Counteracting Stigma in Sexual Health Care Settings

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Abstract

Sexual health clinics and the people who visit them commonly face stigma. Sexually transmitted infections have historically been used to divide people into "clean" and "dirty". A grounded theory study of the work of sixteen nurses in six Sexual Health services in New Zealand was undertaken to explore the management of sexual health care. The study uncovered the psychological impact of negative social attitudes towards the people who visit sexual health services and to the staff who work there. Sexual health nurses manage the results of stigma daily and reveal in their interactions with clients a process of destigmatisation.

INTRODUCTION

The provision of sexual health care is socially complex and difficult work. A contributing factor is the widespread stigma associated with sexual health clinics and sexually transmitted diseases (STDs) [1]. Daily, nurses encounter people who feel ashamed, humiliated, defensive and frightened about their situation. Nurses working in sexual health clinics know how to respond to social, psychological and cultural reactions based on their experience in practice and are aware that clients anticipate negative reactions.

Sexual health nurses also encounter negative public and professional reactions to their work. Other health professionals and the community may view sexual health nurses, as being involved with the 'dirty' aspects of sexuality. [2,3,4,5] Accordingly, staff in sexual health settings adopt strategies that convey humanity, safety and normality to counteract stigma. Counteracting stigma (destigmatisation) is a complex process during which sexual health care nurses are engaged with dignifying and advocating for clients who attend sexual health clinics. The destigmatisation process was uncovered through a grounded theory study of sixteen sexual health nurses in New Zealand. In this paper, the study will be described and the theoretical framework of destigmatisation explained.

BACKGROUND

The concept of stigmatisation associated with sexually transmitted infections is well identified in the social science and medical literature. [1,6,7,8,9] Historically, people with sexually transmitted diseases have been stigmatised. Sexually transmitted infections were incurable until the advent of antibiotics in the 1940s.[1] Prior to this time; syphilis and gonorrhoea were difficult to treat. Venereal diseases were a serious threat as they could be fatal, commonly caused infertility, infected neonates, and caused chronic debilitating illnesses [10]. Although medical treatment has been available for sexually transmitted diseases since the 1940s, curable diseases such as chlamydia and gonorrhoea persist, and the prevalence is increasing. [1] Individuals and society use the coping mechanisms of denial and displacement including, stigmatisation, scapegoating and discrimination when faced with illnesses that are threatening or fatal, or for which there is no cure. [9]

Stigma remains a significant barrier to the prevention of curable infections even when treatment is freely available. Often society, including some health care professionals consider that clients have deviated from the norms of respectable illnesses, and therefore should be punished by being treated as socially undesirable. The sociological phenomenon of stigmatising sexual minorities and people with HIV/AIDS and STDs is well documented in the literature. [6] Stigma operates when individuals fail to meet what is considered to be normal and healthy which ''spoils' the social identity, isolating the individual from self, as well as, societal acceptance' [6].

The tools of derogatory language, mythology and negative social responses are used to shape attitudes towards targeted social groups. People with sexually transmitted diseases become 'them' or the 'other''. Gilmore and Somerville [9]

explored the process of polarising 'them', the indecent, dirty and diseased from 'us', the decent, clean and healthy. Through disidentification, scapegoating and discrimination 'them' become separate from 'us'. For instance, the association of genital wart virus with sexually transmitted diseases has been recognised as a significant factor in stigmatising women with cervical cancer. [7] Braun and Gavey [7] in a study of cervical cancer prevention programmes in New Zealand reported that key informants were not in favour of associating cervical cancer with the genital wart virus as this was likely to stigmatise women who developed cervical cancer. Eng and Butler [8] explored the hidden epidemic of sexually transmitted diseases in American society. These authors considered that the deeply embedded secrecy surrounding sexuality was a major contributing obstacle to effective prevention campaigns. Eng and Butler [8] commented that while there are consumer-based political lobbies and support groups for almost every disease and health problem, few individuals are willing to admit publicly to having an STD.

