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An Investigation Into the Relationship Between STI-Related Stigma and the Psychological and Social Wellbeing of Individuals Diagnosed With an STI in an Irish Sample: A Cross-Sectional Study

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Abstract

Background: Little is known about the relationship between the stigma associated with sexually transmitted infections (STIs) and the psychosocial wellbeing of those living with STIs. Stigma stems from societal norms and no prior study has explored this relationship among adults living in Ireland, where traditionally chaste and religious views regarding sexuality are upheld. The present study aimed to explore the psychosocial wellbeing of adults living with STIs in Ireland and identify if female and Catholic participants were disproportionately affected by STI-related stigma.

Methods: 685 participants (224 male, 450 female, 10 non-binary, 1 unknown, aged 18-51 years) completed an online survey consisting of questions regarding demographic information, STI history, four measures of wellbeing (depression/anxiety, mental wellbeing, self-esteem and social wellbeing) and STI-related stigma. **Results:** Participants reporting higher STI-related stigma had significantly lower psychosocial wellbeing than those reporting lower STI-related stigma ($p < .001$). Females with an STI reported significantly higher STI-related stigma ($p = .001$) and significantly lower psychosocial wellbeing than males ($p = .001$). No differences were found in overall wellbeing or stigma between those with and without an STI and between Catholics and non-Catholics. **Conclusions:** Based on these findings, it is recommended that targeted support is provided to women and those living in culturally stigmatising environments to buffer the risk of stigmatisation and decreased psychosocial wellbeing associated with an STI diagnosis.

Keywords: sexually transmitted infections, stigma, psychosocial wellbeing, sexual health, religion, Catholicism, gender

Introduction

Sexually transmitted infections (STIs) are some of the most common medical conditions experienced worldwide (1). An STI is the transmission of bacteria, viruses or parasites from one individual to another as a result of sexual contact or, in some cases, STIs may also be transmitted from mother to child during pregnancy (2). The World Health Organisation estimates that every day one million people contract one of the four most common curable STIs: chlamydia, gonorrhea, syphilis and trichomonas vaginalis (3).

Despite high prevalence rates, STIs are often associated with a high degree of stigma. Stigmatisation occurs when a negative social label is placed on an individual due to their possession of an undesirable characteristic (4), reducing them “from a whole and usual person to a tainted, discounted one” (5, p. 3). Hood and Friedman’s conceptual framework (6) cites social and cultural norms, institutional settings, media and healthcare settings as sources of STI-related stigma, with lower sexual health knowledge (7, 8) and media representation of STIs as repulsive ailments (9), fuelling negative attitudes towards STIs. Stigma typically manifests in three ways in the targeted individual; anticipated, enacted and internalised. Anticipated stigma refers to the extent one expects to be stigmatised due to their specific characteristic (10). Enacted stigma relates to the active discrimination of those by society, such as marginalisation or abuse (11). Internalised stigma refers to the internalisation of negative attitudes held by society, resulting in self-hate, shame or low self-esteem (5, 12, 13). STIs have evolved to become something of a “hidden epidemic” due to their concealable identity (6); however, suppression of a stigmatised identity can cause disclosure-related anxiety and psychological distress in affected individuals (14).

The link between STI-related stigma and wellbeing has primarily been explored in the context of human immunodeficiency virus (HIV), a disease in which stigma has been identified as a major challenge (15). A systematic review examining the association between stigma and HIV found strong links between stigma, higher depression rates and lower social support, as well as weaker relationships with anxiety and mental distress (16). While social support has been found to act as a protective factor against poor mental health (17), individuals with HIV have been found to withdraw socially due to the stigmatised status of their illness (18). Poor psychosocial wellbeing associated with stigma appears to be a major challenge for those living with HIV; however, these findings cannot be applied across all STIs due to other strongly linked stigmatising factors to HIV, including homophobia (19, 20), sex work, drug use (19) and treatment-based depression (15).

