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## “That sort of place . . . where filthy men go . . .”: a qualitative study of women’s perceptions of genitourinary medicine services

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**Background:** A stigma is a pejorative social label. Stigmatisation is a process by which individuals are made to experience isolation and reduced opportunities in life. Some diseases are particularly associated with stigmatising attitudes; this applies particularly to sexually transmitted infections. Although several studies report the effects of stigma, no study to date has attempted to investigate its nature, which is a prerequisite to designing health interventions.

**Methods:** This qualitative, exploratory study investigated the experience of stigma among young women recently diagnosed with an STI and considered the implications of these experiences in terms of maximising access to GUM clinics.

**Results:** Three themes were identified from interviews undertaken with women recruited in family planning and genitourinary medicine (GUM) clinics: the perception of STIs as a condition of “others,” the threatening nature of the GUM clinic, and the evolution of the experience of stigma within the GUM clinic.

**Conclusion:** More open discussion and education about sexual health services and STIs should take place at a general population level; awareness of sexual health services should be raised in inclusive ways, which are seen as relevant to the needs of a wide range of individuals; medical, nursing, and counselling staff in GUM clinics should be supported in their efforts to reduce the experience of stigma. Finally, future interventions designed to improve access to sexual health services should formally assess their impact on stigma.

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### Introduction

Both the causes and effects of stigma are important medical issues. A stigma is a pejorative social label, attached to those who are perceived to deviate from some socially constructed expectation, whether this is physical, mental, or behavioural. Stigmatisation is a process by which individuals are made to experience isolation and reduced opportunities in life.<sup>1</sup> Some diseases, because of their link with behaviours that are regarded as “deviant” or amoral, are particularly associated with stigmatising attitudes.<sup>2</sup>

Sexually transmitted infections (STIs) have long been associated with the institutionalised persecution and ostracism of affected individuals, because of their direct association with sexual behaviour, with its attendant religious, cultural, and political dimensions.<sup>3</sup> STIs have been blamed for a wide range of societal ills, ranging from the disintegration of family life to the breakdown of social order and the fall of empires.<sup>4</sup> Historically, many public health control efforts have, paradoxically, merely served to intensify stigma, by reinforcing fears and marginalising affected individuals.<sup>5</sup>

Stigma has previously been reported in association with a diagnosis of STI,<sup>6,7</sup> is associated with delay in seeking treatment,<sup>8,9</sup> and is perceived by prospective patients as a barrier to referral to genitourinary medicine (GUM) clinics.<sup>10</sup> Although previous work in this area has described the possible effects of stigma, few studies have investigated its nature. Such

research is important for two reasons. Firstly, empirical evidence is required to investigate the significance of stigma for both patients and service providers. Secondly, understanding stigma in relation to GUM service use is a prerequisite to design of interventions in this area. This exploratory study aimed to investigate the experience of stigma among young women recently diagnosed with an STI and to consider the implications of these experiences for optimising access to GUM clinics.

### Methods

This study is part of a larger investigation in Glasgow into the psychosocial impact of genital *Chlamydia trachomatis* infection in women.<sup>7</sup> Women with a recent chlamydia diagnosis were recruited from two large clinics in central Glasgow in 1997–8—one GUM clinic and one family planning clinic. A qualitative methodology was employed; this approach is well suited to the exploration of issues which are likely to be complex and/or poorly understood.<sup>11</sup> Semistructured interviews were open ended and non-directive. All interviews were conducted by BD. Interviews of between 40 minutes and 2 hours were audio recorded and transcribed verbatim. Transcripts were coded to identify emergent themes; those concerning stigma were then further analysed, separately, by two investigators (BD and AS), to identify recurrent themes.

## Results

Seventeen women (age range 18–29) agreed to participate, 10 from the GUM clinic and seven from the family planning clinic (participation rate 62%). None of the respondents attending the family planning clinic had ever attended a GUM department and, of those women recruited from the GUM clinic, only one had previously attended. Six participants had co-infection with other STIs (four with genital warts, one with gonorrhoea, and one with both pelvic inflammatory disease (PID) and genital warts). Three themes were identified from the data: the perception of STIs as a condition of “others,” the threatening nature of the GUM clinic, and the evolution of the experience of stigma within the GUM clinic.

