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# Stigma as a barrier to treatment of sexually transmitted infection in the American deep south: issues of race, gender and poverty

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## Abstract

Sexually transmitted infections (STI) occur at high rates in the US compared to other Western nations. Sociocultural indicators such as race and ethnicity, lower socioeconomic status and historically higher rates of certain diseases, such as syphilis, are correlated factors but do not explain fully why STI rates are particularly high in the American Deep South. One salient factor is the stigma associated with STI and its effect on screening and treatment. This paper presents the results of six focus group interviews that were conducted among mainly African-American health workers, patients and students in Alabama, USA. The results showed that STI-related stigma directly and indirectly affected willingness to be treated for STI at public health clinics. Four dimensions of stigma emerged: (1) Religious ideation affected how health workers felt about 'promiscuous' patients (especially women), (2) privacy fears discouraged male patients from seeking treatment at local clinics, (3) racial attitudes affected willingness to be treated for STI and (4) Stigma transference (being "scarlet lettered") emerged as a potent disincentive to treatment. Partner notification was more likely if patients felt betrayed by a sexual partner. Further research is needed to clarify these stigma-related dimensions and the impact on screening, treatment and partner services.

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## Introduction

The elimination of sexually transmitted infection (STI) is an important but elusive goal. In the US, not only are STI rates higher than in most other developed nations, but diseases such as gonorrhea, human papilloma virus (HPV) and genital herpes are increasing (CDC, 2001). Chlamydia and genital herpes alone now account for an estimated four million new infections per year, with the highest rates in the South (CDC, 2001). Gonorrhea, which had steadily declined until 1998, has increased somewhat in recent years, in line with increases in Northern Europe and Canada. The majority of all STI occurs in young people up to 29 years of age; thus by the age of 21 years, 1 in 5 of the US population

will have had an STI (Healthy People, 2000). The United States, in fact, has the highest rates of STI in the industrialized world; up to 12 million new cases are reported annually despite nationwide efforts at reduction (Marwick, 1997). On a more optimistic note, syphilis has been eliminated in some areas of the US and greatly reduced in others (CDC, 2001). Nevertheless, the US lags behind the successes of other developed nations, such as Britain, Canada and Sweden, which have essentially eliminated syphilis.

Stigma is an important factor in STI control efforts in the US (Battelle Report, 1998). Stigma is associated with emotional distress, treatment delays and poor health outcomes for a number of diseases, but especially for STI. The adverse psychosocial effects of stigma include guilt, embarrassment, isolation, fear and denial following a diagnosis, meaning that patients are concerned about both the social and physical impact of STI on

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their lives (Gilmore & Somerville, 1994; Wright & Rodway, 1988; New Zealand Herpes Foundation, 2002). The fear of stigma contributes to delays in screening for STI. For example, Fortenberry et al. (2002) found that stigma had a significant role in unwillingness to be tested for both gonorrhea and HIV across the US. A study by Hook et al. (1997) further found that delays for screening and treatment are common, even though waiting only a few days can result in increased morbidity and exposure of sexual partners to infection. STI-related stigma and associated treatment delays occur in other countries as well (see studies of China, Britain, New Zealand and Africa by Hongjie, Detels, Xiaojing, Erjian, & Yueping, 2002; Lacey, Higgins, & Graham, 2001; Pitts, Bowman, & McMaster, 1995; Carlin & Barton, 1995). STI-related stigma is therefore implicated in these delays around the world, although cultural factors may affect its level of intensity.

The adverse effects of stigma have been a common theme in the literature on HIV/AIDS over the past 20 years. However, relatively little has been written about stigma associated with other STI (i.e., gonorrhea, syphilis, genital warts, herpes) except in historical studies of syphilis (e.g., Gilman, 1988). Yankauer (1994) has noted how the recent focus on HIV/AIDS has tended to isolate it from the other sexually transmitted diseases and also obscured the broader public health issue of preventing the spread of all infections that are sexually transmitted. Holmes et al. (1999) have written that stigmatizing attitudes towards syphilis and HIV/AIDS converge in some important respects such as blame for spreading disease, the societal prudishness that prevents frank discussion of sexuality and STI, and inadequate prevention measures. The representations of STI as a “carnal scourge,” and the labeling of infected persons as “vectors” and of uninfected persons as “innocents” are examples of the blame motifs in both the syphilis and HIV/AIDS epidemics.