When compared with the HIV evidence base, little research exists exploring the relationship between non-HIV STI-related stigma and psychosocial wellbeing. In qualitative studies, social stigmatisation is frequently cited, with individuals diagnosed with herpes feeling like “damaged goods” and expressing relationship concerns (21). For those living with genital warts, social withdrawal was reported by participants to be induced by stigma relating to their hidden identity (22). In quantitative research of genital herpes in women, higher STI-related stigma has been associated with lower quality of life, depression, physical functioning and relationship functioning (23). In contrast, one study found no difference in depressive symptomatology between those living with chronic or curable STIs and those without an STI (24). Upon being divided into subgroups, Hispanic, non-native individuals and those with low social support experienced significantly higher rates of depression (24), illustrative of the cultural norms influencing stigma perception. However, while

stigma was speculated to be the reason for this difference, no explicit measure of stigma was employed in this study and thus, this hypothesis could be neither confirmed or falsified.

One society that has a particularly unique relationship with STIs and sexual stigma is Ireland. STI rates have been rising in Ireland since 1995 and increased by 12.2% between 2010 and 2012 (25). Despite their prevalence, STI-related stigma exists in Ireland and is illustrated through HIV-positive individuals in Ireland reporting higher suicidality, fear of rejection, guilt, shame, blame, anger and low self-esteem (26). The source of such stigma may stem from the conservative and traditional ideals surrounding sexuality cultivated by the Catholic Church through narrow sexual education and the perpetuation of sex as sinful and morally wrong (27, 28). With 78.3% of the population identifying as Catholic (29), these views are thought to be strongly ingrained into Irish culture, creating guilt stemming from the sinful nature of sex (30). The burden of these Catholic ideals also tends to fall most heavily on women, such that, traditionally, women are conveyed as virgins or chaste mothers (31). Shame and eradication of promiscuous women from society became a strongly ingrained Irish tradition (32), with many sexually active women in Ireland fearing being labelled a “slut” (33). This attitude towards sexuality appears to be a problem deeply rooted in Irish history and society, rather than the straightforward stigmatisation of a concealable disease. To the knowledge of the research team, STI-related stigma and psychosocial wellbeing has not been addressed in an Irish sample, despite Ireland appearing as an ideal test-bed for such an investigation due to the existing STI-related stigma and traditional values outlined. Large gaps exist not only in Irish literature, but across the literature relating to STI-related stigma and

psychosocial wellbeing in general and, in this sense, the present study stands to make a significant contribution to our understanding of a global health issue.

It is evident that challenges of an STI diagnosis span beyond the direct physical and sexual consequences (2, 34) and the associated stigma of living with an STI may lead to more sinister psychosocial issues. This magnitude of STI-related stigma may also be affected by the social and cultural norms in which it exists; Ireland exhibits a cultural context suggestive of an environment where sexual stigma thrives. Building from the limitations of prior research, the present study incorporates an explicit measure of STI-related stigma (35) and defines psychosocial wellbeing comprehensively, by incorporating hedonic, eudaimonic and subjective wellbeing, explored through depression, anxiety (36), positive mental wellbeing (37), self-esteem (38) and social wellbeing scales (39), allowing for symptomatology but also subjective aspects of wellbeing to be explored. Furthermore, the present study incorporates all STI diagnoses, chronic and curable, with previous research primarily focusing on chronic STIs (21-23). The present study has two aims; [1] To establish an insight into the psychological and social wellbeing of adult individuals living with STIs in Ireland and [2] To identify if religious populations and women are disproportionately affected by STI-related stigma in Ireland.

Methodology

Participants

A cross-sectional anonymous survey was distributed online through social media advertisements on Twitter, Facebook and Instagram. Eligibility criteria included individuals over 18 years old residing in Ireland. In total, 1135 individuals participated. Only data of those who had completed all components of the survey were used in the analysis; 448 were removed due to partial survey completion. A further two participants were also removed due to their most recent STI being HIV. The total sample used consisted of 685 participants, 224 male, 450 female and 10 non-binary individuals. One participant did not disclose their gender. The age range of the total sample was 18-51 ($M = 23.81$, $SD = 5.24$). The majority of the sample were Caucasian (97.8%), with Black (0.6%), Asian (1.2%), mixed-race (0.3%) and Indian (0.1%) making up the remainder of the sample.

