EFFECTS OF NON-PHYSICAL STIGMA IN VENEREAL DISEASE

Elaine Fox and Charles Edgley, Oklahoma State University

STIGMATIZATION

Much of the literature investigating the process of stigmatization has dealt with visible stigmas such as physical handicaps, racial identities, departures from standards of beauty or other apparent deformities. As a result, Goffman's critical distinction between *discredited* and *discreditable* social identities as being the difference between the general 'known aboutness' of the negative attribute and that which is only potentially 'known about' has not been fully appreciated (Goffman 1963). One is discredited, and therefore stigmatized only when the viewing audience is aware of the negative characteristic and has completed the steps in Garfinkel's now-classic notion of a "degradation" ceremony (Garfinkel, 1956). Discreditable aspects of one's social identity are only potentially stigmatizing and are therefore not really social at all *unless and until*, the audience to one's performances become aware that negative information exists and are prepared to do something about it.

In the case of discreditable information, then, prevention of stigma is a matter of concealing that aspect of the self. Davis (1961) suggests three possibilities: 1) passing which involves concealment of the defect; 2) normalization in which the person makes light of the differences and bring forth normal qualities; and 3) disassociation which occurs when the person relinquishes normal standards and no longer attempts to live up to them.

With non-visible stigma, however, a wide range of techniques of information control are possible, for here we have a case in which that which is descredited and that which is merely discreditable are separate, and the person will suffer no stigma unless the audience somehow manages possession of the discreditable information. In this light, we wish to examine the case of venereal disease, for like a prior record of hospitalization for mental illness, the fact that one has had V.D. exists primarily in the form of information and is therefore open to various management techniques. Should anyone know? If so, who? Under what circumstances should one tell? How should one phrase the matter? These and many other questions are the rhetorical matters to which the actor turns when confronted with a potentially discrediting piece of information about self.

To fully comprehend the precarious social delemma of an individual infected with venereal disease, one must understand the dual nature of the disease. Venereal disease is referred to as a social disease by medical personnel primarily due to the fact that it is contracted through particular types of sociosexual encounters. However, the scope of the concept of a social disease should be enlarged when attempting to view the consequences of being infected with venereal disease, for the resulting stigmatization of known infection culminates in social changes for the infected individual. The damage inflicted by the disease pertains as significantly to the social identity of the individual as it does to the physical condition of the body, and considering the successes of modern medicine when applied to the treatment of the disease, the social consequences can often be far more devastating then the physical implications of the infection.

This research was undertaken to come to some understanding of the social changes which occur to an individual who has been infected. We were also interested in exploring the various techniques of information control which infected persons may use in attempts to negotiate the stigmatizing nature of the illness.

METHODOLOGY

In-depth interviews were undertaken with men and women ranging in age from 17 to 37. Most of the respondents in the study were college students and all has been diagnosed as having had at least one episode of venereal disease. Respondents in the study were secured through the placement of an advertisement requesting volunteers, so we have the unavoidable problem of the self-selected sample. Unfortunately, due to the sensitive nature of the disease in association with the standards of confidentiality expressed by the doctor-patient relationship, it is impossible to obtain a sample in any other manner.

All interviews were tape recorded and later transcribed. At the conclusion of the field work, all interviews were examined for generic re-

sponses by the respondents to the stigmatizing social category of possessing a history of veneral disease. The basic questions explored in this study are 1) what is the nature of stigmatization as it relates to the discreditable aspect of a social identity with regard to venereal disease and 2) what are the methods employed by the respondents in the negotiation of the stigmatization process?

PHYSICAL DAMAGE AND SOCIAL SELF

From a medical and sociological perspective, venereal disease must primarily be viewed as an illness which occurs to people in relation to other people and never as a singular effect on the individual alone. Respondents in the study perceived their disease within a social context and not as an individual response to a physical change in the body. Most of the respondents, when asked to explain their initial reactions to the the realization that they were infected with venereal disease, expressed devaluations of their perceived social identity. "I felt plagued", or "I felt as if I had leprosy" were common assertions. Those who had contracted venereal disease were forced to re-evaluate their own personal identities, a reevaluation which resulted in a devaluation of self.

