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Stigma, Sexually Transmitted Infections and Attendance at the GUM Clinic

An Exploratory Study with Implications for the Theory of Planned Behaviour

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Abstract

A gap in the literature regarding understanding of people's health care seeking behaviours in relation to sexually transmitted infections is identified. Employing both deductive and inductive methods, 10 patients (five female, five male) were interviewed to explore the psychosocial, motivational and attitudinal factors associated with attendance at a Genito-Urinary Medicine (GUM) clinic in a close-knit community in the north of England. Seven stigma-related themes were identified as salient issues surrounding perceptions of sexual health screening and included: (1) prejudice surrounding STIs; (2) fear of exposure; (3) isolation; (4) reluctance to attend; (5) contamination; (6) relationship issues; and (7) perceived invulnerability. Within these themes distinct gender differences were identified. Implications for the theory of planned behaviour (TPB) are discussed against the factors identified.

Keywords

- *contextual issues*
- *qualitative methods*
- *sexually transmitted infections*
- *stigma*
- *theory of planned behaviour*

Introduction

KNOWLEDGE is limited about the actual health seeking behaviours of individuals in relation to sexually transmitted infections (STIs), as psycho-social research in this area is lacking for both men and women, except where it is incidental to AIDS (Dixon-Woods et al., 2001; Holgate & Longman, 1998; Pryce, 2001; Wellings & Cleland, 2001). Previous survey-based research (Meyer-Weitz, Reddy, van den Borne, Kok, & Pieterse, 2000; Wilson & Williams, 2000) has however identified many barriers that contribute to the UK's increasing rates of STI transmission, which are intertwined with barriers to sexual health screening in Genito-Urinary Medicine (GUM) clinics, such as: (1) fears about embarrassment; (2) confidentiality; (3) perceptions of stigma; and (4) perceived invulnerability as a function of stereotypical beliefs. Other studies have identified organizational factors, i.e. barriers to access, such as lack of information and awareness of GUM services (Harry, 1999; McLean & Reid, 1997). Findings such as these have contributed to the development of a policy directive (DoH, 2001), recommending that STIs and GUM clinics should be de-stigmatized.

Despite an extensive literature search, few studies were found to be conducted from psychological perspectives on individuals suffering from STIs, only one of which utilized a theoretical framework to explain the findings. Godin et al. (1993) used the theory of planned behaviour (TPB) (Ajzen, 1991) and found that attitudes towards seeking healthcare for suspected STIs was the most important factor among male and female students, suggesting that the motivation to act promptly was strongly related to the perceived positive outcomes of seeking healthcare. In addition to this, intention to seek healthcare promptly was negatively affected if perceived or actual barriers to such action were indicated. Such barriers included inaccessibility of services, availability of services, insufficient knowledge of STIs including how to recognize symptoms and concerns regarding confidentiality. Gender differences were also found with women demonstrating stronger intentions to seek prompt medical care.

Findings of a qualitative investigation into the psychological experiences of GUM clinic attendees conducted by Holgate and Longman (1998) identified three salient themes: anxiety, stigma and isolation surrounding attendance and subsequent diagnosis of an STI. The factors contributing to anxiety included

concerns about social exposure at the clinic, together with concerns about the effects it would have on current and future relationships as well as the impact upon self-image demonstrated by descriptions of feeling 'tainted' (Holgate & Longman, 1998, p. 95). Embarrassment and shame surrounding diagnosis resulted in feelings of isolation. These themes were however only briefly described and participant details regarding gender were not documented.

More recent qualitative findings on the psychosocial impact of obtaining a diagnosis of an STI for women, identified concerns about the perceived stigma of STIs that was associated with GUM clinics. Social isolation was experienced by the women, which led to the suggestion that anxieties were compounded if access to usual support networks is denied as a result of stigma (Duncan, Hart, Scouler, & Bigrigg, 2001). A further qualitative study by Dixon-Woods et al. (2001) identified five motivational 'prompts' to attending for a sexual health screen in a GUM clinic. These prompts included symptoms such as pain and discomfort, and prompts as a result of their partner's symptoms or 'sleeping around' behaviour (Dixon-Woods et al., 2001, p. 336). Further prompts were due to the patient's own evaluation of their 'risky' behaviour, which led to attendance as a result of health maintenance, as well as the need to assure that they would not pass any infection on to a new partner, thus highlighting a degree of personal/moral responsibility towards self and others. Most women reported feeling exposed, vulnerable and nervous. Confidentiality and anonymity were recurring themes with a key priority being the management of their feelings of stigma and embarrassment. Although these studies provide greater insight into the psychosocial issues involved in attendance for sexual health screening, psychological theories were not utilized to help explain them. The application of such theories can 'provide accounts of how psychological processes affect individual health experience' (Marks, Murray, Evans, & Willig, 2000, p. 7).