When split into two independent groups to reflect participants who were previously diagnosed with an STI and those with no previous diagnosis (hereafter referred to the STI and non-STI groups), the non-STI group consisted of 560 participants, 184 male, 366 female and 10 non-binary with an age range of 18-51 ($M = 23.46$, $SD = 5.02$). 97.7% of this group were Caucasian with the remainder made up of 1.3% Asian, 0.7% Black and 0.4% mixed-race participants. The STI group consisted of 125 participants, 40 males and 84 females. One participant did not disclose their gender. The age range of this group was 18-47 ($M = 25.35$, $SD = 5.93$) and consisted of 98.4% Caucasian, 0.8% Asian and 0.8% Indian participants.

Materials

Qualtrics (40) was used to produce and display the survey to participants. SPSS 27 computer software (41) was used to analyse the data.

Demographic Variables

Demographic information regarding age, gender, race, religion and importance of religion was collected from participants. Importance of religion was measured using a 4-item Likert scale from “not important” to “very important”.

STI Status

All participants provided information regarding their STI status. This included; [1] if they ever had an STI, [2] if they had one or multiple STIs in their lifetime, [3] if their most recent STI diagnosis was <1 years ago, 1-2 years ago, 2-5 years ago or >5 years ago and [4] what their most recent STI was.

STI-related Stigma

Participants in the STI group had their STI-related stigma measured using the HIV Stigma Scale (35), adapted to include all STIs. This HIV Stigma Scale is made up of 32 items. Original items, such as “most people believe a person who has HIV/AIDS is dirty”, were adapted to be inclusive of all STIs, e.g. “Most people believe a person who has an STI is dirty.” Items were rated on a 4-point Likert scale from 1 “Strongly Disagree” to 4 “Strongly Agree”. The adapted HIV Stigma Scale demonstrated good reliability with a Cronbach’s Alpha of 0.94.

Psychological Wellbeing

Two scales were used to assess psychological wellbeing, the short version of the Depression Anxiety Stress Scale (DASS-21; 36) and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; 37).

The DASS-21 has been recommended for research purposes to assess the different dimensions of depression, anxiety and stress (42). It consists of 21 items rated from 1 “Does Not Apply to Me” to 4 “Applies to Me Very Much, or Most of the Time”. Items included “I experienced trembling”. The DASS-21 demonstrated good reliability in the present study with Cronbach’s Alpha equalling 0.93.

The WEMWBS is a 14-item scale focused on positive aspects of mental health. Items were rated on a 5-point Likert scale from 1 “None of the Time” to 5 “All of the Time”. Items included “I’ve been feeling loved”. The WEMWBS had a Cronbach’s Alpha of 0.91 in the present study, indicating good reliability.

Social Wellbeing

Social wellbeing was measured using the 15-item version of the Social Wellbeing Scale (39). Items included “I believe that people are kind”. Responses were recorded on a 6-point Likert scale from 1 “Disagree Strongly” to 6 “Agree Strongly”. The 15-item Social Wellbeing Scale is a well-known instrument in research (39) and demonstrated good reliability in the present study with Cronbach’s Alpha equalling 0.82.

Self-Esteem

Self-esteem was measured using the well-established Self-Esteem Scale (38). This 10-item scale contained items such as “on the whole, I am satisfied with

myself” which were responded to across a 4-point Likert scale from 1 “Strongly Disagree” to 4 “Strongly Agree”. The scale demonstrated good reliability in the present study, with a Cronbach’s Alpha of 0.91.