Concern regarding the actual physical damage venereal disease might inflict on the body was always seen by our respondents in the light of the relational changes which might occur as a result of the diesase. One young woman, for example, when asked if her immediate concern upon diagnosis was one of damage of her body or damage to her relationships, stated the point precisely:

> Hell, I didn't even think about that until the next day. The only thing I could think of at first was who I would have to tell and how to tell them. The next day I read the pamphlet the doctor gave to me and then I got scared about being made sterile. I mean, I though about how I would go about telling someone I wanted to marry that I couldn't have kids because I had had the clap.

Anxiety over possible physical damage was actually a concern over the potential effect V.D. might have on social interactions of a specified nature, such as sexual intercourse and child birth.

Furthermore, infection by venereal disease represented to our respondents a lack of wisdom and good judgement. If others find out, the person is cast into the role of fool. Our respondents stated that they had always assumed that if a person demonstrated a certain amount of judgment and common sense, such as the choice of sexual partners or the use of prophylactics, the V.D. whould never occur in the first place. Getting the disease, then, was equated with stupidity and the feelings of mortification that are attendant to such a self identification. The blemish of V.D., then, can be seen as two-fold; the problem of the disease on the one hand, but also its social meaning on the other. The latter problem is by far the more important to the individual.

ALTERATIONS IN SELF-ESTEEM

Self-esteem is composed of two components, self-evaluation and self-worth. While most analyses of self-esteem equate the two, they are not necessarily the same. One can have high self-evaluation stemming from all kinds of objective sources, but still feel that one is not worth anything. In the case of venereal disease, for all the alleged changes we have supposedly undergone in our views of this disease "It is just like any other disease". "Anyone can get it." "It doesn't mean you are a bad person." None of these evaluations seemed to have any negative effect on the respondent's feelings of self-worth. Ironically, the trigger in all of this seemed to be what the contraction of V.D. said about the social stability of the person. One can judge oneself to be a person capable of attracting others to a sustained relationship only be participating in sexually exclusive relationships; that is, in the words of one respondent, "by being a participant in a lasting relationship." V.D. says, in effect, that the person is a bed-hopper, incapable of forming an enduring relationship and forced to seek sexual gratification in one-night stands.

Again, the irony of all this is that despite everything sophisticated professionals have said about the "myths" of V.D., in everyday life people are reguarly supporting those myths. Contracting V.D. is a symbolic reference point

around which a person reconceptualizes his lifestyle as one fleeting encounter after another, totally lacking in substance. As explained by one of our respondents:

> Well, if I told anyone I had V.D. I was afraid they might think that I had never had any kind of serious emotional and sexual relationship with anyone. They might think I was the kind of guy that haunted bars. They might think they could get V.D. from me.

Becoming stigmatized by venereal disease represents to the individual, then, a process whereby he is recategorized by himself and others as lacking in basic interpersonal skills which are utilized in the formation of sexually exclusive relationships. Thus, one could say that the stigma attached to venereal disease is not a case of stigmatization as a result of what a person does, or who he associates with, but rather represents a total social identity, and identity devoid of qualities which would attract desirable persons. The stigma attached to venereal disease then is generated not by who the person is, but rather by what the person no longer is.

V.D. AND THE UNINFECTED PARTNER

The stigmatization process involved in venereal disease is pervasive to more social selves than simply those of the persons infected with the disease. Stigma has the ability of generalizing discreditableness to those in close association with infected persons. This can be observed by studying the effect of the disease on uninfected partners in a relationship.