There may be important differences between HIV/AIDS and other STI that are likely to affect treatment decisions. For example, people may delay seeking care for non-HIV STI if the perceived stigma of these “lesser” infections is high compared to their perceived threat to physical health. Alternatively, people might be more willing to seek treatment for such infections compared to the highly stigmatized and often fatal HIV/AIDS. The literature on HIV/AIDS is replete with examples of the extreme effects of stigmatization such as withholding of medical treatment, rejection by families and community, denial of jobs and housing, and even suicide and homicide (e.g., Joint UNAIDS Report, 2000). According to Yankauer (1994), less is known about the outcomes of stigma for other types of STI because of this current preoccupation with the catastrophic social and medical effects of HIV/AIDS.

However, it is important to identify the barriers to STI control for other infections, which are markers for HIV transmission and which also take a significant toll on physical and mental health around the globe. The role of stigma in creating this toll is suggested in the fact that STI has been termed a “hidden epidemic” (Eng & Butler, 1997).

### *The regional context*

STI rates are higher in the American South than in other US regions. Alabama has historically high STI rates of syphilis, gonorrhea, chlamydia and other STI (including HIV/AIDS), which is consistent with neighboring states. Most of these infections occur among African Americans, both locally and on a national scale (CDC, 2001). The reason for the prevalence of STI among African Americans is unclear, although homophily (intra-community sexual relations) and partner-sharing are believed to be contributing factors (Lau-mann, Gagnon, Michael, & Michaels, 1994; Pfingst, 2002). One local factor that is pertinent to STI and stigma in the South is the Tuskegee experiment, in which 400 African-American men in Alabama were denied treatment for syphilis. The legacy of the Tuskegee experiment has resulted in mistrust of the health system among African Americans in Alabama, particularly among men (Lichtenstein, 2000a). The Battelle Report (1998) on stigma-related barriers to STI treatment in the American South has identified this and other regional factors, including strong conservative influences that severely limit discussion of sexual health issues in schools, reports of being mistreated at clinics, concerns about confidentiality, and embarrassment, particularly in small rural towns. These factors, and the high STI rates in the American South, suggest that “local moral worlds” (Kleinman, 1999) are important in understanding how STI-related stigma affects willingness to seek health care, and how stigma is utilized as a method of social control in local communities.

The primary research question for the present study was: “What are the stigma-related barriers to screening and treatment of non-HIV STI?” This question takes account of two issues that have received relatively little attention in the US public health literature to date; namely, the cultural and regional factors concerning STI-related stigma in the US and the stigma associated with STI that are not HIV/AIDS. These foci are important because most of the human, social and economic costs of STI (including HIV/AIDS) in the US fall disproportionately on communities in the South (Healthy People, 2000), and because there is a correlation between STI and HIV rates in the region. This paper will identify some of the stigma-related barriers to treatment that have a direct effect on screening, treatment and partner services in a Southern state.



## Definition of stigma

As suggested by Fortenberry et al. (2002, pp. 1–2), the definition of stigma utilized in this study is “an attribute or label that sets a person apart from others and links the labeled person to undesirable characteristics.” This definition is consistent with that of Goffman (1963, p. 3) who refers to stigma simply as “an attribute that is deeply discrediting.” An attribute in itself is neither creditable nor discreditable, but becomes defined as one or the other through the linking of the individual with undesirable or discrediting socially defined characteristics. Goffman notes that stigma typically results from three broad conditions: (1) abominations of the body (i.e., physical deformities), (2) blemishes of character and (3) tribal stigmas of race, nation and religion. STI appear to qualify primarily as “blemishes of character”—despite the physical origin of the stigmatizing condition—because of their association with a perceived moral failure. People who contract STI are typically regarded as having done so through immoral sexual acts (that is, outside of wedlock, with disreputable persons, or through sexual promiscuity).

According to Goffman, stigma represents a rupture between an individual's *virtual* and *actual* social identity that is regarded as a failing. This failing places the stigmatized individual in a category of people whose character and body are tainted. Consequently, “passing” as normal (e.g., keeping a diagnosis secret in the case of stigmatizing disease) is a common strategy for the afflicted even at the risk of increased morbidity or spreading infection to others. The fact that passing is often successfully achieved in the case of STI is simply because symptoms or “signs” are often invisible to others. The fear of being stigmatized may affect patients' willingness to advise health department officials of the names of their sexual contacts or to disclose to sexual partners of exposure to infection (partner notification). Lindemann (1988), among others, has stated that the difficulty in disclosing to partners is highly correlated with feelings of shame. This paper will focus on the social dynamics of stigma in relation to STI, particularly the issue of “passing” and its consequences for screening and treatment.