Although nurses often use interventions to counter stigmatisation, little is known about the social processes of managing clients in sexual health services. Research concerning nurses and sexuality care has mainly focused on values, attitudes and beliefs. [3], [11], [2], [5] Findings have indicated a need for more and improved sexuality education. In order to improve nursing practice, however, sexuality education needs to be informed by the practical realities of practice settings. [12], [13]

The study undertaken aimed at examining the management of sexual health practice from the perspective of nurses employed in sexual health care settings in New Zealand. [14] In the study a grounded theory approach was used to uncover the processes of the everyday interactions between sexual health nurses and their clients. The significance of the study was that the findings articulated the processes by which the nurses managed their work, their role and explored the ideological frameworks that assisted or impeded the sexual health nursing role. Data collection was guided by the question "How do nurses manage their encounters with clients in sexual health care settings?"

DESIGN AND METHOD

Sixteen sexual health nurses located in both urban and rural clinical settings in New Zealand were interviewed using a semi-structured technique. In addition, an expert panel of sexual health nurses participated in a critical examination of the preliminary findings. The study gained ethics approval from Massey University Ethics Committee and the Auckland Health Funding Authority. Participants self selected having been given information about the study from service managers. The initial interviews were minimally structured using questions such as "tell me about your role," and "how do you manage difficult situations?" Following analysis of the early interviews, theoretical leads were explored in the later interviews. Examples of leads were listening and reading verbal and non-verbal cues; building trust and rapport; maintaining professional boundaries; encountering sexual vulnerability and sexualising behaviour.

Constant comparisons established commonalities and differences between nurses in their interactive management and accounted for variations between them. This process was continued until theoretical saturation was achieved and the information confirmed the data collected. Informal discussions with nurses, nursing students and physicians working in sexual health gave greater scope, meaning, and accuracy to the data.

Substantive coding offered a focus for early data analysis. Constant comparative analysis gave substance to the data and coding. Data were reduced into concepts and categories through line by line analysis looking for words and gerunds that indicated action. Participants' language was used to ensure the concepts remained factually grounded in the data. Theoretical concepts were developed and connected through the reduction of coding categories. In this way original categories could be abstracted into a theoretical code. As each theoretical code emerged new data were compared; previous tentative codes were recategorised and reorganised.

Selective sampling of the literature reinforced the resulting conceptual framework. At this stage a core variable emerged which synthesised a number of related themes of social interactions and applied to a range of concepts and conditions. Glaser [15] indicated that the core variable is realised when it accounts for most of the variation in patterns of behaviour and draws together relationships between concepts and functions to integrate a theoretical framework. The core variable that emerged was Destigmatisation.

THE PROCESS OF DESTIGMATISATION

Health care practitioners have a powerful role in destigmatising the experience of sexual health care. If the health care environment for people with sexually transmitted diseases is to change, it is important that the wider context of societal attitude is understood and that professional

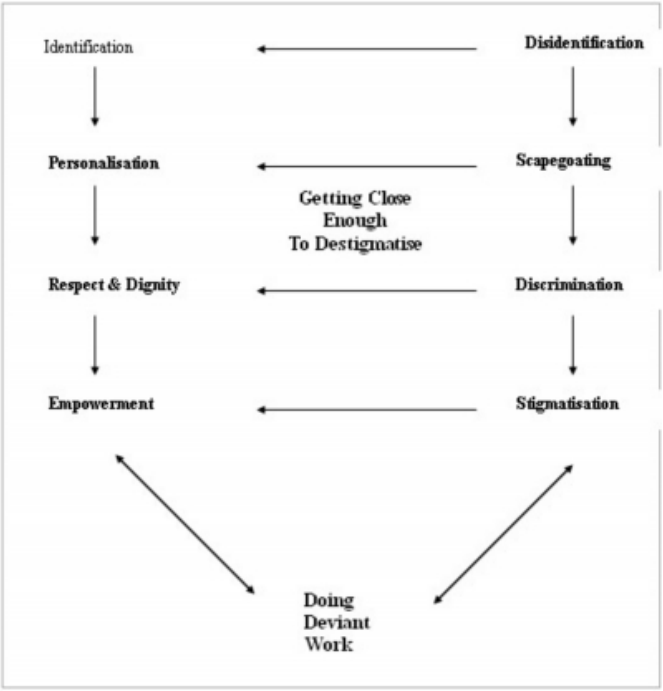
responsibility is taken to change the secrecy, stigma, and silence around sexuality. The commonness and normalisation of prejudice and discrimination against sexual health populations requires sexual health nurses to work through destigmatising processes. In general, a lack of sympathy occurs for those considered sexually careless and irresponsible. Although a general awareness exists that marginalisation is an indicator for poor sexual health status, the issue is generally viewed as a matter of individual risk and lifestyle. STDs are believed by some health professionals to be the result of immorality and clients affected may not receive adequate medical or nursing care. Braun and Gavey [7] state that 'the stigma that people feel, rather than how stigmatised they are by others' is distressing and is crucial in understanding individual reactions to STDs.