When an individual is purported to be in a sexually exclusive relationship and must later inform his partner that he has contracted venereal disease from an outside source, this information tends to destroy the relationship. Obviously there is a loss of trust between the two partners since the previous view of sexual exclusiveness has been spoiled. But the death of the relationship is the result of the stigma of venereal disease rather than the extra curricular sexual activity. The infected partner, upon informing his counterpart of the disease, is immediately reevaluated by his partner. The infected partner becomes altered in the eyes of the partner. He or she is now seen to be no longer capable of sustaining a lasting relationship, not because the person has violated a sexual norm, but rather because he lacks the interpersonal skills and mechanical sophistication necessary for such an activity. The uninfected partner must break off the relationship or possible doubts will be cast on his or her capacities as well. As one young lady stated:

> I thought he loved me but then he went out and got the clap. I had to break up with him or if anyone found out about it, they would think that I was the kind of person who went around with skudsy people too.

Thus, in order to maintain the appearance of being the type of individual who is capable of engaging in a sincere relationship, it is necessary to end the relationship with the person who is not capable of the same, the infected partner. To avoid a devalued social identity, the uninfected partner must not continue association with the diseased person.

NOTIFYING CONTACTS

When a person is first informed by a health agency that s/he is infected with venereal disease, s/he is usually given the option of informing his/her sexual contacts of possible infection or allowing the agency to do this. Our respondents, when given a choice, chose to inform the sexual partners personally, or at least agreed to do this while in the presence of health personnel. However, whether they followed through was dependent on the nature of the relationship and from whom they got the infection.

Getting V.D. from a prostitute almost always insures that an active effort will not be made to seek out and inform the contact. It was assumed that the prostitute already had knowledge of the infection and declined to inform the patron prior to the sexual transaction for economic reasons. The one exception to this general pattern was a man who felt it was necessary to cure the infection before resuming a paying relationship with the same prostitute.

Women may be infected with gonorrhea and not be aware of the symptoms and thus can be

infected for extended periods of time lasting over several intensive relationships. This creates the problem of informing several contacts of exposure to infection. However, when it came time to inform the contact who they believed initially infected them, they typically made no effort to inform that particular contact at all. It is assumed that males, due to the usual immediacy of symptoms of the disease among men, were aware of the disease and simply failed to inform the women of possible infection at the time of intercourse or shortly thereafter. Much anger was genereated when our female respondents assumed their male partners failed to inform them of possible infection through negligence. One woman stated the attitude quite precisely.

> I quess he might not have known he had it so that's why he didn't tell me. I could understand that. But I've heard that men always know they have it. It's not like women, and if he did know he had it and he didn't tell me, then I'm real hurt and disappointed in him and I hope he rots with it.

With the exception of prostitutes, men were also inclined to inform contacts of possible infections. Certainly the matter of risk to the body of the sexual contact is a crucial point in the decision to tell, however, other factors are also just as vital.

An infected person in a relationship, may feel compelled to inform the partner of possible disease in order to force the partner to seek treatment or risk reinfection. As one young man stated:

> I has to tell her so she could get checked up too. It was either that or stop screwing and I didn't want to stop screwing plus I couldn't think up any reason she would accept if I didn't want to anymore (have intercourse). I mean, who's going to believe that a nineteen year old has prostate problems?

An additional reason for informing contacts, particularly in casual relationships, is prevention of anger on the part of the contact should he discover the infection on his own. As one respondent stated, "I figured if I didn't tell him and he came up with symptoms he would be upset with me for not telling him and he would never trust me again." There appears also to be a need to insure the image of a responsible person. Another respondent explained, "I want it taken care of and wouldn't I look like an ass if the state came around to take care of my dirty work."

If the need to inform arises and the contact is someone with whom no future sexual encounters are expected, then the infected person appears not be feel an obligation to explain the circumstances of the contraction. However, when the individual is involved in an exclusive relationship with a contact or perceives that intercourse might possibly occur at some future time then absolute honesty appears to be the motto. Perhaps the need to tell the entire truth is a means of salvaging some remnants of the social identity of the infected person which was offered prior to the devaluation which occurred at the moment of confession. If this need to tell the truth is viewed as a disclaimer (Hewitt & Stokes, 1975), then one can perceive the act as an attempt on the part of the person to prevent the total destruction of his social self. In essence, he may be attempting to prove that he is not totally devoid of qualities necessary for sustained interaction since he is capable of honesty.