Procedure

Participants were provided with a Plain Language Statement and provided informed consent before study commencement by selecting “yes” or “no” to nine questions surrounding informed consent. After providing informed consent, participants completed the demographic, STI, STI-related stigma and wellbeing measures, respectively. Participants who had an STI in the past were asked to answer retrospectively to reflect their wellbeing when they were living with an STI. Participants were provided with a debriefing page with support contact details at the end of the survey. All recruitment strategies and study procedures were approved by the School of Psychology Ethics Committee, Dublin City University (DCUPEC_2021_139).

Data Analysis

Overall Psychosocial Wellbeing

The total scores from the four psychosocial wellbeing scales were totalled to provide each participant with a score for overall psychosocial wellbeing. The WEMWBS was reverse coded in full. Items 2, 3, 4, 6, 7, 10 and 15 of the Social Wellbeing Scale were reverse coded, with higher scores indicating lower social wellbeing. Items 1, 3, 4, 7 and 10 of the Self-Esteem Scale were reverse coded to allow for higher scores to signify lower self-esteem. The totals of the three reverse coded scales were added to the DASS scores to give an overall score for

psychosocial wellbeing. Lower psychosocial wellbeing was indicated by higher scores.

Total Stigma

All 32 STI-related stigma items were totalled to provide each participant in the STI group with a score for overall STI-related stigma. Items 8 and 18 were reverse coded. Higher scores indicated higher STI-related stigma.

Statistical Analysis

All statistical analysis was carried out using SPSS. Data met all assumptions for parametric testing. Analysis was conducted separately for STI and non-STI participants, STI group participants experiencing high and low levels of stigma, STI group Catholics and non-Catholics and STI group males and females. When comparing non-STI and STI groups, two multivariate outliers were removed from the analysis. One-way non-repeated MANOVAs were used to assess differences in each group across the four measures of wellbeing and independent-sample t-tests were used to compare groups across total wellbeing across all groups and STI-related stigma for Catholics and non-Catholics and males and females. Potential covariates for the STI group, time since diagnosis and repeat diagnosis, were assessed across the dependent variables. A p -value of <0.05 was considered significant and all tests were one-tailed. When multiple ANOVAs were performed, the Holm-Bonferroni correction method was used to maintain a family-wise Type I error rate at 0.05 and the adjusted p -value was reported.

Results

Participants were split into two groups, STI ($n = 125$) and non-STI ($n = 560$). Means and standard deviations of each group for each of the scales can be seen in Table 1. The STI group provided additional information about their STI status history and religion. Those who identified as being religious ($n = 60$) also provided how important their religion was to them. A summary of this information can be seen in Table 2.

For all statistical testing, Box's M was not significant, thus Wilks' Lambda was used in MANOVA interpretation. Levene's Test of Homogeneity was also not significant in ANOVA and t-test analysis. Potential covariates of time since STI diagnosis and diagnosis history were not found to have any effect on wellbeing or stigma outcomes and thus were excluded from further analysis.

No significant difference was found between the STI group and the non-STI group across the four different domains of wellbeing (Wilks' $\lambda = .99$, $F(4, 678) = 1.95$, $p = .051$, partial $\eta^2 = .011$). No significant difference was found between the STI group and the non-STI group for total wellbeing ($t(681) = -1.47$, $p = .07$).

Using a median split ($Mdn = 80$) of the STI group, a high-stigma group and a low-stigma group were created. Table 3 shows the means and SDs for these groups across wellbeing measures. A significant difference in wellbeing between the two groups was found (Wilks' $\lambda = .83$, $F(4, 120) = 6.08$, $p < .001$, partial $\eta^2 = .17$). Tests of between-subject effects showed significant differences between groups across all four wellbeing variables; DASS-21 ($F(1, 123) = 13.01$, $p < .001$); WEMWBS ($F(1, 123) = 14.76$, $p < .001$); Social Wellbeing ($F(1, 123) = 8.98$, $p = .002$); Self-Esteem ($F(1, 123) = 23.68$, $p < .001$). In each case, participants who reported higher levels of stigma experienced lower levels of wellbeing. A significant difference was also found between groups in terms of total wellbeing ($t(123) = -4.28$, $p < .001$, $d = -.77$, 95% CI

[-1.13, -0.4]). Those who reported higher stigma reported significantly lower wellbeing across all levels of psychosocial wellbeing.

