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SHORT REPORT

Folk Constructions of Syphilis in an African-American Community in Houston, Texas

PAIGE PADGETT

This paper analyses folk constructions of syphilis in a predominately African-American community in Houston, Texas. In-depth interviews with 17 African-Americans were conducted to describe the folk models of syphilis present. Interviews centred on prevalence transmission, risk, personal protection and detection, relationships and expectations for the future. Physical appearance, the earwax test, the match test and the smell test were used to 'detect' syphilis infection. Respondents conflated the symptoms of several STDs including syphilis, gonorrhoea, herpes and chlamydia into a single class. The study findings indicate miscommunication regarding STD information and use of different models (folk vs. medical) to explain risk of infection and prevention. The use of folk constructions in syphilis interventions would provide a better understanding of the community's knowledge and perceptions of STDs and a better focus for future education and prevention programmes.

Introduction

Although rates of infection are the lowest since 1941, syphilis remains a sexually transmitted disease (STD) of significance in the USA. Its persistence in the southeastern part of the country, especially among racial/ethnic minorities, creates a potential reservoir for infection and underscores the failure of traditional public health efforts to eliminate this disease. Patterns of syphilis infection also reflect the racial disparities in health status. Nationally, African-Americans have experienced syphilis rates 34 times higher than whites (Mitka 2000). Currently, relatively low rates of infection, geographic concentration, and curability create an opportunity to eliminate syphilis, provided that education and prevention efforts are successful.

This study seeks to describe folk constructions of syphilis in a predominately African-American community in Houston, Texas. Understanding these folk constructions may shed light on people's beliefs and attitudes about the disease, transmission, and risk of infection. This in turn will help identify misconceptions about syphilis, which ultimately lead to

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increased infection risk. In the study reported here, three research questions were explored: (i) how might the folk constructions of syphilis be described, (ii) what are the salient themes concerning syphilis biology, risk and transmission, and (iii) how can folk constructions of syphilis be successfully integrated into STD intervention and education efforts?

People explain their world and experiences using individual and community knowledge bases. Folk constructions model the ways in which people explain situations or solve problems that have meaning to their group or community (Lett 1987). In the context of disease or illness, folk models represent how members of a community explain the prevalence and mechanisms involved in the development of the disease.

Individuals base their decisions about sexually transmitted disease on perceptions and attitudes about the diseases (Levine and Siegel 1992, Lowy and Ross 1994). These include beliefs about biology, transmission and risk of infection. For this reason, folk models represent the normative perceptions shared by a community to describe or explain their lives. However, in contrast to folk constructions, public health or medical model have as central tenets those explanations of reality that are recognized by the medical/scientific community (Lawless 1979).

Folk and public health models represent two disparate ways of interpreting illness and disease (Levine and Siegal 1992). These two models correspond with Arthur Kleinman's (1986) discussion on the different meanings of illness and disease. Folk constructions are often shaped by illness meanings. These include the overt experience of symptoms which are communicated and interpreted by a group or community, and the cultural significance of an illness. Disease meanings, on the other hand, are constructed by the doctor/practitioner's interpretation of a disorder.

Applied to health and illness, public health models represent, the viewpoint and reality of the medical and scientific community. Folk models, on the other hand, represent how the general public interprets their reality, which may have some basis in the public health model, but also a local context of images, metaphors, and cultural themes. In this way, the folk model is used by individuals trying to cope with and explain health/illness issues by providing answers to questions such as, 'What is this?', 'Why me?,' and 'Why now?' (Helman 1994). Prevention and education approaches that ignore such folk constructions are unlikely to be effective.

Methods[1]

Research setting

This study took place in an inner-city neighbourhood characterized by a large ethnic minority population, poverty, and unemployment. This area has some of the highest registered rates of syphilis at 117.62 per 100,000 for 2000, compared to 26.1 per 100,000 for the city of Houston as a whole (Bureau of HIV/STD Prevention, Houston Department of Health and Human Services 2001). The study was located in Houston's Third Ward, an inner-city neighbourhood with a total population of 29,755. This

community is predominately African-American (80%) and is characterized by low socioeconomic status.

The locality has a median household income of $12,173, with 41% of African-Americans living below the poverty level compared to 17% of whites in the same zip code (US Census Bureau 1990). Unemployment rates are also high, at 48.9% for men and 69.8% for women. In terms of education, most individuals in this community have either attained a high school diploma or attended some high school. This area is associated with persistent high syphilis rates, even in non-epidemic times.