A recent study by Nack (2000) has extended Goffman's theory to include “stigma transference.” Nack defines this concept as the act of deflecting blame for being infected to someone else (usually a sexual partner) in an effort to salvage self-esteem and maintain a sense of moral integrity. Nack's concept is similar to Gilmore and Somerville's (1994) notion of “displacement,” except that the latter is defined as the stigmatizing reaction of “normals” to the fear of associating with someone who is infected with STI, whereas “transference” involves the response of someone who has been infected. Nack framed her concept of stigma transference

in terms of the coping mechanisms of infected women (i.e., being the “innocent” party). Stigma transference has implications for STI transmission if it results in “revenge sex” (as reported in the AIDS literature) or in blame, deflection and denial, which were salient factors in Nack's article on women and STI. Both Goffman's theory of stigma as “spoiled identity” and Nack's concept of stigma transference will frame the understandings of STI-related stigma that are presented in this article.

## Method

The study consisted of six focus group interviews that were evenly divided between a small city and a large city in West and Central Alabama for comparison of stigma-related effects. The focus group method was selected for three reasons: focus groups can offer an in-depth understanding of perceptions, attitudes and beliefs about a particular topic, they can provide social and cultural interpretations of health-related topics, and they can generate often unexpected or novel insights (Gorbach, 2001). Focus groups are particularly good at “reach[ing] the parts that other methods cannot reach” (Kitzinger, 2000, p. 21) because they can identify shared knowledge and understandings or dominant cultural values on topics such as sexuality. Kitzinger (2000) also writes that the diverse and multiple explanations that can be obtained from focus group discussions may not be readily accessed through traditional survey methods or even other qualitative methods such as individual interviews. Further, these factors make focus groups a particularly culturally sensitive data collection technique that can be employed in cross-cultural research and work with ethnic minorities. This rationale provided the basis for using focus groups in a southern US setting for information on cultural discourses about morality, sexuality and STI, and the means by which these phenomena “show themselves” (Creswell, 1998) in barriers to treatment. While the small number of participants in these focus groups mean that the findings cannot be quantified in relation to how stigma presents a barrier to treatment, the results presented in this paper do offer a porthole into the ways in which STI-related stigma is both perceived and experienced in a southern US context.

The participants were recruited from the staff and patient lists of public health clinics and students were recruited from a college and high school for broader input on community attitudes. Three focus groups, consisting of separate groups of clinic workers, patients and students, were conducted in each city. Almost all of the clinic workers and patients were African American: this grouping relates to the fact that Alabama clinics are located in black or urban neighborhoods that serve the



**Table 1**  
Characteristics of focus group participants (*N* = 42)

Item	Staff	Patients	Students
Large City			
No. of participants	6	6	7
Sex	Female	Female	Male
Race/Ethnicity	Black	Black	Black
Age range	29–53	21–61	20–22
Finished high school	5	3	7
Employed F/T	6	0	0
Health insurance	6	0	4
Married	3	0	1
Children	5	5	3
Small City			
No. of participants	9	8	6
Sex	Female 6 Male 3	Male 8, Black 6, White 3	Female 4, Male 2 White
Race/Ethnicity			
Age range	19–40	28–46	15–17
Finished high school	9	3	N/A
Employed F/T	9	0	N/A
Health insurance	9	0	Parents'
Married	1	0	0
Children	6	5	0

local population. The patients were all unemployed, single (most had children), uninsured, and most had not finished high school. By contrast, the clinic employees were employed on a full time basis, had private health insurance, and had a high school education or better. The student groups were divided by ethnicity (black/white) and type (college/high school) for comparison. The majority of patients self-identified as heterosexual, although the perspectives of several gay men were captured as well. The characteristics of the participants are listed in detail in Table 1.