Wellbeing and stigma scores were compared between Catholics and non-Catholics in the STI group (Table 4). No significant difference was found between groups in the four wellbeing domains (Wilks' $\lambda = .98$, $F(4, 120) = .77$, $p = .275$, partial $\eta^2 = .03$). No significant difference was found between groups in terms of total wellbeing or STI-related stigma scores ($t(123) = 1.35$, $p = .09$).

Stigma and wellbeing scores were also compared across males and females in the STI group (Table 5). A significant difference was found between males and females in terms of wellbeing, (Wilks' $\lambda = .92$, $F(4, 119) = 2.76$, $p = .02$, partial $\eta^2 = .09$). Tests of between-subject effects showed significant differences between groups across all four wellbeing measures; DASS-21 ($F(1, 122) = 5.44$, $p = .011$); WEMWBS ($F(1, 122) = 5.2$, $p = .012$); Social Wellbeing ($F(1, 122) = 10.55$, $p = .001$); Self-Esteem ($F(1, 122) = 7.21$, $p = .004$). There was also a significant difference found between males and females on the aggregated wellbeing scores ($t(122) = -3.09$, $p = .001$, $d = -.59$, 95% CI [-.98, -.21]), with females reporting significantly lower levels of wellbeing than their male counterparts overall and across all scales. A significant difference was also found between males and females on the STI-related stigma scale scores, ($t(122) = -3.13$, $p = .001$, $d = -.6$, 95% CI [-.98, -.22]), with females reporting significantly higher levels of stigma than their male counterparts.

Discussion

The present study aimed to [1] gain an insight into the psychosocial wellbeing of adults living with STIs in Ireland and [2] explore if religious and female participants are disproportionately affected by STI-related stigma due to the unique context of sexuality stigmatisation that exists in Irish culture and society. No significant difference was found across wellbeing levels of those with and without STIs. Similarly, no significant differences were found between Catholics and non-Catholics with STIs in terms of STI-related stigma and psychosocial wellbeing. Significant differences were found in total wellbeing and across all four psychosocial wellbeing scales between the high-stigma and low-stigma participants of the STI group, with participants reporting higher levels of stigma also reporting lower levels of wellbeing. A significant difference was also found in STI-related stigma and wellbeing scores between males and females, with women perceiving and experiencing significantly higher levels of stigma and significantly lower levels of psychosocial wellbeing than men.

These findings contrast previous research that found that HIV-positive individuals (43-46) and those with chronic STIs (47) are at a greater risk of experiencing lower psychosocial wellbeing than the general population. However, as STIs are not subject to the same blanket discrimination as HIV, the interpretation of the severity is open to interpretation and the effect of an STI diagnosis on wellbeing may vary from individual to individual as a result of their surrounding environment, in much the same way as wellbeing can vary from individual to individual in the general population. Notably, however, this finding adds weight to previous findings that found no difference in depressive symptomatology between those living with and without

an STI (24), suggesting that an STI diagnosis by itself does not necessarily impact on psychosocial wellbeing.

A key finding of the current study is that participants who experienced higher levels of STI-related stigma also experienced poorer psychosocial wellbeing. This finding supports the literature that notes HIV-related stigma as a major challenge for those living with HIV (15) and suggests that this relationship also appears to exist for other STIs. While the present study does not address the causality of this relationship, it provides a strong foundation for the continuation of research in this area and points to the need for research exploring the link between pre-existing individual factors, such as mental illness, and the external factors that may increase an individual's susceptibility to endorsing stigmatising attitudes. As perceived stigma is considered to change depending on the environment in which it is fostered (48), it is essential that the environmental and societal factors which can influence levels of STI-related stigma are identified.