Interview protocol

This research was based on in-depth face-to-face interviews. All interviews were conducted by the author. Respondents were recruited from a halfway house, a community outreach centre, a PWA (people with AIDS) house, and by street intercept. The interviews lasted from 40 minutes to 1 hour. Interviewees received an information sheet about the study and their rights as a study subject. All interviews were tape-recorded with the interviewees' permission. Each interview was transcribed *verbatim* for use in analysis. Names were not used or identified on tape, notes, or transcriptions and thereby anonymity was insured.

Informants

The sample consisted of 17 individuals. Respondents were African-American, aged 18 or older, and living in the study area. The sample consisted of ten individuals who had contracted syphilis within the last 8 years, four earlier cases, and three non-cases. Of the 17 interviews conducted, 4 were with males and 13 were with females. The sample proportion of males to females reflects the distribution of syphilis in this high-risk population and community, where more women than men are infected (Williams *et al*. 1996). Recent trends have indicated an increased risk for females possibly due to the sex for drugs, better identification and reporting of female cases, decrease in low-risk male partners, and a decline in long-term relationships (Aral 1996, St. Louis 1996).

Method of analysis

Each interview was subsequently coded for references to the respondent's beliefs, attitudes, images, experiences with syphilis. Interview data was analysed using grounded theory, to identify central themes describing community knowledge of syphilis.

Results

Discussions with respondents focused on prevalence, transmission, risk, personal protection and detection, relationships and the future. The most recent syphilis epidemic was seen as closely related to sexual activity within the crack cocaine scene (Koumans *et al*. 2001, Balshem *et al*. 1992). Poverty, unemployment, lack of education, and crime have caused African-American communities to suffer disproportionately from the crack cocaine trade. Because of lack of income, employment and opportunities, some African-Americans have turned to selling crack (Balshem *et al*. 1992).

When respondents discussed the risk of syphilis in their community, illicit drugs and sex trade were their main concerns.

> You probably wouldn't understand a person that used to get high, how it makes you feel. You fiend, you fiend for it. You going there and try to steal your Momma's purse or cut your Momma's throat or your Daddy's throat to get to that dope. To get the money you sell everything in your house you got. (Respondent 12, female, age 41)

> Being an addict you want to get your high going you'll do whatever it takes to get your high going, and so this is what I did and so I wasn't conscious, I wasn't really thinking that maybe I could get a bad disease from these people and doing what I was doing for them to get my drugs. (Respondent 7, male, age 39)

Prostitution or sex for drugs or money, were frequently offered by respondents as explanations for their syphilis exposure. Women respondents, in particular, explained how sex for drugs can become an all-encompassing factor in their lives, eclipsing most thoughts of danger or health risks.

> When I was out there, baby, I wasn't looking, I wasn't doing nothing. I just look at him and say, 'Alright, come on.' You know that's in the fast lane but all you want is the money to go and buy you some drugs. (Respondent 1, female, age 35)

> Sometimes I didn't really care because I was an alcoholic and a drug addict at the time and I didn't, wasn't my mind fixed on that. My mind was just on trying to get money to get my next hit or get my next drink, you know what I'm saying. (Respondent 14, female, age 37)

Potential sex partners were discussed in terms of cleanliness and physical appearance as indicators of infection status. Individuals with a clean-cut appearance, who were clean shaved, had neat hair and dress well, were seen as displaying characteristics indicating cleanliness on the outside as well as on the inside.

> Yeah, if he was clean, you know I would look at his feet and all the way up. Nice shave, not a lot of hair on the face, clean haircut, dress nice. (Respondent 13, female, age 38)

> Yeah, it (syphilis) made me aware of who I was talking to, whether they were clean or not. You know, they didn't have a hygiene problem. They had to be dressed well. (Respondent 11, female, age 42)

One respondent though, talked of the deceptiveness of using cleanliness to judge infection status.

> You wouldn't think that he had a disease and she wouldn't think that she had a disease cause it all looks so good on the outside, but all of a sudden it happened; he had some kind of disease or she had some kind of disease. (Respondent 1, female, age 35)

Respondents described syphilis as a disease of dirty or filthy people.