The topics focused on knowledge, perceptions and practices that would help explain stigma-related barriers to STI treatment and partner notification. The a priori topics were always covered, but not exactly the same questions were asked at each interview. This variability is a normal part of the focus group discussion, in which insights may be obtained when participants move into unexpected cultural terrain. Most of the participants spoke about the behavior of others (for example, health workers about patients and vice versa, female patients about male partners and vice versa). This externalization is also a normal and non-threatening part of focus group discussions, and is useful for eliciting operational assumptions about stigma-related perceptions or behavior, and for matching the perceptions, attitudes and knowledge of different groups.

The taped transcripts were transcribed and analyzed according to the major concerns of the study (stigma,

barriers to treatment, religious influences and partner notification). The elicited material was organized by constructing a grid of related themes for comparative purposes as recommended by [Shedlin and Schreiber \(1995\)](#) for studies on sensitive topics, and by using key words to identify stigma-related areas of discussion. In the results, interview quotes are used to illustrate the perceptions of the participants concerning STI-related stigma. These quotes are followed by the type of focus group (for example, Patient Group) and by the following race and sex identifiers: White Male = WM; White Female = WF; Black Male = BM; Black Female = BF. Patient and clinic names have not been presented in order to protect the identity of the participants.

## Results

### *Women and stigma*

Women were described as either "good" or "bad" according to their behavior or STI status. The health workers' definitions of stigma centered on attributions of shame, with qualified approval for clients who felt ashamed at being infected, and disapproval for those who did not. This "good woman–bad woman" theme dominated the interviews. For health workers, good women were mostly those who were older than teenage years, who were employed or in college, or who had a steady partner. Good women were reported to be visibly embarrassed at having to attend clinics, and were keen to avoid being seen by others in the waiting room. For one health worker: "You can tell [the good woman] because she be kinda decked out, and she wants to know 'How long is this gonna take? I'm gonna wait in my car with my daughter, I'll be right back.' She's gonna make sure no one sees her, that nobody's gonna recognize her." (BF: staff, small city). Good women were also reported to have regular health checks, to notify partners of exposure to infection, and to make sure they were not reinfected. In the words of one health worker: "They will carry themselves like ladies." (BF: staff, large city). Women were expected "to be a lady," to persuade men to use condoms, and to encourage male partners to be checked for STI. The health workers expressed frustration with women who did not conform to this model.

Definitions of stigma differed according to whether participants were patients or health workers. Most of the health workers were mature-age women who disapproved of the way "the young girls of today" flaunted their sexuality, and they kept an evaluative eye on the appearance or behavior of women who attended the clinics. Clinic workers were likely to say that a monogamous relationship, preferably within marriage, was ideal. For patients and students, however, definitions of



STI-related stigma were less value laden. Patients' definitions of sexual morality centered on the informal "one man at one time" rule, and their criticisms were mainly directed at: "The [women] that have a different daddy for all of their kids" (BF: patient, large city), or worse: "The ones who never keep track of the names of their babies' daddies." (BF: patient, large city). "Keeping record" of the names and details of sexual partners was deemed important by female patients for child support purposes, and retrospectively, in the event of being infected with STI. The common tendency for both clinic workers and patients was to blame women for "spreading" STI. This sexual double standard was acknowledged by one male staffer who said: "It's always about the woman, isn't it? They'll always be the ones to be blamed." (BM: staff, large city).

Teenage girls attending the clinics were particularly likely to be assessed with respect to "proper" or "improper" behavior. According to the staff, "bad girls" were identifiable by the way they behaved in the waiting area. Here, they would joke freely about their sexual escapades to friends and staff before and after their appointments regardless of whether they had a positive diagnosis for STI or pregnancy. These extraverts did not fit the "good woman" model as framed by clinic personnel primarily because they did not exhibit a sense of shame or humility. Adult women who returned to the clinic to be treated for second or third infections also fell short of the good woman ideal. All patients who attended clinic more than once for STI symptoms were called repeats; these women were said to be either too weak or too young to know what they were doing, or were too brazen to care. The female patients were acutely aware of the need to appear "good" to health workers, but they were also concerned about how they would be viewed by their sexual partners. For this reason, "You wouldn't tell [the health department] you had more than one man, and you wouldn't go and all tell all the men [for partner notification purposes] because you'll be known as a freak." (BF: patient, large city).