### STIS—A PROBLEM OF “OTHERS”

The majority of women in the sample had never previously considered themselves to be at any risk of STIs:

*I think of, like, I don't know, prostitutes and backstreets and everything but, em, like I know that anyone can get them . . . but it's still sort of . . . you know “nice girls don't” or whatever (Respondent 4, family planning clinic)*

Women associated STIs with attributes deemed as socially and morally unacceptable. Consequently, initial reactions were of shock and disbelief that an STI had affected them, having previously considered themselves to be invulnerable to conditions associated with a stereotypically polluted or soiled image.<sup>7</sup> These initial feelings of contamination were pervasive, even among those women who considered themselves knowledgeable about sexual health:

*There just seems to be such a stigma attached, you know, to anything transmitted down below you know . . . . I would say that I felt dirty and I'm quite [well informed] and I'm not particularly bothered by body bits and body functions, you know. But . . . definitely there is a stigma attached . . . . (Respondent 4, family planning clinic)*

Some experienced feelings of isolation because of the fear of public disclosure and censure:

*R: I don't know really, its just you don't expect to be coming to somewhere like this and you feel as if, I don't know I just feel really funny about coming and I wouldn't tell anybody where I was going or anything. I had . . . to keep telling my work I'd got problems with periods and things like that . . . I would never say to anyone*

*BD: Not even your best pal?*

*R: I told one of my friends, uhuh, but . . . that was it (Respondent 11, GUM clinic)*

Women perceived a low level of community awareness about STIs and risk factors for their acquisition; this increased feelings of isolation, by escalating anxieties about disclosure to others. They were also pessimistic about the ability of others to understand fully the issue of vulnerability to STI:

*They don't want to know about them [STIs], they don't want to think that you could ever get them because everyone as I said probably thinks like me and thinks that isn't something that I*

*will ever have to worry about. It's like ‘I don't sleep around—I won't get it.’ So they automatically don't think they need to know about them. Even when you are being told about them you just kind of think it is something that someone else has...probably (Respondent 5, family planning clinic)*

Additionally, there was a recognition of a societal inability to discuss more general issues surrounding sex:

*R: I think . . . there's a sort of reluctance to know what's down there, [people] don't want to know, it's like sexuality, people . . . don't want to talk about it, they don't want to confront it at all (Respondent 7, family planning clinic)*

### “GUILT BY ASSOCIATION”: TRANSFER OF STIGMA TO GUM CLINICS

The views expressed above provided a frame of reference which impacted significantly on participants' expectations of the GUM clinic:

*BD: What did you think about the [GUM] clinic before you went [there]?*

*R: ...like seedy, seedy people and people that are—not, not prostitutes, I wouldn't go so far as to say that, but just a lot . . . that sort of place, you know, like filthy men go and a lot of men sitting about. Cos I mean, I don't sleep about and that's why, like, why do I have to go to one of these places, you know. I guess you have like a preconceived idea about what it's gonna be like . . . (Respondent 4, GUM clinic)*

Fears and expectations about the GUM clinic appeared largely to be a product of a fear of the unknown. The majority of women had not previously believed that either STIs or GUM clinics were in any way personally relevant; the absence of knowledge about procedures and even the general nature of the service provided:

*BD: Had you ever heard of the clinic . . . . before you'd been?*

*R: Nope.*

*BD: No. How did you feel about going there?*

*R: Em, kind of scared at first didn't know what to expect because I'd never heard of it either. I mean I didn't know exactly what it was for, I didn't know what to expect or I didn't know what treatment I was going to get or what they [the staff] were going to say . . . (Respondent 1, GUM clinic)*

Women expressed fears about several aspects of GUM clinics; these included public disclosure (focusing particularly on fears of sitting in waiting rooms), uncertainty regarding clinical practice, and censure by staff:

*You know oh, it's the VD clinic . . . . That is how I felt because even when I was sitting in the waiting room, I thought my god this is awful. The both times that I went I had to wait for quite a while before I was actually seen which I felt myself getting so wound up, sitting in the waiting room. I just didn't want to be there, I think he [partner] felt very much the same . . . . I didn't know what to expect . . . I was sure that it would involve some sort of internal probing about or whatever . . . I didn't know whether it would be a female doctor or a male doctor . . . I didn't know if it was a big waiting room like in casualty and they shout your name. I'm not here! (Respondent 3, GUM clinic)*