Destigmatising in the context of this study means that sexual health nurses engage in a process to counteract prejudice and negative social attitudes towards people who attend sexual health clinics and who have sexually transmitted infections. The analysis of nurse's counter reactions to stigma is compared to Gilmore and Somerville's [9] model of stigmatised reactions towards people with sexually transmitted diseases. The model describes the processes that characterise stigmatised reactions: disidentification, depersonalisation, scapegoating, and discrimination. The process occurs through the nurse's therapeutic engagement with the client which is one of identification, personalisation, respect and dignity and empowerment.

The process of destigmatisation is diagrammatically represented in Figure 1.

Figure 1

Figure 1: The Basic Social Processes of Destigmatisation (The Destigmatisation Of Clients Who Attend Sexual Health Services)



Nurses form the view that it is the negative characteristics attributed to people who attend sexual health clinics that is antisocial and not the individuals who present. Nurses position themselves to counteract the social stereotypes held of people who attend sexual health clinics and who have sexually transmitted infections and HIV/AIDS. An alternative experience is offered to clients in which nurses deliberately construct care to overcome anxiety and fear and to turn the event into a positive experience. The nurse, by identifying how they would feel in a similar situation, comprehends the social dilemma of the individual. A process of experiential reframing is occurring in interactions with nurses, in which clients are able to view themselves differently from the prevailing external views of people with STDs. The received view is to label individuals as sexually indiscriminate, irresponsible, unworthy and deviant. From the initiation of the interaction with the client, the nurse is engaged in an intensive process of rapport building. In the words of one nurse:

I think you have to have a special skill at developing rapport quickly with people who are extremely nervous about attending. And very uncomfortable. It's taken a lot of courage to walk through the door and I think that they pick up if you're uncomfortable so nurses have to be, or anyone working in sexual health not just nurses, nurses have to be

particularly aware of their own sexuality and their own sexuality issues, values and beliefs. I think that's so important to know that so then if something sort of hits you in the face, you can think where's this coming from and then think I know, it's a value I have and it's coming hard up against that. And just being able to put that aside then and work with the client in a constructive way rather than a judging way ... (Jill. 1:69).

The social responses and attitudes of sexual health nurses are shaped by the wider context of societal prejudices, values and beliefs. Through a process of self-awareness and reflection nurses put aside attitudes that may be detrimental to client care. This is part of an active process of personal and professional destigmatisation. Gilmore and Somerville [9] state that the target of stigma must be identifiable, recognisable and assigned. In the case of sexually transmitted infections, people are not socially identifiable. Being identified occurs in private, intimate and vulnerable contexts. The points of identification are within sexual relationships, with health care practitioners, and in the act of entering a sexual health clinic. The meanings that STDs have for people will be influenced by the responses encountered in each of these contexts. Health professionals have a powerful role in determining how the individual will internalise the experience. One outcome may be the internalising of an experience of open distaste and condemnation. The health professional in this case is in the act of assigning the individual with the negative characteristics associated with stigma, the client in turn perceives those characteristics as belonging to them. For stigma to operate effectively the individual must own that they belong to the stigmatised category. Attending a sexual health service meets recognisable social criteria for people who should be stigmatised. Being seen in a sexual health service does identify people as different individuals from others who do not attend. Unless the professionals employed in those services construct the event as other than the social interpretation given to such health care, client self-labelling is reinforced. Communities tend to treat individuals and groups in society, associated with sexual infections as social problems, to be distanced, separated, and disempowered. One nurse identified the use of social myth making about marginalised sexual minorities as a means of distancing ‘them' from ‘us':

... I think that people making that kind of person different ... they don't want to be seen as anything like ... what they see as a sexual deviant, whatever that is ... I think that because it's ... so close, like just the whole sexuality thing, anybody who perhaps is perceived as being slightly different, the sex worker; the gay man you make myths about them just to get them away from being anything like you ... So all it's doing is making it work so that you're further away from it ... (April, 1:401).