According to Orbell and Sheeran (1993), theoretical models that combine psychological factors with a consideration of aspects of service provision and delivery are better equipped to explain the uptake of screening opportunities. The TPB as used in the previously described study of Godin et al. (1993), proposes that behavioural intentions are the outcome of a combination of beliefs, attitudes, subjective norms and perceived behavioural control. It has been widely tested to predict patterns of behaviour change with a wide range of health behaviours including the uptake

of health screening but not specifically STI screening (Boreland, Owen, Hill, & Schofield, 1991; Connor & Sparks, 1996; Godin & Kok, 1996; Norman & Connor, 1993; Sheeran & Orbell, 1996; Sheeran & Taylor, 1999), albeit with the exception of the study by Godin et al. (1993).

According to the TPB individuals will have strong intentions to perform a given behaviour if they evaluate it positively (positive attitude), believe that significant others would want them to perform it (subjective norm) and perceive that it is easy to perform (perceived behavioural control) (PBC). Based on a combination of attitudinal and normative or social influences, this model assumes that the stronger the intention to implement behaviour the more likely the behaviour will be performed. Influencing intention, the attitudinal component comprises of the appraisal of a particular behaviour, such as attending for a sexual health screen, together with the beliefs of the outcome of the behaviour, e.g. attendance will improve one's health or give peace of mind. The influencing normative component or subjective norms reflects the individual's perception of social norms and pressures to perform a behaviour. For example, 'People who are important to me will approve/disapprove of my attending for a sexual health screen at a GUM clinic'. This is weighted together with an evaluation of the motivation to comply with this pressure and whether approval is desired. This can also be weighted by the appraisal of the value or importance of the impact of the negative aspects of attending for a screen such as the fears surrounding intimate examinations, embarrassment and social exposure together with the uncomfortable acknowledgement of potential relationship infidelities. Of more psychological significance however, when the behaviour is not completely under volitional control, i.e. as a result of barriers to access to the GUM clinic/low self-efficacy, PBC can serve as an independent predictor of attendance to the extent that PBC accurately reflects actual ability to attend.

PBC reflects people's appraisals of their ability to perform a given behaviour, i.e. 'how easy or difficult would it be for me to attend for a sexual health screen at the GUM clinic?'. It is assumed that this component influences intentions and behaviour to the extent that a person's perception of control accurately reflects actual control over behavioural performance. PBC is closely related to Bandura's (1977, 1986) concept of Self-Efficacy, which proposes that although knowledge and skills are necessary for the

facilitation of a given behaviour, alone they are insufficient, as self-referent thought and emotions mediate the relationship between knowledge and action (Ajzen, 1998). This is evidenced by the general view that people who do possess the knowledge surrounding what should be done to achieve a certain goal, do not always behave optimally, thus highlighting the concept of individual agency.

People's sense of personal self-efficacy refers to a person's confidence in his/her ability to perform a given behaviour and could reflect internal factors of control. For behaviours that are not completely under volitional control, PBC can be used to predict behavioural outcome over and above intentions, thus besides having a positive attitude towards attending for a sexual health screen and having social reasons for this, a measure of PBC should predict action to do so. Therefore if an individual perceives that he/she has internal (confidence) and external (resources/opportunities) control over turning up for a sexual health screen at the GUM clinic, the person is more likely to form strong intentions to attend and is more likely to show up. When the behaviour is not completely under volitional control, i.e. as a result of barriers to access to the GUM clinic/low self-efficacy, PBC can serve as an independent predictor of attendance to the extent that PBC accurately reflects actual ability to attend.

However, it has been argued that the combined constructs of perceived control and self-efficacy in the PBC component are two separate, distinguishable variables and therefore the concept of PBC lacks clarity (Terry & O'Leary, 1995). For example an individual may appraise the amount of control over performing a behaviour on a practical level (external), and/or they can equally evaluate performance of the behaviour in terms of how capable they feel they are to perform it and thus on an affective level (internal). Moreover, there may not be a correspondence between the two (Triandis, 1977) as an individual may perceive few external barriers to accessing the GUM clinic, but may lack the (internal) confidence to attend. Equally, a person may perceive many barriers to access such as transport difficulties and/or inconvenient appointment times, but may possess the confidence or self-efficacy to overcome these obstacles in order to achieve the desired outcome that a sexual health screen will achieve. Thus highlighting the role of intrinsic versus extrinsic motivations.

These motivational implications that can reflect factors internal or external to the individual, may be

dependent upon individual agency as highlighted by its relationship to perceived sense of self-efficacy. In this context it could therefore be argued that external factors of PBC may be weighted against internal factors and therefore quantitative analyses may vary depending on the operationalization of the PBC construct. Support for this view is highlighted by Wilson et al. (1989) who found that reasons for certain attitudes towards an object were primarily cognitive in nature, whereas behaviour is often driven internally by affect, which reduces the attitude-behaviour correlation of the TPB. Therefore when PBC is operationalized to measure internal factors that may facilitate or inhibit behavioural achievement, this measure is predictive of behaviour, however, when it is operationalized to measure external factors, i.e. inconvenient clinic opening times, such a measure may not accurately predict behaviour as it may be weighted against internal (self-efficacy) factors and is thus dependent upon the individual.

