Reactions Measure items for Study 2 (Chapter 4) are the same as those for Study 1 (Chapter 3; Appendix 4), except the language was changed from anticipated to actual reactions. For example, instead of saying, "I *would* let my partner know I was there for them," items read, "I *let* my partner know that I was there for them."

VITA

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