Having an STD is a common experience, however in health care it is often treated as if it was extraordinary. Sexual health nurses recognise the paradox of sexuality. Sex is considered normal and natural however having a sexual infection is not. One nurse quoted a colleague as saying:

If you do something as natural as breathing, you risk getting the influenza virus, and if you do something as natural as having sex, you risk getting human papilloma virus (Pia, 1:18).

Unlike people with other communicable diseases, people with STDs are treated as if they were unnatural. People with sexual health problems frequently report that they are treated in general health settings as if they were offensive. Having an STD places people on the social margins along with other stigmatised social groups. Behaviours towards people who are identified as having an STD are similar to those towards people who belong to populations where sexually transmitted infections are considered to be common, sex workers, injecting drug users, street people, and gay men. One nurse emphasised that clients were:

... disempowered by coming in here anyway. You know, they're under an awful lot of stress (William, 1:319).

For many people a visit to a sexual health clinic is the first of experience of being an outsider. Attending a sexual health clinic is stressful as the client is entering a new social category and in doing so loses the status and power of social acceptability.

IMPLICATIONS FOR NURSING PRACTICE AND EDUCATION

There is a growing recognition in nursing education that it is an area of specialised practice, however, little is understood about the social reality of the work. There is a concern within the profession to improve values, attitudes and beliefs about sexuality and the practice of sexual health care. Teaching strategies that raise awareness and desensitise nurses to the discomfort of discussing sex, need also to incorporate an examination of the social and cultural context in which sexual health care takes place. An understanding of the cultural operation of stigma is essential to nurses who

work with peoples with sexual health care needs.

Understanding the relationship between poor socio-economic and cultural conditions and poor patterns of sexual and reproductive self care is significant in future health prevention and promotion strategies. The practices of sexual health nurses model brief individualised harm minimisation strategies that can be used in the time available in a busy clinical setting. Sexual health nursing presents an opportunity for the teaching of community based care of marginalised peoples. Future graduate and postgraduate nursing education needs to include concepts of shame, stigma and disgrace as issues of social ill health and dis-ease. Progressively sexual health care is being presented as a part of the holistic care of the client, however the implications of the study undertaken are that the practices are not considered professionally normal, natural or healthy. For nurses new to the area of sexual health, the findings of destigmatisation represent the processes of coming to terms with sex and sexuality. Finding meaning in sexual health work is balancing the social problems encountered with the rewards of social agency. New practitioners need to consider that the work involves a professional commitment to the rights of women to reproductive choice, to sexual diversity and to sexual health care for minors. It needs to be professionally recognised that being involved in work which is contentious and controversial over a long period of time has a personal impact. The study reinforces the need for the teaching and incorporation of nursing debrief and supervision processes.

CONCLUSION

The process of destigmatisation is the process that nurses use to manage sexual health care. Through interactions with clients, colleagues and communities, sexual health nurses learn the symbolic meaning of work that is involved with sexuality. Sexually transmitted infections are a social attribute as much as they are health problem. The experience of an STD is feeling socially and physically contaminated. The management of sexual health involves the treatment of infection and of the social impact of such infections. Destigmatisation is a conscious process of the reversal of the negative cultural messages about STDs. Nurses daily are engaged in counteracting shame, fear and anxiety among sexual health clients. Destigmatising is a concept for care that is based on the human rights and dignity of each individual in health care. A positive experience of health care with a stigmatised disease can alter client self-perception and self-esteem.

The secretiveness and silence that impedes sexual health care and stigmatises both clients and practitioners needs recognition as a social system which health services continue to perpetuate. The study presents a model for the treatment of stigma that can be applied in other areas of health care. It is evident that individual nursing practice is reflective of the social norms and attitudes of the workplace, which in turn reflect a wider social context. Setting standards of dignity, decency and respect for sexual health care populations is an environmental issue that requires interdisciplinary workplace consensus. There are few models of care based on the knowledge and experience of nurses in sexual health practice that are available to inform the social management of clients. It is recommended that nursing care is reexamined from the perspective of the theoretical framework of destigmatisation and in particular the role of advocacy and social empowerment in nursing.

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