According to the TPB, individuals will have strong intentions to perform a given behaviour if they: evaluate it positively (positive attitude); believe that significant others would want them to perform it (subjective norm); and, perceive that it is easy to perform (PBC). However, although meta-analytical reviews have demonstrated that attitudes, subjective norms and perceived behavioural control can account for significant variance in intentions, subsequent prediction of behaviour within the TPB has not been so substantial (Ajzen, 1991; Armitage & Connor, 2001; Godin & Kok, 1996; Sheeran & Taylor, 1999; Sutton, 1998) as intention has repeatedly been found to be a poor predictor of behaviour. Thus, exposing a gap between intentions and behaviour. It is thought that this is because there are many other variables that the TPB cannot account for which include the roles of personal norms (Parker, Manstead, & Stradling, 1995), self-identity (Terry, Hogg, & White, 1999) and the influence of gender on motivation (Sheeran, Connor, & Norman, 2001).

In addition to this, other methodological limitations have also been identified (Sutton, 1998) such as lack of clarity surrounding the operational definitions of the constructs of the model as highlighted earlier, as well as criticisms towards the predominant use of questionnaire formats which may threaten the reliability and validity of the TPB (Armitage & Connor, 1999). This could be in part due to discursive/semantic interpretation and/or socially desirable responding, as Potter and Wetherell argue that it is unclear 'whether people

filling in an attitude scale are performing a neutral act of describing or expressing an internal mental state or attitude, or whether they are engaged in producing a specific linguistic formulation tuned to the context at hand' (1987, p. 45). These criticisms towards quantitative approaches to the TPB have been supported by experimental studies where differences were found in statistical significance, internal reliability and the strength of inter-correlations as a function of questionnaire format and social desirability (Sheeran & Orbell, 1996). This view is also supported by Sheeran et al. (2001) who propose that quantitative methods may impose limitations upon the theory due to lack of insight into the processes involved from intentions through to behaviour.

In addition, Smith (1999) argues that the TPB's location within the positivist paradigm is not conducive to individual agency. Criticizing it for having rigid, mechanistic properties he suggests that what is needed to ascertain how the processes of intention actually works is to explore the accounts of 'individuals who have interesting combinations of responses' as the statistical techniques utilized so far are 'impotent to provide any analysis requiring individual focus. A move away from the positivist paradigm would be necessary before the appropriate accounting methodology could be embraced to further such investigation' (Smith, 1999, p. 683). This therefore suggests that the use of questionnaire-based formats as a method of data collection together with the varied statistical analyses utilized may moderate the relationships between the components of the TPB. Supporting theorists' recommendations that 'more research needs to explore the ways intentions are/are not translated into behaviours' (Marks et al., 2000, p. 220), these issues provide a rationale for further qualitative investigations.

Furthermore, Crossley (2000) postulates that health psychologists should become more critical in their approaches, and gain a greater 'understanding' of health behaviours as opposed to continuing attempts to predict, control and manage them. In view of this and in light of the literature reviewed, the aims of this explorative qualitative study were to gain further understanding of healthcare seeking behaviour in relation to STIs/HIV of attendees at a GUM clinic in the north of England. From these observations the components of the TPB were examined in the exploration of female and male participants' accounts to identify the psychosocial, motivational and attitudinal factors associated with attendance at the clinic,

Table 1. Participant Details

<i>Participant Number</i>	<i>Gender</i>	<i>Age</i>	<i>Health Problem/Diagnosis</i>	<i>Number of sexual partners in past 12 months</i>
1	Female	20	Genital Herpes	1
2	Male	23	Chlamydia/Genital Warts	2
3	Male	22	Genital Warts	4-5
4	Male	22	HIV test	3
5	Female	18	Genital Warts	1
6	Male	22	Chlamydia	25
7	Female	24	Chlamydia	2
8	Female	24	Chlamydia	4
9	Male	28	Gonorrhoea	2
10	Female	18	Gonorrhoea/Chlamydia	2

and thus attempt to explain how psychological processes affect individual health experience.

Method

In order to move away from the positivist paradigm and explore the accounts of 'individuals who have interesting combinations of responses' (Smith, 1999, p. 683) the heuristic framework for this study incorporated both deductive and inductive methods. A deductive method was incorporated within the design of the interview framework to explore whether the components of the TPB could be endorsed in relation to the health seeking behaviours of the participants. However the open-ended nature of the semi-structured interview technique was used to explore further psychosocial phenomena. This technique allows the researcher to follow up and explore particularly interesting issues that emerge in the interview, and the participant is able to provide a more detailed account of the full picture. Thereby allowing much more flexibility than the more conventional structured interview, questionnaire or survey for the researcher and respondent (Smith, Harre, & Langerhove, 1995, p. 9). According to Shutz (1967) individuals have a store of knowledge that develops within a social world, and the theories, values and attitudes that are subsequently formed are applied to aspects of experience in order to make them meaningful. This provides a methodological orientation for this study as it examines the reality of the participants' social experience.

Participants

The most common curable bacterial STIs are reported highest in the 16–29-year-old age group (PHLS,

2002). Therefore, a theoretical, purposive sampling technique based upon age, gender and attendance at the GUM clinic was utilized. The first 30 patients (15 female/15 male) who satisfied these criteria during the recruitment period were approached and invited to participate in the study. In order to ensure a diverse sample of attendees and maximize representativeness both from a theoretical and population perspective, they were invited to partake regardless of reasons for attendance. Unfortunately, only 10 (five female/five male) of these consented to take part in the study. All participants identified as being heterosexual. Participant details are shown in Table 1.