*I just felt, what must they think of me, they must think I'm the one that's sorta, you know, sleeping around or something like that, you know and I knew it wasn't anything to do with, although I knew it wasn't my fault I still felt horrible, you know (Respondent 9, GUM clinic)*

Additionally, women also feared the reactions of the wider hospital population, which could lead to pragmatic difficulties:

*. . . . . I thought, oh no, and I've got to walk here [through the hospital] and if I get lost, I was too embarrassed to ask anybody where this area of the hospital was . . . . (Respondent 8, GUM clinic)*

Thus, simply being identified as a patient attending a GUM clinic was perceived as rendering women vulnerable to sanction. The clinic itself clearly shared the stigmatising connotations associated with the conditions it treated and, by implication, the “deviant” population it served. In contrast, other sexual health services had a “safer” association.

*Family planning sounds less scary [than the GUM clinic] . . . . (Respondent 2, family planning clinic)*

*Family planning . . . feels really nice and safe do you know what I mean, and . . . em without going back to what I was saying about stigma which is all like just completely in my mind but it's still there, and say the GUM clinic like genitourinary medicine and it just like sounds . . . the family planning seems like it's a much easier place to go to . . . . . (Respondent 5, family planning clinic)*

It appeared that attending a family planning clinic, as opposed to GUM, allowed women to distance themselves, both from the negative associations of an STI and from the “disease model” of health care that GUM represented:

*R: Mm, I think . . . . . I would be happier with sort of overall women's health than just specifically sexually transmitted, I think there's more stigma actually about going along to the GU, you are going along because you have an infection, as soon as you walk through that door, do you know what I mean? (Respondent 7, family planning clinic)*

*BD: . . . you said you thought family planning was safe?*

*R: Well I don't mean safe it's just like it's removed from the hospital, it's not like a strict medical environment, it doesn't seem as sort of clinical and you've got a disease and that's why you're here, it's more sort of open . . . [going to a hospital] . . . . . makes it seem a bit more, a bit more like you've got an illness . . . And em because it's called a disease as well right it sounds really, well sounds like something major traumatic thing wrong with you . . . (Respondent 5, family planning clinic)*

#### EVOLUTION OF THE EXPERIENCE OF STIGMA WITHIN THE GUM CLINIC

For women attending the GUM service, it was apparent that this experience initiated a process of normalisation which served to substantially reduce feelings of stigma. This process was facilitated by two factors; firstly, the realisation that fellow patients did not conform to stereotype:

*Because I've been to the clinic and I've visited it and . . . it's like all professional people, it's all different people round about . . . . . it's like anybody could have it [an STI], . . . and there were the doctors and the nurses [they] were explaining as well and that helped a lot . . . And I feel like totally naive and uneducated in the matter and like now . . . I know that it could be anybody, you know (Respondent 4, GUM clinic)*

Secondly, the proactive efforts of staff provided patients with a therapeutic experience in which STIs were treated as relatively routine:

*It turns out it wasn't as bad as I thought, it really wasn't. And everyone was really, really nice and very down to earth and very matter of fact about the whole thing, which was good (Respondent 3, GUM clinic)*

It was also apparent that some women became much more relaxed about being “seen” attending the clinic:

*I mean . . . . . I was, like, what was I so worried about when I sat down? At first I thought oh my God, somebody [an acquaintance] knows I'm here. I mean I was fine, it wasn't such a big thing. So I mean . . . . . why was I so, not why was I so embarrassed about it but why I am keeping it in so much kind of thing? (Respondent 10, GUM clinic)*

#### Discussion

Stigma associated with GUM clinics is recognised to be a barrier to patient access. This has led to exploration of alternative public health strategies for the diagnosis and management of STIs, despite the absence of research investigating the nature and effects of stigmatisation in the context of GUM services. Most importantly, the question of how modern GUM services can work therapeutically to modify individuals' experiences of stigma associated with STIs has been largely ignored.