The designated "bad girls" were described as high school dropouts who "hooked up" with older men for gifts, money and thrills. These girls were said to pursue the men, rather than the other way around. In the words of one clinic worker, "These are a different breed of children from when we were [growing] up" (BF: staff, large city). However, one teenage male disagreed. In his view, the men initiated these encounters and used money and gifts to "hook" the girls. This process had limited his ability to attract a girlfriend. He explained that: "The older men prey on the younger females because they know the younger females are impressed by the little materialistic things. But young guys, you can't just put on a new outfit and say: 'I'm going to have sex.' It's deeper than that. They [girls] say: 'You're going to have

to work a bit harder than that, baby.' And most young guys realize that so they don't even try." (BM: patient, small city). Such older men were unlikely to disclose a STI diagnosis when seeking sexual partners.

### *Men and stigma*

Male sexual behavior was not framed in negative terms, and sexual adventuring was considered acceptable or even inevitable in young men. The possible presence of STI was used to advantage by some youths who would attend the clinics in groups after having sex with the same female partner. Their request to be screened was interpreted as sexual machismo by the staff, with one health worker reporting that they would: "brag about it when they got back to school. They tell everybody they got checked, and they tell everybody who the girl was." (BM: staff, small city). Generally speaking, these youths would not be infected, but: "They think it's so cool that some girl burnt [infected] them and gave them a disease." (BM: staff, small city). In this case, the youths' desire to establish their sexual reputation among peers at school was a compelling, if sometimes fanciful, stimulus for STI screening.

By contrast, there was agreement that most adult men were embarrassed about attending the clinics for STI treatment. At one clinic, the men were reported to approach the receptionist in a surreptitious manner, lean across the counter, and whisper to the receptionist: "I got this discharge, I got this burning." (BM: staff, large city). In fact, embarrassment was seen as normal for adult men who attended clinics by themselves. A lack of treatment sites for men increased the potential for embarrassment, especially in the case of those who visited women's health clinics for referral or advice. The section on "passing" below discusses privacy concerns for men as a major barrier to STI services.

### *Passing, privacy and public health clinics*

Visibility was a major barrier to screening and treating STI. Men in the small city clinic were particularly likely to mention visibility as a problem because of the location and layout of the clinic, but also because STI was the only reason they attended. There was a range of services for women and children, which offered women a greater opportunity for privacy. The clinic had a separate entrance for STI patients and a general waiting area for anyone visiting the Health Department. This distinction meant that: "If you're a man, they know it's about sex" (BM: patient, small city); [while] "If a woman goes there, she can just say that something's wrong with her kids." (WM: patient, small city). The large city clinic attracted less criticism from both men and women even though the STI and other



health services were assigned to visible designated areas of the Health Department.

"Patient spotting" had become a local sport at the small city clinic, which was surrounded by public housing in a low-income neighborhood. Here, the ease with which neighbors in the double-storied public housing complex could view patients leaving or entering the STI clinic meant that: "They [neighbors] will know that you're there. They will recognize you or they will recognize your car." (BM: patient, small city). Several men attending the clinic were humiliated by the gossip that had been spread about them in the neighborhood, and were even more annoyed if they had tested negative for STI. Their comments included: "The clinic is a social gathering place. Everybody goes there to see who's who and what's what." (BM: patient, small city); and: "When you're seen at the Health Department, it turns into gossip, and gossip ends up all over the place and the next you know, so and so's got VD." (WM: patient, small city). In some cases, the men traveled to STI clinics in another town or city to avoid this type of scrutiny. One man's privacy concerns were so intense that he had arranged to be tested by a health worker in a local park to avoid being seen at the clinic.

The desire to avoid patient spotting meant that some men pursued alternative methods of treatment or that they delayed seeking care or failed to keep appointments for follow-up care. There were reports of buying over-the-counter medications, procuring medications from street dealers or borrowing antibiotics from friends. One man commented: "You know, a lot of younger people would rather ask their girlfriends for pills than go to the clinic. They won't go because they know they've got another way of getting a type of antibiotic or something that will clear it." (BM: patient, small city). Women voiced complaints about this type of behavior, however, saying: "Men don't care about themselves. They always say that it's your responsibility." (BF: staff, small city). They also complained about how men procrastinated, were in denial, were too busy, or were too proud or too private to see a doctor. In the words of one woman: "That's just a stereotype of a man. He won't go to the doctor, period. That's just not going to happen" (WF: staff, small city). The staff of the large city clinic related how female patients would occasionally phone to say that their prescription was lost or stolen and to request a replacement. These requests were taken to mean that the women were seeking medications for male partners and friends, or for male members of their family.