Procedure

Following informed consent, the female researcher, a sexual health advisor employed at the clinic, conducted 10 separate interviews lasting between 20 and 45 minutes. Each interview was tape-recorded. The interview framework was of a semi-structured format with the use of 13 open-ended questions designed to explore the psychosocial experiences of the participants (see Table 2). The deductive set of questions asked were designed to reflect the components of the TPB model, i.e. 'how long did you wait before you decided to come?' was asked to elicit potential beliefs, attitudes and intentions towards attendance together with the control factors involved. Although all questions were covered with every participant, due to the exploratory nature of the study, the framework was used only as a very loose guide to allow the participants more freedom to 'share more closely in the direction of the interview, as he or she can introduce an issue the investigator had not thought of' (Smith et al., 1995, p. 12).

Analyses

The first inductive stage of the analysis was data driven and consisted of utilization of Burnard's (1991) stage method of thematic analysis. All transcripts were read and re-read separately by two researchers (researcher triangulation) and general themes were noted for each participant. In the next open-coding stage of the analysis, the themes highlighted by each investigator for each participant were then categorized under general headings. In order to 'facilitate richer and potentially more valid interpretations' (Banister, Burman, Parker, Taylor, & Tindall, 1999, p. 145) the two investigators discussed their individual interpretations of the categories which were subsequently collapsed into common themes until a final list of overall themes was agreed. In the end, seven themes were identified (see Table 3) which were all linked with and dominated by an overall theme of perceived stigma surrounding STIs and the GUM clinic.

The second deductive stage of the analysis was theory driven and comprised of identifying whether these themes were endorsed by the TPB components that structured the interview framework. This was achieved by utilizing a focused coding method of analysis that is less open ended, more directive and therefore conceptually based (Charmaz, 1995). For example the salient themes identified from the inductive stage of analysis were analysed further to identify directly potential beliefs, attitudes, intentions, social norms and control factors (i.e. barriers), and how these influenced actual attendance, as can be seen from the results and discussion section.

Results and discussion

In what follows, an integrated qualitative analysis will be presented in which the themes and their relationship to the TPB will be discussed concurrently with the gender differences observed in the participants' responses.

Perceptions of prejudice attached to having a STI

In support of previous findings (Dixon-Woods et al., 2001; Duncan et al., 2001; Holgate & Longman, 1998; Meyer-Weitz et al., 2000; Wilson & Williams, 2000) all participants reported considerable embarrassment and anxiety prior to attendance and during the sexual health screening process as well as during the interviews. These affective components

were principally as a result of stereotypical notions associated with perceptions of the stigma attached to STIs and GUM clinics. All 10 participants consistently and repeatedly alluded to the self-referent impact of STIs, related to stereotypical notions of perceived stigma as found by Dixon-Woods et al. (2001), Duncan et al. (2001) and Holgate and Longman (1998). The impact upon self was expressed as greater by the female participants (F) than males (M):

I felt like a slapper really—like a tart. (F/10)

It reflects badly on me and my character and implies that I sleep around a lot. (F/8)

I was gutted—I was really really gutted . . . and when they said it was herpes, it broke me heart . . . the fact that it's like a sexually transmitted disease and it's looked upon as being horrible and like as if you're some kind of slut . . . I felt really naughty. (F/1)

These described experiences by the female participants also highlight the concept of deviant behaviour that was not reflected by the male participants. Although equally 'embarrassed' about 'the fact that I've got an STD and I suppose society these days sees that as something bad' (M/3), stereotypical attitudes were mainly directed towards women as opposed to themselves and therefore not internalized by the male participants:

some people would probably think you were dirty . . . for a lass some people could think they were a slut or a slag—that's just the way people think and people would point a finger and think she has had so and so and she has been with him—that's the stereotype people get if they have an STD . . . I think it would be harder for a woman . . . I have nothing against them—nothing personally—we all get it—it's a bit harder for women than men. (M/6)

These attitudes support the existence of a dominant patriarchal ideology serving against women previously highlighted by Campbell (1995) and Stewart (1999) who postulate that the coincidence of sex with power structures are commonly based on gender. This was also reinforced by one of the female participants:

if you are a girl who has slept with a lot of people it looks quite bad—for a bloke it is different because men are out and they sleep with a lot of people—it is a manly thing—it is quite good and stuff—but a girl who has slept with a lot of people is viewed as a bit of a tart and a slag. (F/10)

Table 2. Interview framework

<i>TPB components to be elicited</i>	<i>Questions</i>
Beliefs Attitudes Intentions Social norms	1. What made you come to the GUM clinic?
Social norms Intentions Internal control factors External control factors	2. How did you find out about it?
Beliefs Attitudes Intentions Social norms Internal control factors External control factors	3. How long did you wait before you decided to come (and why)?
Beliefs Attitudes Intentions Social norms Internal control factors External control factors	4. What might have stopped you coming?
Beliefs Attitudes Intentions Social norms Internal control factors External control factors	5. Did you discuss it with anyone else?
Intentions in relation to social norms	6. If so did this help you decide?
Internal control factors	7. How did you feel about coming to the clinic?
Attitudes and beliefs towards clinic	8. What did you expect?
Social norms	9. Where do you think these expectations came from?
Attitudes and beliefs surrounding social norms	10. How did you feel when you were told you had a sexually transmitted infections?
Gender differences Social norms	11. In what ways do you think it might be different for a man/woman?
Beliefs Attitudes Intentions	12. What did you know about sexually transmitted infections before you came.
	13. Is there anything else you would like to say about your experience?