This study has investigated the experience of stigma reported by young women attending a GUM clinic in a metropolitan city and the part that stigma plays in accessing GUM services. Its main findings are that the stigma surrounding STIs pervades GUM clinics, that this can create a barrier to access and may induce fear and isolation in individuals who do manage to attend such clinics. However, while attending the GUM clinic was experienced as stressful, it did not correspond to study participants' worst fears, and reduced anxiety was associated with staff efforts to “normalise” the experience of having an STI.

Negative feelings about STIs, such as guilt, “dirtiness,” and fear of the moral judgments of others have previously been reported in individuals who suspect they are at risk of STI.<sup>6 7 10</sup> These feelings are then transferred to the services for treating STIs—GUM clinics. Such negative views are not limited to patients; previous work in Glasgow demonstrated that 86% (n = 101) of healthcare workers surveyed perceived GUM services as stigmatising to patients and this was regarded as a significant barrier to referral.<sup>12</sup>



In this study, the factors contributing to stigma in relation to GUM clinics were those connected to STIs themselves, specifically their association with deviancy and social undesirability. Like the "alien" nature of STIs themselves, they believed that GUM clinics catered for "other" groups of people and attendance at such clinics associated the attendee with such groups in the minds of staff and the wider community.

The impact of stigma associated with GUM clinics was, firstly, to reduce the perceived accessibility of services by patients, because they did not consider themselves to be within the social category perceived as "typical" GUM clinic attendees. GUM clinics were viewed as more "dangerous" than family planning services, which had a more benign appeal. Secondly, stigma adversely affected the experiences of individuals who did manage to access GUM clinics. Fears of judgmental staff, censure, and disclosure, as well as a generalised anxiety related to inexperience of clinic procedures, were reinforced by the aura surrounding STIs and GUM clinics.

The women in this study experienced "felt," rather than "enacted," stigma. The first refers to a person's internal negative thoughts about the impact of a condition, the second to the words or actions of other people against an affected person.<sup>13</sup> In some respects, it resembles the hidden distress model of coping with epilepsy,<sup>14</sup> where adults experience a high degree of "felt" stigma and adopt strategies of concealment which reduce the possibility of enacted stigma. Thus, felt stigma is potentially more disruptive to sufferers than is enacted stigma.<sup>15</sup> In the case of STI, felt stigma may mitigate against individuals disseminating their relatively positive experiences of attending a GUM clinic to their wider peer group and thus may contribute significantly to continuing fear of GUM clinics.

What implications does this study have for sexual healthcare providers and planners? One of the most important consequences of stigma is reduced access to GUM services. Previous research has demonstrated that lack of knowledge about GUM clinics and inexperience with clinic procedures increases delay in attendance.<sup>8,9</sup> The respondents in this study had very little previous knowledge or understanding of STIs. Public awareness of STIs and GUM services must be improved, both in quantity and quality. Secondly, the evidence in this study that family planning services are perceived as more acceptable, because of their distance from a "disease model" of health care supports the case for integrated models of sexual health care. Co-location of GUM with other reproductive healthcare services provides opportunities to circumvent the stigma associated with "stand alone" GUM services and optimise access to the destigmatising experience which GUM clearly provides. Thirdly, medical, nursing, and counselling staff in GUM clinics (for those who do manage to access them) can play a major part in reducing stigma and they should be supported, through training and staff development, in this role. Finally, previous public health strategies

merely intensified the marginalisation and stigma associated with STIs and GUM clinics; deliberate concealment of GUM clinics in inaccessible locations, giving them euphemistic titles, or naming them after great dermatovenerologists has often served to disguise their true identity and purpose. These physical and linguistic efforts to render open access difficult have reinforced public silence and ignorance of the nature of STIs, paradoxically contributing to their further stigmatisation. Strenuous efforts should be made to overcome the stigma associated with STIs and, by default, GUM services, and to present sexual health services in a way that is seen as inclusive and relevant to a wide range of individuals.

However, the difficulty of this task should not be underestimated. Given the social and moral taboos and complex emotional investments associated with sexual activity<sup>16</sup> it is perhaps unsurprising that a pervasive sense of stigma is still, in the 21st century, associated with infections transmitted via sexual activity and the services which treat them. Future national strategies designed to improve access to sexual health services should formally investigate the role of stigma, both in relation to issues of access and the impact of utilising such services on the experience of stigma.

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