No differences were found between Catholics and non-Catholic participants in terms of psychosocial wellbeing or STI-related stigma. This contrasts previous literature that found high religiosity as a stigmatising factor and low religiosity as a protective factor in STI diagnosis (49). However, as Catholicism is largely ingrained into Irish culture and society, particularly through education (50), and as many leave Catholicism as adults (51, 52), Catholic core beliefs and values may remain with individuals after their shift in religious identity. Such core beliefs formed in children are likely to have lasting influence on the self and attitude development (53). This calls into question if the Catholic culture present in Ireland mediates the gap between these two groups.

The present study supported previous research that suggested women are burdened with significantly lower psychosocial wellbeing than men with STIs (54-56) and the inclusion of a quantitative measure of stigma in the present study adds weight to this assertion. Stigma occurs when an individual possesses a devalued trait (4) and the increased prejudice towards sexually active women in Ireland may be more negatively affecting the psychosocial wellbeing of women as a result. However, due to Irish women in general experiencing poorer wellbeing than men (57, 58) the causal nature of this relationship is unclear and longitudinal research is needed to investigate the relationship further. Despite this, it is clear that women are at increased risk of poorer psychosocial wellbeing and experience higher levels of STI-related stigma than their male counterparts.

The present study had some limitations. Firstly, while offering valuable insight in an area of research that is, at present, in its infancy, the cross-sectional design and correlational nature of the data prevented causal conclusions from being drawn. However, our findings suggest that special care should be provided to women seeking STI tests, such as information pamphlets and support groups after STI diagnosis. To combat high-stigma groups, risk of stigma should also be reduced through education programmes and positive media campaigns. Secondly, in those with more than one STI diagnosis, a prior diagnosis of HIV was not controlled for, introducing a potential confound to the findings. Despite this concern, only 18.4% of the STI group reported having more than one STI diagnosis and only two participants reported HIV as their only STI diagnosis; therefore, it is unlikely that the results were meaningfully altered by the possible inclusion of participants with HIV. Finally, the online nature of the study may have prevented older respondents from participating. With older adults tending to be more religious (59), this hindered the full

exploration of the relationship between religiosity, STI-related stigma and wellbeing. To gain insight into older adults' religion, STI-stigma and psychosocial wellbeing, specific targeting of this group is recommended.

For future research in an Irish context, it is recommended that endorsement of Catholic beliefs is measured, for example by the Christian Moral Values Scale (60), as opposed to explicit religious identity, in order to assess the impact of an environment rife with religious customs and attitudes on STI-related stigma and psychosocial wellbeing. Additionally, while retrospective questioning did not appear to be an issue in this study, to rule out any risk of decreased accuracy due to retrospective bias, it is recommended that future studies recruit a convenience sample from STI clinics to ensure that the participants' emotions are captured accurately at a time close to STI diagnosis.

Conclusion

The present study found that of those living with STIs, individuals perceiving higher STI-related stigma experienced lower psychosocial wellbeing. Women also experienced higher levels of STI-related stigma and lower psychosocial wellbeing than their male counterparts. No difference was found between Catholics and non-Catholics living with STIs in psychosocial wellbeing or stigma. These findings identified two populations, women and those perceiving higher stigma, at risk of low wellbeing upon contraction of an STI, suggesting targeted protective measures be put in place for these groups. Our results suggesting no differences between Catholics and non-Catholics in terms of STI-related stigma and wellbeing raise questions surrounding the extent to which Ireland's culturally Catholic environment is impacting sexual attitudes. Future research is needed to investigate this relationship further.

Conflicts of Interest

The authors declare no conflicts of interest.

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author, A. Robinson, upon reasonable request.