Table 3. Salient themes identified by participants

STIGMA
1. Prejudice surrounding STIs
2. Fear of Exposure
3. Isolation
4. Reluctance to attend
5. Contamination
6. Relationship issues
7. Perceived Invulnerability

The anxiety created by the perceptions of stigma for the female participants may therefore be a function of concern for their reputation also highlighted by Campbell (1995) and Stewart (1999), reflecting a spoiled identity (Goffman, 1963) which was not voiced as a salient issue by the male participants. This provides evidence that the social stigmatization of STIs, which is constructed and re-enacted within dominant patriarchal ideologies has a greater negative impact upon the self and social identity of the female participants. Having a STI is not a typically feminine attribute, due to its association with deviant behaviour based on concepts about masculinity and femininity adopted from their culture (Pleck, Sonenstein, & Ku, 1994). Due to this link with culturally determined stereotypical behaviours, gender is not so much what a person is but what a person does (Crawford, 1995). Even though the attitudes towards STIs and the subsequent negative impact on the self were experienced by both males and females as a barrier to attending for a sexual health screen, the personal obstacles were greater for the female participants.

In relation to the TPB, the role of self-identity has been found to be an additional predictor of intentions to behave in as much as a person will be more motivated to perform a behaviour if the behaviour is regarded as an important component of their self-identity (Terry et al., 1999). Although the effects of perceived stigma upon the self-identity of these participants created significant distress, and negatively affected intentions to attend, support for the role of self-identity on attendance was not found, as the participants did attend the GUM clinic despite these perceptions.

Nine participants, five females and four males described perceptions of stigma in relation to attendance of the GUM clinic that were inextricably linked

with their perceptions of stigma regarding STIs. Having to attend the GUM clinic seemed to reinforce the negative impact upon self-identity. These perceptions of prejudice associated with the GUM clinic were similar for both female and male participants and do not support Foley and Patel's (2001) claim that GUM clinics are now acceptable to the general public:

I was thinking God does everyone else (know) as well . . . so I was like really . . . in a kind of way ashamed that I had to come here kind of thing . . . I was really very nervous. (F/1)

it's just all embarrassment—having the STD—the—having to come and get treatment—if anyone finds out—erm—it's all embarrassing . . . I mean I imagine it's quite a hard thing for most people to come through the door—because they'll feel embarrassed about themselves. (M/3)

As highlighted by Katz (1981), this discomfort could be as a result of perceptions of feeling 'blemished' that can lead to individuals wanting to avoid situations where their differences may be a source of discomfort for them as in line with the subjective norm component of the TPB. Attendance at the GUM clinic potentially exposes such blemishes to the visibility of an 'unaccepting world' (Goffman, 1963), as demonstrated via their expectations of the GUM clinic:

I expected lots of stern faces judging me. (F/1)

when I first went to a clinic I thought everyone was going to be judgemental of me and it's nice that people aren't. (F/8)

However, the male participants did not voice concern regarding potentially unaccepting judgements:

I didn't know what to expect really—I didn't know what kind of an atmosphere it was going to be. (M/6)

I just expected a general sort of—er—doctor's room basically—it pretty much met my expectations when I got here. (M/3)

Fear of exposure

However, all 10 participants described fears of exposure or a desire to conceal their problem that was linked with attendance to the GUM clinic:

at first it felt like—my God—does everyone know that I've got some kind of sexually transmitted disease—and I was looking about thinking

don't let anyone catch my eye—I felt horrible. (F/1)

there may be somebody I knew sat in the waiting room—I mean that's still a problem now—I wouldn't know what to do in that situation—me or the other person—a bit embarrassing—erm but I don't know—just sort of reluctant to come—erm—I wanted to just sort of keep it to myself basically. (M/3)

Highlighting negative factors relating to PBC, this fear was also anticipated before attendance:

really nervous—I told myself I would be able to notice the signs and find it myself without asking anybody where it was because it was embarrassing. (F/5)

However, it is possible that the significance of exposure for the male participants may have a different impact upon their self and social identity:

a few friends of mine have been down—they said just go down—some of them were saying it was embarrassing and it doesn't really bother me—I would rather get it sorted if I did have something and get it out of the way . . . it's the ego thing—they just keep thinking at the back of their mind it would go away or I have not got anything—but deep down they know they have got something—they are too embarrassed some of the lads to come down here . . . I would rather be safe than sorry. (M/6)

Attendance or non-attendance at the GUM clinic could reflect a form of 'doing gender' previously highlighted by Courtenay (2000) which reflects attitudinal differences between men and women. These differences surrounding patriarchal societal expectations also featured within this theme for the female participants:

I think it is the fact that with lads they sleep about—they don't get caught where girls do—I wouldn't feel embarrassed bumping into a girl who I had met in there—but if I had to go past a group of lads that had seen me—I would feel really embarrassed—in case they started pointing and saying she was in that clinic where we went to. (F/7)

This fear could be linked with local cultural or 'tribal' (Goffman, 1963) issues surrounding exposure within the very close-knit community where the GUM clinic is situated. Fear of exposure may not only be confined to exposure within the hospital or GUM clinic,

but also the wider community. This is in direct contrast to the findings of Brook, Tanner and Green (2003, p. 348) whose study was conducted in two inner-city areas of London. Their findings indicate that 'confidentiality and stigma were not stated as important issues' and clinics located closer to home was the over-riding influence on patients' preferred choice of service location. Thus suggesting that stigma surrounding social exposure was not an inhibiting factor for those people living in inner cities, therefore highlighting the importance of cultural context on sexual health seeking behaviours.

In relation to the TPB the attitudes of the participants of this study surrounding STIs were evaluated as negative, and these attitudes were reinforced by their formulations of negative attitudes surrounding the GUM clinic. Both of which are functions of the stigma associated with stereotypical beliefs. This can be seen to have negatively impacted upon self and social identity, resulting in a desire to 'conceal' their 'blemishes' (Goffman, 1963; Jones et al., 1984; Katz, 1981). However, this impact was voiced as greater by the female than the male participants which could be argued is as a result of the subtle patriarchal pressures experienced by women. Their attitudes towards STIs and attendance at the GUM clinic were formed via internalization of stereotypical beliefs. Although the pressures underlying the subjective norms appeared to affect the male and female participants differently, overall these norms reflected a perceived disapproval of attendance at a GUM clinic.

Isolation

These attitudes and the pressures of subjective norms also contributed to isolation. In support of previous findings (Duncan et al., 2001; Holgate & Longman, 1998) the perceived stigma surrounding STIs, attendance at the GUM clinic and the subsequent fear of exposure, contributed to isolation from their usual support networks. Seven participants (three male/four female) indicated that they were unable to discuss their health problem with friends and family:

well my parents for example know that I've got an appointment every week—they just don't know where I go—it's not something I'd tell my mum and dad, my friends, brother or sister for that matter . . . it's all embarrassment. (M/3)

I just don't want them to—to think I'm dirty—I think that's the main thing you know—because—er—like my best friend—she's my best friend in the world—I can really tell her anything—but

this—I just don't want to tell her—I just would rather not tell her—I don't want her to think anything worse. (F/1)

Reluctance to attend

Perceived social stigma also led to the desire to conceal their 'blemishes' which resulted in an expressed reluctance to attend the GUM clinic by eight (five female/three male) participants, reflecting factors relating to internal PBC:

... waited about a year—I didn't dare come—seeing someone I know—I made an appointment and then I didn't turn up—that was for about a month after that anyway. I made another appointment and that was about 2 months after and I didn't turn up for that so then I made an appointment and turned up ... I didn't know where it was and stuff like that—I didn't know who would be in there. (F/10)

I went to the doctors and she said it and I thought she would just be able to get rid of it but she said I had to go down to the clinic to get it sorted out—I was really nervous about that ... when I got here I was tempted to turn round. (F/5)

Control factors seemed to be perceived as more negative by the female than male participants, which in support of Sheeran et al. (2001) the TPB cannot account for. However, as identified by McLean and Reid (1997) and Harry (1999) organizational barriers to access to GUM clinics were also found in the present study by both genders:

lack of knowledge basically—I didn't know what was going to happen to me when I came up here—I didn't know who was going to be treating me. (M/3)

I came and I didn't even have a clue where it was. (F/10)

I found it quite difficult to find out where to come and get tested. (M/4)

That is the only thing I find annoying coming to these clinics is because they are only open certain times and it is very hard to get an appointment that you don't have to take time off work for. (F/8)

In support of the findings of Godin et al. (1993) these negative perceptions of control were weighted against their attitudes towards the perceived positive health outcomes that influenced their intentions to eventually attend:

I'd been to my GP and he'd done just about as much as he could—erm—to save me coming here basically—in the end he said that I'd have to come here if I wanted to get treatment and get rid of my problem—so I just had to swallow my pride and come along basically. (M/3)

Being motivated to attend because of the weighted value of desired positive health outcomes despite the perceived lack of internal and external control, it is possible that these outcomes involved the desire to get 'rid of' perceived contamination associated with the stigma.