A lack of health insurance was also a problem for some men who: "Just can't afford their shots and can't afford their medication." (BM: patient, small city). Women were more likely to have access to public forms of health care such as Medicaid. Having a "wait-and-see" attitude for STI symptoms was therefore said to be more typical of men than women, not only because of

visibility, "male pride," and denial, but also because fewer health care options were available for uninsured men. In such cases: "He's gonna wait to see if it's gonna get better by itself or whatever or try some home remedy or over-the-counter medicine." (BM: patient, small city). Men who were involved in illicit drug use or criminal behavior were particularly likely to avoid public health clinics because they feared being seen and reported to the authorities. These men were unlikely to seek help from formal treatment services.

Privacy concerns were not confined to uninsured patients or those who attended public health clinics. The high school students also spoke about how confidentiality might be breached if they visited their private doctor for STI screening or treatment. One adolescent believed that: "The doctor would notify parents about that, I assume. Especially if the parents and him are friends, or if [the doctor] goes to the same church as his parents." (WM: student, small city). The topic of STI was rarely raised at home, school or church, and with one exception, the adolescents spoke about being too embarrassed or ashamed to approach their parents with STI-related problems. The adolescents preferred keeping such health problems a secret from adults but believed that discovery was inevitable once their parents received an itemized statement from their health insurer in the mail.

#### *Race and stigma*

Mistrust of the health system by African Americans was an important theme. One African-American student voiced the concerns of his all-male group when he said, "There's a hidden agenda in this country. The government has done a lot of quirky stuff—I mean, look at the Tuskegee project. Blacks have way far more STDs than whites. I feel it's because certain diseases have been planted in certain communities. Personally, I feel that AIDS is genocide, you know? I feel that HIV was planted to keep our population down." (BM: student, large city). The women did not refer to race and stigma in these terms, but did say that there was an undue focus on birth control (abstinence) in schools, which they attributed to concern over high rates of pregnancy among black girls. One participant complained that, "They teach you more about not having children than they do about diseases. Birth control here. Birth control there. They're always talking about not having children in our schools." (BF: patient, large city).

The "blackness" of STI rates in public health reports was also a source of speculation. There was a strong suspicion that STI tracking systems focused on patients in public health clinics, who were mostly black. The assumption was that Health Department patients would automatically be listed in state reports on STI but that private (white) patients could escape detection.



Participants expressed disapproval of this type of injustice, which they contextualized in terms of stratified health care in the US. Said one man, "Whites can afford to go to private doctors because they've got better jobs and insurance, but blacks have to go to the clinics because they just can't afford those shots and can't afford their medication." (BM: patient, small city). Another man agreed, saying, "You know, if I go to the Health Department here, ninety percent of the time I'll be one of only two or three [white] people in a room of 50." (WM: patient, small city). The STI clinics were therefore viewed as "belonging" to blacks, which meant that they were perceived in negative terms by the general public.

This perception was supported by white participants in the focus groups. The notion of "Black clinics" was said to present a problem to uninsured whites, either because they did not know that the clinics existed, or because of racist sentiments. In the latter case, "the rednecks I know will tell you bluntly that they're not going to go there and hang out—excuse the phrase—with a bunch of niggers to get waited on. They just won't go." (WM: staff, small city). Racial stigma was also reported to affect partner notification for some gay men because: "My lover might hate Blacks. If I got infected he'll want to know who I was fooling around with. I can't tell him what I got (STI) because I had sex with a Black man. I know some couples like that. There's a lot of mixing out there in the woods, people "bumping" into someone out there, and they won't tell their lovers about getting infected by someone of another race." (WM: patient, small city). These perceptions were not only insulting to African Americans, but resulted in treatment delays for uninsured whites, including for gay men who were at high risk of HIV/AIDS.

#### *Stigma transference and gossip*

Both men and women believed that if they were the victims of sexually transmitted disease they would not infect other people. When the topic of being infected was broached, the participants all agreed that they would react with hurt, hostility or anger to the news. In their minds, being infected in this way was proof of infidelity (betrayal) by a sexual partner. Some of the participants were more concerned about this possibility than about the harmful physical effects of disease. Hypothetical reactions to being infected included: "If they ever infected me they better watch out, they [partners] better worry about what I'll do to them." (BF: patient group, large city); "I'd feel betrayed. Violent." (BM: student, large city); "I'd get very upset, you know, betrayed. I'd have nothing more to say to that person." (BM: student, large city); "I'd feel like you'd been messing around on me, you cheated. I'd feel like you don't care enough

about me, I mean you just don't care about me. Oh Lord." (BM: student, large city). Heterosexual relationships often ended after a partner was infected or notified of exposure.

