Exploring emerging adults’ felt shame and stigma of sexually transmitted infections in the process of disclosing and seeking support from parents and sexual partners

**Literature & Justification**

Sexually transmitted infections (STIs) are a constant threat to this country, with over 20 million new cases a year (CDC, 2013a). Emerging adults (EA; ages 18-25) make up 25% of sexually active adults and yet they comprise 50% of all STI cases (Satterwhite, 2013). Emerging adulthood is a transitional time, often marked by personal and sexual exploration (Lefkowitz, 2005) and the development of personal health behaviors (Harakeh, Scholte, Vermulst, de Vries, & Engels, 2004) as adolescents navigate their way into adulthood. During this period, EAs are more likely to partake in risky sexual behavior, have multiple and simultaneous sexual partners while using less protection (Paik, 2010), perpetuating the spread of STIs, HIV/AIDS, and increasing the risk of teen pregnancy (Anderson, Wilson, Doll, Jones, & Barker, 1999; Lewis, Granato, Blayney, Lostutter, & Kilmer, 2012). Additionally, the CDC notes EAs’ lack of STI screening increases their risk for contraction (2013). A number of demographics may also lead to this behavior (Fortenberry et al., 2002), including a superhero mentality and perceived barriers although EAs are not getting tested, and seemingly experiencing shame and stigma to do so, as per past research (e.g., Fortenberry et al., 2002), previous studies have found a lack of shame or stigma towards STIs as an entity, talking about STI testing with health care providers, or even getting tested. This may be due to a variety of factors including the hook-up culture (Bogle, 2008), increased sex education, and/or the perception that STIs are treatable, if not curable (CDC, 2013a). There has also been increased awareness surrounding HPV and its prevalence in recent years (CDC, 2013b), and thus an increase in knowledge of the STI. While this is only one STI, such awareness may decrease the shame and stigma surrounding the medical and corporeal aspect (e.g., talking to health care providers) of all STIs.

STIs have consequences for the infected individual’s psychological well-being (Lee & Craft, 2002), self-esteem, sexual self-concept, (Newton & McCabe, 2008), and physical health (CDC, 2013a). Disclosing an STI status is important to coping with the diagnosis by receiving support in the process. However, many infected individuals avoid disclosing their status due to the potential risk of rejection by a loved one, as well as feelings of anxiety, stress, and shame (Newton & McCabe, 2008). As disclosure is necessary for social support, EAs diagnosed with an STI are less equipped for efficacious coping, lowering sexual self-confidence, thus less likely to engage in conversations in order to practice safe sex (Newton & McCabe, 2008; Noar et al., 2006).

Despite the role shame and stigma has as a predictor of engaging in sex communication (e.g., Widman, Choukas-Bradley, Helms, Golin, & Prinstein, 2014), little has explored how emerging adults experience shame and stigma of an STI beyond the stigma of seeking treatment. Yet, it is imperative to understand shame and stigma of talking about an STI to fully explore motivators to engage in sex communication and disclosure of an STI in both support seeking behaviors and safe sex practice negotiations. Therefore, the aim of this study is delve into sex communication between EAs and their parents and sexual partners, as the shame and stigma surrounding STIs may potentially be the process of engaging in conversation about STIs and disclosing an STI status than the STI itself.

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<th>Identify the ways emerging adults experience sexually transmitted infections?</th>
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<td>RQ 1.1</td>
<td>In what ways do emerging adults experience seeking out medical advice and medical treatment in order to partake in safe sex and after being diagnosed?</td>
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<td>RQ 1.2</td>
<td>How do emerging adults experience a sexually transmitted infection diagnosis?</td>
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<th>Aim 2</th>
<th>Explore how emerging adults feel shame and stigma about STIs that differ from traditional felt shame and stigma about STIs.</th>
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<td>RQ 2.1</td>
<td>In what ways do emerging adults feel shame and stigma about STI diagnoses, treatment, and treatment adherence?</td>
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RQ 2.2 In what ways do emerging adults feel shame and stigma in the process of practicing safe sex (e.g., getting tested for STI’s, asking sexual partners their status, etc)?

Aim 3 Explore the role shame and stigma of STIs have on other communicative processes.

RQ 3.1 How does shame and stigma of STI diagnoses impact emerging adults’ communication with parents about their health?

RQ 3.2 How does shame and stigma of STI diagnoses impact emerging adults’ communication with current and potential sexual partners?

With STIs and HIV/AIDS remaining a national concern, especially in American’s youth and young adults, it is imperative to conduct research to better understand sexual health, sexual self-esteem, and support seeking and treatment adherence behaviors. As sexual exploration is commonplace (Lefkowtiz, 2005) for EAs, and the hook up culture occurring on campuses across the country (e.g., Bogle, 2008) it is important to consider the communicative processes surrounding EAs' perception of STIs and HIV/AIDS. Seemingly they are willing to get tested and find out the results, however the ability to engage in conversation about STIs and HIV/AIDS is more difficult. Thus, while it is important for EAs to get tested and get treated, talking about STIs/HIV/AIDS can help to prevent spread and contraction (e.g., Newton & McCabe, 2008). The results of my past research in conjunction with the proposed study provide foundations for targeted health promotion tactics that encourage talk, the starting point towards increasing condom usage, consent, and healthier sexual relationships within the EA population (e.g., Noar et al., 2006).