> When you say syphilis what comes to my mind is filth, nasty. Yeah, I know I'm a clean person, its just something that happened. (Respondent 9, female, age 39)

> That's where it's (syphilis) coming from these prostitutes on the streets, these nasty women.
> *Interviewer:* What do you mean nasty?
> *Respondent:* They're just nasty, don't bathe, don't take douches, don't keep their bodies up whew. (Respondent 12, female, age 41)

Among women interviewees, cleanliness was considered not only a desirable trait, indicating an infection-free sex partner, but also as a method of personal protection. Bathing and douching (flushing a jet of liquid into the vagina), were folk strategies for personal protection used to prevent STD infection.

> *Interviewer:* When you were on the streets did you have a way you protected yourself?
> *Respondent:* I would take douches, you know, not right after I was having sex with a man but, you know, after that night, after I turned all my tricks. Then I go home take me a bath and douche. I was douching to clean myself out and you know, I thought maybe it would protect me from getting any kind of disease. (Respondent 14, female, age 37)

> When I have a relationship (sex) I bathe and I keep a douche bag in my room. They ain't nothing but a dollar or something and you get two packs for a dollar and it will prevent syphilis. (Respondent 12, female, age 41)

Several strategies were described by respondents as methods of determining their personal risk of infection with a potential sex partner. They included the earwax test, the match test, the smell test, and the '3-day wait'. Both the earwax test and the match test use a burning sensation felt by a potential sex partner in his or her genital area to indicate syphilis infection. The following respondent describes the earwax test and his use of it to determine personal risk.

> I wouldn't get no disease. I could tell who had a disease and who didn't. If you want to have sex with someone or if they want to have sex with you, whatever the case, stick your finger in your ear and get wax on it and put it on the genitals. If it burned them then you can't have sex with them because they're infected with a disease. The wax will burn the penis or the clitoris. This is what I would do and this is how I thought I kept myself safe from disease. So really I didn't know anything about keeping myself safe.
> *Interviewer:* What did you do exactly?
> *Respondent:* I would put my hand on their penis or clitoris and rub the wax and if she or he flinch, well I didn't go any further. I made up an excuse. (Respondent 7, male, age 39)

The match test is similar to the earwax test. As one respondent explained,

> You get some earwax or you get a match with the red and white on it and you put it on the man's penis and if it burns (the penis) that means they got something. (Respondent 14, female, age 37)

According to respondents, the earwax and the match tests were meant to be performed discreetly and the outcome used to determine the progression of sexual relations. A foul odour was also thought to indicate syphilis infection. This folk test relates back to the imagery of syphilis as an unclean disease. If the respondents detected such an odour, 'a nasty stinky smell,' they would assume their potential sex partner was infected.

Yet other respondents talked about a '3-day wait' period to tell if their partner was infected with syphilis. A woman would wait three days before having sex with a man and if, within that time, he did not show symptoms

of 'burning and dripping' then that would indicate that he was clean: i.e. not infected with syphilis. The 3-day wait was also discussed as a method of maintenance within a relationship, to ensure that one's partner was not 'messing around.'

> I'm saying men always think its your women gonna give him something but it's not true he could be out there messing around and come back and have sex with you. He don't know if this person has it and give something to you. He messing around with her and gonna bring it home. Then he starts it and men got 3 days.
> *Interviewer:* What do you mean 3 days?
> *Respondent:* Three days before they start dripping and smelling real bad, they got 3 days.
> *Interviewer:* How can you tell about him?
> *Respondent:* If I'm looking I can tell but only after the 3 days cause they'll be a smell on him a nasty stinky smell. (Respondent 1, female, age 35)

> Some people don't know their body, don't know the difference but some women can carry it. They carry the stuff on and on until they get really sick later on down the road and before you know it they pass it to this person here. Men should find out about it in 3 days. If their privacy get to burning or leaking, whatever you call it, they know about it in three days because when their pee starts burning they know they got something. (Respondent 3, female, age 41)

The 3-day wait is an example of yet another folk strategy used to determine syphilis infection. These symptoms, burning on urination and discharge indicate gonorrhoea or chlamydia infection, not syphilis. Respondents also discussed their ability to self-diagnose whether or not they were infected with syphilis. The true symptoms or signs of syphilis infection are not well known, and symptoms of a number of different STDs tend to be conflated

> Syphilis is something you don't like but you don't know you have it until you get the heavy discharge and the smells. You'll use the bathroom and your urine will start burning. (Respondent 2, female, age 48)

> I was diagnosed with syphilis 6 years ago. I was wondering what was going on with the drip and all. (Respondent 5, male, age 31)

The above respondents reported the symptoms they believed to indicate syphilis infection in their bodies. The notion of being 'forever infectious' represents how respondents felt after learning that although they had been treated and cured for syphilis. Evidence of the disease would always remain in their blood stream.