Contamination

The desire to be free from contamination was strongly expressed by eight participants (four male/four female) when asked as to why they eventually attended the GUM clinic. This was not reflected in the findings of Dixon-Woods et al. (2001), but does reflect Jones et al.'s (1984) and Katz's (1981) dimensions of stigma such as threat, responsibility, origin and peril:

I think it's more to do with being dirty really ... because it's an infection and like in private places and they're classed as being dirty anyway ... you know if I had a cold sore on my lip—that wouldn't be classed as dirty but because it's in like private places—then maybe that's why. (F/1)

Desire to be free from such contamination was frequently described as a desire to 'get rid of' the infection:

I thought she would just be able to get rid of it. (F/5)

that's the whole thing—to get rid of it—for it not to be there any more ... let's get it sorted—get rid of it ... to get rid of the problem. (M/3)

some people would probably think you were dirty ... come down here to make sure that I'm all right—make sure that I'm clean ... that's it really—I feel a lot happier—a big relief off my shoulders knowing that I am clean. (M/6)

I wanted to get it sorted out as quick as I can—you know—I just want rid of this. (M/2)

It is possible that the overwhelming desire to 'get rid of' such perilous contamination generated an internal power that facilitated attendance despite the personal obstacles. It could be argued that to get rid of the stigma that coexisted with the infection was the motivating factor to attendance, supporting Sideridis's

(2001) view of goal importance acting as the causal or motivational agent in behavioural action. Dimensions of personal responsibility related to contamination also seemed to contribute to this internal drive:

I don't want to give anybody anything because I don't want to catch anything . . . kind of relieved in a way that I'd finally got it sorted out . . . at least I would be able to relax a bit more and am not going to give anybody anything at the moment and am happy with myself . . . I am not going to put them at risk. (F/8)

yeah I was keen to get this sorted out—go back to having a normal sex life . . . I've got a clear conscience now—peace of mind—that's what it is. (M/2)

The desire to 'get rid of' such contamination voiced so strongly by these participants reflected the internal or agentic drive that appeared to have a direct influence on the motivation to attend and facilitated actual attendance over and above the negative attitudes, subjective norms and PBC surrounding the perceived stigma of STIs and attendance at the clinic. In this context, actual attendance was motivated by an attempt to reduce the psychological discomfort brought about by perceptions of a spoiled identity, which the TPB cannot account for.

Other variables that the TPB cannot account for are also linked with this desire to be free from contamination such as the role of personal or moral norm. Parker et al., (1995) found that when added to TPB the role of personal norm, reflecting perceptions of what is morally right or wrong, contributed to intention formation over and above attitude, subjective norm and PBC. It is equally possible that the desire to be free of perceived contamination may have reflected such moral norms demonstrated not only in relation to gender-behaviour constructions highlighted earlier, but also by not wanting to put others at risk, an issue which was also found by Dixon-Woods et al. (2001).

A salient theme also arose regarding relationship issues, which influenced attendance for a sexual health screen and for which gender differences were found.

Relationship issues

It is possible that the male participants' intentions to attend for screening were influenced by the adverse impact the infection may have upon their sexual relationships as they voiced concerns surrounding this:

I was keen to get this sorted out . . . go back to having a normal sex life. (M/2)

I didn't really know what it was so I thought I would come down and have myself checked over—just to be on the safe side—well that I haven't actually got an STD and that I can sleep with people knowing that I have a clear conscience—so I'm not passing things onto anyone. (M/6)

This therefore could be explained by the role of moral or personal norm on intentions as identified by Parker et al. (1995). However, the main concerns of the female participants were the possibility of infidelity in their current relationships, which increased their anxiety and distress. Furthermore confusion over how they contracted the infection was indicated and therefore possibly linked with perceived invulnerability due to lack of knowledge surrounding STIs:

like I've only had one partner and—I was distraught at the fact that he might be sleeping with someone behind my back—all that on top of it and I was just—just gutted—there's no other way to describe it. (F/1)

shock—unexpected—and I hadn't been with a partner for a while so if that had happened—why is it just appearing now. (F/5)

Perceived invulnerability

Seven participants (five female/two male) also highlighted perceptions of invulnerability, which, it could be argued were involved in the formation of attitudes surrounding STIs and subsequent intentions to attend for a screen. This was linked with misperceptions surrounding the risks of contracting STIs and involved a lack of knowledge, demonstrated by:

I was really very naïve until it actually happened to me—you know . . . you kinda feel this is not going to happen to me—you know—that's something you hear about on the news . . . but you never think it's gonna happen to me you know—it's the old superman effect. (M/2)

when I first got Chlamydia I was very frightened of the fact that I hadn't slept with that many people and that I'd managed to catch something—and I'd never heard of this before. (F/8)

Also highlighted was the lack of knowledge linked with perceived invulnerability associated

with the asymptomatic nature of STIs (Simms & Fairley, 1997) as the following participant who waited one year before attending was diagnosed as having both Chlamydia and Gonorrhoea:

there had been rumours about this lad—had everything—and he had done it to loads of people—I didn't think they were true but I just came in for a check up—I thought I didn't have nothing because I didn't have anything wrong with me. (F/10)

Supporting the proposition that failure to acknowledge personal risk is also thought to be a major barrier to adopting health behaviours (Janz & Becker, 1984). It is further argued that these findings suggest that stereotypical attributions influenced by patriarchal ideologies play an important role in perceived invulnerability. This carries serious health implications, as coupled with the danger of a higher risk of contracting HIV (Fleming & Wasserheit, 1999), the consequences of undetected and therefore untreated STIs include infertility, ectopic pregnancy, premature births, miscarriage, certain types of cancer and premature death (PHLS, 2002).

Conclusion

Seven themes were identified as salient issues surrounding the perceptions of sexual health screening to the participants in this study, and within these themes distinct gender differences were identified. Although these themes were dominated by perceptions of social stigma as described by Goffman (1963), Jones et al. (1984) and Katz (1981), these were not all endorsed by the TPB.