Design & Methodology

20 participants who have been diagnosed with a sexually transmitted infection at some point in their life will be recruited for in-person or phone interviews (since some participants will be from geographically different locations). In-person interviews will be held over the phone or at the Moody College of Communication Behavioral Science Lab. The lab has specially designed rooms with audio recording equipment. Thus, I am able to conduct the interviews in a private and quiet space, where participants feel more at ease and able to answer question as fully as they can, especially considering the content. Phone interviews will be recorded with a hand recorder and participants will be told to find a space where they are comfortable to answer questions. The interviews will be facilitated by the principal investigator of this project. I have previous experience conducting interviews and working with diverse research participants.

A) Through semi-structured interview protocol, participants will be asked to describe their health behaviors and overall feelings towards sexually transmitted infections, getting tested, getting treated and treatment adherence, and the process of disclosing to parents and sexual partners. Participants will be asked to describe conversations that they have had with others about their STI and the feedback they received after disclosure and safe sex conversations with partners. The interview will also focus on their general feelings surrounding those interactions. The moderators will probe for specific examples of these conversations and how they were perceived. The interview process should take about an hour. Upon completion, participants will be given a $15 gift card to Amazon.

B) Using notes taken during the interview process and the software, each audio recording will be transcribed either through the use of consultant services or students with the IE pre-graduate mentorship program who are interested in research. The analysis will begin with a constant comparative technique (Strauss & Corbin, 1990), which will be used to fine-tune the definitions and properly identify themes across the interviews (Strauss, 1967). A subsample of the transcripts representing 20% of the responses will be coded for these themes identified. The entire set of transcripts will be analyzed, using Dedoose software, to explore the presence of the themes and identify exemplar quotations. I will clearly present the various coding schema, frequency of each theme throughout the units of analysis, as well as examples from the text in the future manuscripts.
After coding, themes will be developed, compared to demographic variables collected during the interview, and utilized to develop quantitative questions and items for the quantitative portion.

C) 500 participants will be recruited by reaching out to undergraduate students enrolled in communication studies undergraduate courses at four different universities \((n = 125 \text{ at each institution})\) in geographically diverse locations (Austin, Texas; Athens, Georgia; Washington, D.C.; San Diego, California). Three colleagues of mine at UC San Diego, University of Maryland, and the University of Georgia have confirmed their assistance in this process. In addition to the population fulfilling the inclusion requirements of being emerging adults, using college students also ensures the participants will likely be a part of the hook-up culture, a likely contribution to changes in felt shame and stigma about STIs. Using this recruitment technique is also for convenience, as many communication studies courses offer extra credit for participation in research studies on campus.

After signing up for the study, participants will be emailed a Qualtrics online questionnaire, in which they will answer questions corresponding to the variables’ measures. The questionnaire should take 45 minutes to an hour.

First, participants will respond to items pertaining how willing they were to get tested for STIs. Participants will fill out a number of measures assessing this willingness, as well as the shame and stigma related to getting tested for STIs and having an STI. Participants will also answer questions to describe their willingness to disclose that they got tested, as well as the potential results of an STI test, to certain individuals. Next, participants will be asked to answer questions about their sexual behavior and safe sex practices. Descriptive analysis will be conducted to examine the mean, standard deviation, and distribution of all primary variables.

E) Statistical analyses will be used to explore emerging adults’ perception of felt stigma and shame of STIs as compared to original measures of shame and stigma of STIs, relations to sexual behavior and safe sex practices, and likelihood to disclose or engage in conversations about their STI to parents and sexual partners. Quantitative analyses and results will be compared to qualitative results.

Conclusions

This study is currently in the data collection stage. By the point of the McCombs Health Symposium, all data will be collected, coded, and analyzed. This study is based on a study that was conducted solely at The University of Texas at Austin which discovered that UT students rarely felt shame and stigma in the traditional senses, including: getting tested, seeking treatment, or talking to health care professionals about sexually transmitted infections or sexual health. From this study, it seems clear, however, that the shame and stigma felt by emerging adults remains steadfast in the disclosure process and support seeking efforts. Furthermore, most emerging adults perceive their peers to feel shame and stigma, and to have more negative experiences with sexually transmitted infections. This study hopes to extend our understanding of how emerging adults feel shame and stigma and the sexually transmitted infection experience. And although the study now aims to reach a more geographically diverse population, we expect the results to remain similar as the theoretical background expected these results due the nature of emerging adulthood rather than upbringing, which can differ due to geographical differences.

Disclosures

The original study, conducted with participants from UT only, was presented at the National Communication Association. The feedback from that study is what has prompted the current study presented here. The original study is also under review at Southern Journal of Communication. The present study has been funded by the Doug Kirby Adolescent Sexual Health Research Grant.