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Tables**Table 1.***Wellbeing Scores of STI and Non-STI Groups*

Scale	Mean (SD) [Min, Max]	
	STI Group (<i>n</i> = 125)	Non-STI Group (<i>n</i> = 560)
DASS-21	42.41 (14.3) [21, 82]	45.61 (12.56) [21, 80]
WEMWBS	41.54 (9.95) [21, 66]	42.47 (9.06) [14, 70]
Social Wellbeing Scale	52.22 (13.11) [23, 82]	52.47 (11.1) [17, 84]
Self-Esteem Scale	24.58 (5.53) [10, 38]	25.3 (5.96) [10, 40]
Total Wellbeing	160.76 (36.97) [83, 259]	165.85 (33.79) [70, 262]
STI-related Stigma	79.65 (15.35) [41, 116]	

Table 2.*Demographic Characteristics of STI Group Participants*

Characteristic	<i>n</i>	%
STI history		
One STI diagnosis	102	81.6
>1 STI diagnosis	23	18.4
Most recent diagnosis		
<1 year ago	33	26.4
1-2 years ago	39	31.2
2-5 years ago	34	27.2
5+ years ago	19	15.2
Most recent STI type		
Chlamydia	58	46.4
Genital herpes	28	22.4
Gonorrhea	16	12.8
Genital warts	8	6.4
Crabs	4	3.2
Scabies	3	2.4
Syphilis	2	1.6
Molluscum contagiosum	2	1.6
Gonorrhea/chlamydia	1	0.8
Hepatitis B	1	0.8
Human papillomavirus	1	0.8
Urinary tract infection	1	0.8
Religion		
No religion	65	52
Catholic	56	44.8
Agnostic	1	0.8

Muslim	1	0.8
Hindu	1	0.8
Spiritual	1	0.8
Religious importance		
No importance	17	13.6
Little importance	32	25.6
Fairly important	11	8.8

Table 3.*Descriptive Statistics for High- and Low-Stigma STI Groups*

Scale	Mean (SD) [Min, Max]	
	Low-Stigma (<i>n</i> = 62)	High-Stigma (<i>n</i> = 63)
DASS-21	37.97 (13.6) [21, 80]	46.78 (13.71) [22, 82]
WEMWBS	38.27 (9.2) [21, 66]	44.76 (9.67) [24, 63]
Social Wellbeing Scale	48.79 (12.86) [23, 82]	55.6 (12.56) [29, 78]
Self-Esteem Scale	22.35 (5.41) [10, 37]	26.78 (4.74) [17, 38]
Total Wellbeing	147.38 (34.69) [83, 259]	173.92 (34.56) [93, 238]

Table 4.*Descriptive Statistics for Catholics and Non-Catholics*

Scale	Mean (SD) [Min, Max]	
	Catholics (<i>n</i> = 56)	Non-Catholics (<i>n</i> = 69)
DASS-21	41.14 (13.58) [21, 82]	43.43 (14.88) [21, 80]
WEMWBS	41.84 (9.41) [22, 63]	41.3 (10.43) [21, 66]
Social Wellbeing Scale	51.43 (12.75) [23, 75]	52.87 (13.46) [23, 82]
Self-Esteem Scale	24.46 (5.37) [10, 38]	24.68 (5.69) [11, 37]
Total Wellbeing	158.88 (34.47) [86, 238]	162.29 (39.06) [83, 259]
STI-related Stigma	81.7 (16.19) [41, 116]	77.99 (14.55) [43, 111]

Table 5.*Descriptive Statistics for Males and Females*

Scale	Mean (SD) [Min, Max]	
	Males (<i>n</i> = 40)	Females (<i>n</i> = 84)
DASS-21	38.1 (13.95) [21, 79]	44.42 (14.18) [21, 82]
WEMWBS	38.63 (11.65) [21, 66]	42.93 (8.84) [28, 63]
Social Wellbeing Scale	46.95 (14.63) [23, 82]	54.85 (11.62) [30, 78]
Self-Esteem Scale	22.68 (5.98) [11, 38]	25.46 (5.12) [10, 36]
Total Wellbeing	146.35 (40.93) [83, 259]	167.65 (33.26) [103, 238]
STI-related Stigma	73.58 (14.85) [41, 116]	82.54 (14.91) [44, 112]