> It will always be in my blood stream and that's something I got to live with and I didn't know that until the doctors told me and you know it kind of bothers me in a way. It makes me angry because I'm scared that I could pass it on to someone else and that I don't want to do. (Respondent 14, female, age 37)

> See it's (syphilis) just like in a little box, I can coat it. It ain't ever gonna go away. I can just coat over it and make it stay right there cause it ain't gonna leave it gonna always be in my blood stream ... If I look at my face and start getting dark dots, I know it's time to take my medication. (Respondent 1, female, age 35)

For some respondents, the idea of 'forever infectious' developed into a fear of relationships and a fear of sex, creating distrust and instability in their lives. Respondents expressed a fear of relationships because they would have to explain to a potential partner that they would always have syphilis in their blood stream. They feared the possibility of infecting their sex partners despite medical advice and information to the contrary.

They just treated it and gave me shots. I won't have it anymore but its still in my system and every time I take a shot or draw blood, syphilis is gonna show up.
Interviewer: Does that mean anything for you – like how you live your life?
Respondent: Yes, I'm afraid to have sex, 'cause protection can still bust and I don't want to give it to anyone else. (Respondent 13, female, age 38)

Female respondents also spoke of a fear of sex, avoiding sex, or making up reasons not to have sex, in order to not have to explain their experience with syphilis, and how it is always in their blood.

Interviewer: Has syphilis affected your relationships with men? What do you feel about a relationship now?
Respondent: I want one. I have a friend now who I'm afraid to sleep with though. I haven't told him I have syphilis. I told him I had a hysterectomy and I don't have no feeling instead. (Respondent 13, female, age 38)

Interviewer: Has it (syphilis) changed the way you think about men and relationships with men?
Respondent: Yeah, 'cause sometimes I don't like to have sex. I really don't like to have sex ... because what I've been through and you just don't know who to trust these days you don't know who. The man I'm with now probably got something. He ain't gonna tell me. (Respondent 3, female, age 41)

'Flare-ups' were another fear talked about. Respondents believed that since syphilis remained in their blood stream it could flare-up and would be transmitted if they stopped treatment, did not continue to be tested, or became infected with another STD.

It can reinactivate at any time because you always carry a trace in your blood. (Respondent 4, female, age 25)

Interviewer: Okay so for the rest of your life you have to keep going in to get it (syphilis) treated or else it can come back?
Respondent: Yeah, it can come back on you. You'll always have it for the rest of your life. As long as you keep it treated and, uh, it will stay within your blood stream and it won't come out, and it won't be a threat to you or anyone else. But if you stop going and get treated for it, it come back on you like in sores or blisters or something. (Respondent 14, female, age 37)

It can flare-up like every 3 months. You can start dripping and burning and you have to go to the doctor. (Respondent 7, male, age 39)

Discussion

The themes in this paper comprise some of the folk constructions of syphilis prevalent within the community studied. The image associated with a disease is an important reflection of cultural constructions of a disease and those directly affected by it. That most closely associated with syphilis was 'uncleanliness'. Similar imagery has been reported in a recent Oregon study by Balshem *et al*. (1992). Respondents here described syphilis as a disease of dirty people. According to the authors, cleanliness has been seen as a symbol of higher status and morality. 'For Americans, staying clean is a marker of keeping dissolution at bay, and an expression of one's commitment to uphold the value of an orderly life' (Balshem *et al*. 1992).

The idea that 'dirt', 'filth', and 'poor hygiene' caused syphilis and other STDs was also projected onto people and inanimate objects like toilets. Vigorous hygiene habits like douching were thought to wash away and reduce one's risk of infection. This is in sharp contrast to the biomedical model, which defines syphilis and STD risk as linked to specific behaviours including unprotected sex, sex with multiple partners, and buying and/or selling sex.

The root of fears connected with being 'forever infectious' lies in confusion over syphilis testing and results. Syphilis seropositivity is most usually determined by a non-treponemal test such as the RPR assay, and then confirmed with treponemal tests (Tramont 1995). Syphilis results are reported quantitatively as titres, and results are also given qualitatively as reactive or nonreactive. Respondents reported confusion over the meaning of titres and the meaning of reactive vs. nonreactive, when told that syphilis would continue to show in their blood tests for months or years after treatment. The idea of being 'forever infectious' and talk of 'flare-ups' also imply confusion with herpes infection, which is known for flare-ups of symptoms and continued infectiousness in afflicted individuals. This suggests that syphilis symptoms are not well understood in this community, and also a lack of communication between medical professionals and those directly affected by the disease.