According to the TPB, individuals will have strong intentions to perform a behaviour if they evaluate it positively (positive attitude), believe that significant others would want it performed (subjective norm) and perceive it is easy to perform (PBC). For the participants in this study the attitudes towards STIs and attendance at a GUM clinic were evaluated as negative due to the negative impact of the subjective norms, which in turn negatively influenced internal PBC factors. Together with the influence of perceived invulnerability, this is due to the patriarchal social construction of stigma surrounding STIs and GUM clinics, which served to create a negative impact upon their self and social identities. This impact was identified as far greater for the female participants, serving to increase their distress.

In contrast to findings of Brook et al.'s (2003) inner-city study where stigma was not considered an important issue in relation to attendance, perceptions of stigma have consistently been identified previously as potential barriers to sexual health screening (Duncan et al., 2001; Meyer-Weitz et al., 2000; Wilson & Williams, 2000) and could therefore be viewed as having a negative impact upon internal control factors. External control factors as a result of organizational barriers were also identified. Thus supporting the need for consideration of cultural context in sexual health research and service provision as the participants in this study lived in a very close-knit community where the potential for meeting family, friends and neighbours in the hospital and GUM waiting room was very high. This highlights the need for the sexual health community to be cautious in attempting to generalize research findings.

Furthermore the role of self-identity has been found to be an additional predictor of intentions to behave only for individuals who identified strongly with the group (Terry et al., 1999). Having a STI and having to attend the GUM clinic for screening and treatment was linked with socially undesirable behaviour and therefore identification with those 'types' who catch STIs and attend the GUM clinic was not acceptable to them. This was more of a salient issue for the women in this study, creating inhibiting conditions to attendance.

However, despite the internal and external obstacles, the participants of this study did attend, and it is possible that their negative attitudes towards attendance were weighted by the goal directed achievement of positive outcomes, albeit not necessarily physical health-related outcomes. These outcomes or goals were dominated by the participants' overwhelming desire to 'get rid of' their perceived contamination that bridged the gap between their negative attitudes towards attending and actual attendance over and above the internal and external obstacles. The TPB cannot explain this effect except possibly in relation to the additional variable of personal norm highlighted by Parker et al. (1995). Future research needs to examine further this desire to 'get rid of' perceived contamination and the effect upon intentions and action to attend for sexual health screening within the TPB framework, together with further exploration into the gender differences that the TPB also cannot account for. Consideration of these issues is particularly important in relation to theory development in health psychology, as Winnett

(1995) reminds us that, psychological theories that do not consider concepts that explicitly operationalize sociocultural, political, policy, community and organizational influences, oversimplify the complexity of individuals within society.

These findings also have implications for the current crisis in GUM service provision in the UK. Rapid access to diagnostic and treatment services for STIs and HIV is a key component of any public health programme, and current data reveal that access remains a major problem, with less than half of all GUM clinic attendees being seen within the recommended 48 hours (HPA, 2005). Compared with a decade ago, there are twice as many new cases of gonorrhoea, three times as many new cases of HIV infection and Chlamydia and 16 times as many cases of syphilis being recorded. Furthermore, as many as one in 10 under 25-year-olds are infected with Chlamydia, but only one in three are aware that they are infected (Rehwagen, 2005). Each treatment delay could have serious consequences, such as an increased risk of complications, further transmission to others and an increased susceptibility to contracting HIV.

In support of Sheeran et al. (2001) and Smith (1999) the exploratory nature of this study has facilitated these findings, which may not have been identified via 'rigid' quantitative methods. Although efforts were made to safeguard and maintain external and internal reliability via methods of researcher and analytical triangulation, it is acknowledged that limitations of this study include the self-selecting, small sample size due to a high refusal rate, together with the possibility of self-reporting bias. Issues surrounding gender, power and the clinical setting may have influenced not only the uptake, but also the responses of participants, as the researcher/interviewer was a female health professional employed by the clinic. It is also possible that the high refusal rate could have been due to the sensitive topic of the investigation and the associated impact of stigma upon the person, highlighted by those who did participate.

In support of Duncan and Hart (1999), this study has demonstrated that sexual health screening does take place against a prevailing sexual (patriarchal) ideology that plays a major role in the construction of barriers to sexual health care in close-knit communities, especially for women. Although the medical profession and the Government are recommending destigmatization of STIs and GUM clinics (DoH, 2001; Foley & Patel, 2001) which, ironically, they

have played a role in creating, the main findings of this study suggest that within close-knit communities it is this very stigma that ultimately motivated individuals to attend. The participants of this study all voiced a real reluctance to attend the GUM clinic and described the psychological discomfort they experienced as a result of stereotypical notions surrounding STIs and the clinic. However, although destigmatization of GUM clinics would be a positive action to lessen this discomfort which then might encourage individuals to attend sooner, the active voices of the participants in this study demonstrated that the desire to 'get rid of' the perceived contamination associated with the stigma of STIs, may have paradoxically facilitated their attendance over and above the personal and organizational obstacles. In the absence of other contextually based research findings on these issues should STIs therefore be destigmatized?

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