"Spreading the word" was a popular form of retaliation. Individuals were named and sexual stereotypes were perpetuated in the name of making or breaking social reputations. The role of gossip in perpetuating STI-related stigma cannot be overstated. Spontaneous comments about STI-related gossip were made in all of the focus groups, with participants reporting actual or rumored incidents for people they knew. The women were particularly likely to say that they would retaliate against a sexual partner. In the words of one participant: "I would tell his mama, his dad, his sister—I'd tell everybody. Even one of his girlfriends, because she might have infected me. I'd tell everyone because I'd be mad." (BF: patient, large city). Another said, "When I found that slip of paper [from the Health Department] in my boyfriend's wallet, I told everybody. His auntie was there, his dad was in the house, his cousin was in the house and so was his little cousin. Man, they were all there." (BF: patient, large city). This desire to retaliate publicly was presented in terms of cultural differences between Blacks and Whites. Said one woman: "White women are more concerned about keeping in their relationships. Black women are more likely to jump on their husbands or boyfriends. They don't want to give him a second chance. We are more likely to beat up on the man and want to kick him out." (BF: patient, large city).

Most participants expressed fear of being the target of STI-related gossip. One participant spoke about being targeted in these terms: "They will talk about you. They will talk about you so bad that it will make you not want to go nowhere to be treated." (BF: patient group, small city). However, this type of retaliation may sometimes be misdirected, with negative consequences for STI screening and treatment. For example, one man said: "I knew a girl who had rumors spread about her by this guy. He told everyone he got a STD from her. After that, she just hid away from everyone, and she wouldn't get checked on." (BM: patient, small city). Other participants were just as adamant about the risks of disclosure. These comments were typical: "I think there's a lot of people out there not willing to admit they have sexually transmitted diseases because they see the way other people get treated that do have them. It's a known fact that no one has anything to do with them, nobody talks to them, and nobody wants to go out with them." (WM: patient, small city); "They do gossip. One friend of mine had a friend who told her [about being infected] and she went and told everyone at the projects. That girl was gossiped about real bad." (BF: patient, small city). This problem is typical of small towns in which anonymity can be difficult to maintain, and where



gossip and name-calling can make life particularly miserable. The topic of STI-related gossip generated some of the most emotionally charged responses in the interviews.

#### *Stigma and religion*

The participants were fairly evenly split between those who held a negative view of religion in promoting STI-related stigma and those who said the church had a positive moral message for prevention. Participants who extolled the positive role of religion were mainly women employed at the health clinics. This group shared the sentiments of the following speaker: "It [morality] works in the church. I believe it works in the church because of the fact that the girls I see for treatment are not the ones that you see in church. That's what I'm finding. And the older ones, they may get infected one time, but they're not going to be a repeat. I think they're smarter and they're not like the younger ones that will go back and do it again. They're not coming back here, you know, to show their face after doing what they should not have done." (BF: staff, large city).

The patients disliked this type of moralizing. One man believed that: "Most of the churches are under the contingency that everyone that is inside of these walls are just pretty much safe and everyone else is just the great unwashed." (BM: student, large city). The church's attitude on sexuality was summarized in these terms: "Sex is thought of as being dirty, something you should purge yourself of. For them it's bad or taboo." (BM: student, large city). One participant spoke of the link between religious beliefs and STI-related stigma in these terms: "The majority of the black population is Baptist, and the strongest thing that comes across the pulpit is that homosexuality, drug use and extra-marital sex are sinful. And that goes hand in hand with HIV and any other venereal disease. If Joe gets blisters and sores, then it's because of what he did wrong." (BF: staff, small city). Another participant remarked that if someone confessed to having an STI: "They would be sitting on the church bench by themselves" (BM: patient, small city) to which his neighbor replied: "You wouldn't even get into the church. You'll be left to sit on the front steps." (WM: patient, small city). It was generally agreed that, "Alabama is an extremely pious region with strong, conservative Baptists." (WM: student, small city). This speaker concluded that STI-related stigma was promoted by the church, because: "I'm not saying that it's bad to be a Southern Baptist or anything, but they're very judgmental." (WM: student, small city). Religious judgmentalism particularly affected women, who were cast in the role of actual or expected moral standard bearers in keeping with religious doctrine, and who also comprised the majority of congregants in African-American churches.