However, there are certain circumstances which necessitate lying. One male respondent admitted lying to his contacts when informing them of possible infection.

> I didn't tell them I caught it from a hooker. It might make them feel bad about themselves to think that they had been with a man that uses hookers.

It would appear that this person was acutely aware of the devaluation which would occur in both the relationship and in the self-esteem of the participants in the relationship.

NORMALIZATION

The stigma generated by venereal disease produces a recategorization of the entire social identity of the individual, or in Garfinkel's terms, a degradation ceremony begins. The individual with venereal disease is placed in

the position of attempting to negotiate the strength of the labeling effect.

While disclaimers are usually viewed as a means of gaining audience acceptance prior to the commitment of a social act which would normally generate a negative response from the viewing audience, disclaimers were also employed by the respondents in a unique manner inasmuch as they were utilized after the fact in an attempt to relieve the severity of the reaction. Persons stigmatized in this manner seemed to accept that their identity would be spoiled, and the argument was not that the spoilage was unjustified. The spoilage was accepted by the person, even to the extent that they had conceptualized themselves as spoiled prior to the offering of the stigmatized attribute to a viewing audience. Disclaimers were utilized in an attempt to salvage part of a social identity. For example, while all respondents expressed some devaluation of self, all respondents explained in great depth the amount of time and trouble they went through in order to notify all possible sexual contacts they may have infected.

> This guy I though I might have given it to was married so I couldn't call him at home or at his work. So I sent him a special delivery letter that he had to sign for. I made sure he knew so he could take care of it. I'm not really so rotten. I do clean up after myself.

Thus, for the respondents, techniques of normalization did not include a concentration on the continuance of a whole, undamaged social self, but rather for the retention of a part of the social identity which was considered acceptable, those qualities of honesty and responsibility expressing a redeemable part.

CONCLUSION

Several basic questions remain unanswered. In a society which is increasingly advocating freedom in human sexuality, particularly with regard to the meanings attached to sexual intercourse, why has this implied liberalism not been incorporated into all aspects of human sexuality? People today may more easily engage in casual sex as recreation without accompanying stigmatization but the moment the presence of venereal disease is established in a relationship, taboos dating from centuries back come into play and the meaning of the sexual encounter is changed for the participants. The sauve, liberated sexual swinger suddenly becomes an inept social deviant and the expressive act of intercourse becomes no longer a sexual communication between two people but rather a vehicle for degradation.

Health personnel are acutely aware of this dichotomous perspective. The Public Health Department has gone to great measures to convince the public that "V.D. is for Everyone" but despite the attitude that sex may be for everyone, venereal disease still remains an aspect of human sexuality which applied only to others.

REERENCES

Davis, Fred. 1961, "Deviance Diswavowal: Management of Strained Interaction by the Visibly Handicapped." *Social Problems 9:* 120-132.

Department of Public Health. 1961, *Venereal Disease.* New York: Medcom Learning Systems.

Garfinkel, Harold. 1956, "Conditions of Successful Degradation Ceremonies." Amer Jo of Socio. 61: 420-424.

Hewitt, J.P., and Randal Stokes 1975, "Disclaimer." Amer Socio Rev 40 Feb. 1-11.

Sykes, Gresham and David Matza. 1957. "Techniques of Neutralization." Amer. Socio. Rev. 22: 664-67).

Warren, Carol and Stephen Phillips. 1976. "Stigma Negotiation." Urban Life 5: 53-74.

UNKOVIC, SCHELL From Page 67

Norback, Judith, 1979. *The Alcohol & Drug Abuse Yearbook.* New York Van Nostrand.

Pleterski, Mary, 1981. *Interview.* New Smyrna Beach, Florida.

Wechsler, Henry, Mary McFadden, 1976. "Sex differences in a adolescent alcohol and drug use: A disappearing pohenomenon." *J Studies on Alcoholism.* 1300 Sept.