The association of burning with syphilis infection also indicates confusion between syphilis symptoms with those of gonorrhoea and chlamydia. Burning, itching, and discharge are not symptoms of syphilis. Gonorrhoea symptoms usually develop 2 to 7 days after exposure with an infected individual. Both men and women can experience pain or burning when urinating and a thick discharge from the penis or vagina. Chlamydia symptoms may occur within a week to a month after an infecting exposure. Both men and women may experience pain or burning during urination, a burning or itching around the genital area, and/or a discharge from the penis or vagina. Importantly, the confusion of symptoms suggests that individuals do not distinguish clearly between STDs but instead operate with a unitary mental montage of syphilis, gonorrhoea, chlamydia, and herpes symptoms, treating them as a single category.

Two major limitations to the study must be noted. First, the work focused only on 17 individuals from a specific high-risk community. Their beliefs and perceptions cannot be considered representative of Houston, Texas or of the African-American community as a whole. Second, due to time constraints and study sample availability, there are likely more folk constructions of syphilis that were not uncovered by this study that relate to this and other communities.

There are a number of ways of improving communication about syphilis and STDs. First, folk models are windows into the social and cultural context of affected individuals and the community in which they live. Consequently, and in certain circumstances, they offer good starting points for educational interventions. Second, once misconceptions are addressed, more accurate information needs to reach the lay public and become part of informal communication networks. Third, folk models need to be shared more widely within formal communication networks. In this way, doctors, nurses, and outreach workers will have access to a valuable tool that helps them better understand the communities with which they work.

Note

1. The research described here was conducted as part of The Innovations in Syphilis Prevention (ISP), which features collaboration between the Centers for Disease Control and Prevention (CDC), The University of Texas-Houston School of Public Health, the City of Houston Department of Health and Human Services, and *Over The Hill*, an inner-city STD education and outreach center.

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Résumé

Cet article analyse les constructions populaires sur la syphilis, dans une communauté à prédominance afro-américaine de Houston, au Texas. Des entretiens en profondeur avec 17 afro-américains ont été réalisés, afin de décrire les modèles populaires de la syphilis dans cette communauté. Les entretiens ont mis l'accent sur la prévalence de la transmission, le risque, la protection individuelle et le dépistage, les relations et les attentes dans

le futur. L'apparence physique, les «tests» du cérumen, de l'allumette et de l'odeur sont utilisés pour «détecter» la syphilis. Les personnes interrogées ont regroupé les symptômes de plusieurs MST comme la syphilis, la gonorrhée, l'herpès et les chlamydiae, en une seule catégorie. Les résultats de l'étude indiquent une mauvaise communication des informations sur les MST et l'utilisation de modèles différents (populaires vs. médicaux) pour expliquer les risques de contamination et la prévention. L'utilisation des constructions populaires dans les interventions sur la syphilis pourrait aboutir à une meilleure compréhension des connaissances et des perceptions de la syphilis par les communautés, et à un recentrage plus efficace des futurs programmes d'éducation et de prévention.

Resumen

En este documento, se analizan las interpretaciones populares de la sífilis en una comunidad mayormente afroamericana de Houston, Tejas, en EE UU. Se llevaron a cabo entrevistas en profundidad a 17 afroamericanos para describir los modelos populares de la sífilis hoy día. Las entrevistas se enfocaron en prevalencías de transmisión, riesgo, protección personal y detección, relaciones y expectativas de futuro. Para 'detectar' la infección por sífilis se utilizaban diferentes métodos: la apariencia física, la prueba de la cera de los oídos, la prueba de la cerilla y la del olor. Los entrevistados combinaron los síntomas de diferentes enfermedades de transmisión sexual, entre ellas sífilis, gonorrea, herpes y clamidia, en una misma clase. Los resultados del estudio indican que se recibe una comunicación errónea en lo que afecta a información sobre enfermedades de transmisión sexual y el uso de diferentes modelos (populares frente a los médicos) para explicar el riesgo de infección y prevención. Si en las intervenciones contra la sífilis se tuvieran en cuenta las interpretaciones populares sobre esta enfermedad, se entendería mejor el conocimiento y las percepciones de la comunidad sobre enfermedades de transmisión sexual y se podría dar un mejor enfoque a la educación futura y programas de prevención.