#### **Discussion**

The most notable finding from the focus groups was that the topic of STI provoked such strong feelings about "dirty" or morally lax persons that the primary barrier to treatment and screening was the wish to avoid negative labeling. The association of STI with moral judgments and shame was clearly understood by the participants in terms of religious teachings about STI as "the wages of sin," in avoidance mechanisms such as blame (stigma transference) and passing, and in disidentifiers such as gossip and stereotyping. Both men and women patients reported a fear of being stigmatized in the event of a positive STI diagnosis, although greater blame was directed toward infected women. The blame component of stigma transference was the unanimous response to being infected, indicating a high level of anxiety or awareness about what STI represented in terms of being labeled and socially ostracized.

Stigma had implications for STI treatment in both structural and moral terms. First, STI-related stigma was attributed to the location and appearance of the clinics. The small-city STI clinic was a clear example of structural problems: it was rundown and unattractive, which [Link \(2001\)](#) and [Dear and Lewis \(1986\)](#) have noted is off-putting to patients but is also typical for stigmatized conditions. Its location in a low income area is also common for stigmatized conditions ([Dear & Lewis, 1986](#)). The proximity of the clinic made it difficult for local patients to escape the notice of public housing residents and their gossip. Intersecting these concerns about structural barriers were suspicions about STI/HIV being a genocidal plot against African Americans, and the assumption that inferior (public) care was meted out to the uninsured poor, who were mostly Black. This combination of neglect, "patient spotting", historical mistrust, together with the lack of institutional attention to privacy needs, all contributed to unwillingness to be treated for STI even if painful symptoms or partner notification laws forced patients into treatment.

Second, the local moral world of the participants constructed STI-related stigma in cultural understandings about sexual behavior, sexual desirability, and the trustworthiness of sexual partners. Stigma transference, for example, was apparent in threats or feelings of violence, in the breakup of relationships, and in retaliatory actions such as "spreading the word." All three factors were important, but "outing" a sexual partner was the most potent in cultural terms. In this case, Goffman's concept of passing (secrecy) had little social relevance and did not act as a deterrent to partner notification, especially for women. Women viewed making someone a target of stigma transference as justification for being betrayed in a sexual relationship; however, they may also have been responding to the



greater stigma attributed to “diseased” women. Being the target of this anger was feared by both men and women. For men, their fear of being targeted was related, in part, to structural problems at the Health Department, and to their dislike of contact tracing laws which they considered to be unfair. The men’s desire to avoid the consequences of being “outed” by a vengeful partner in this way was compounded by the feeling that the public health system was not to be trusted in its dealings with African-American men.

The concept of stigma transference bears further examination in relation to partner notification. The women’s willingness to “out” a sexual partner who betrayed them seems paradoxical given the high degree of partner sharing among low-income African Americans in Alabama. However, two studies of African-American women and HIV risk by Bowleg and Belgrave (2000) and Fullilove, Robert, Haynes, and Gross (1990) found that few women in such arrangements perceive themselves to be at risk of STI/HIV, in part because of their need to make strong romantic connections with men. In a study by Lichtenstein (2000b), the romantic ideal of monogamy and marriage was a primary organizing construct in heterosexual relationships for low-income African American and white women in Alabama, and a STI diagnosis indeed represented betrayal in relationship terms. Men’s fear of being “outed” meant that they would not disclose a positive STI diagnosis to sexual partners, and if confronted, were likely to deflect blame for being infected to the women. Sexual relations between men and women, therefore, represented a delicate balance in terms of trust and betrayal. For women, being infected with STI was a potent reminder of the conflict between romantic ideals and the reality of partner sharing practices in low-income African-American neighborhoods in which women often outnumber available men (see Fullilove et al. (1990) for a discussion of this issue for HIV risk).

A convergence between the local moral world and structural barriers was evident in the clinic workers’ role as “respectable” community members. These mature-age women held more traditional views about marriage, religion (“church mindedness”) and gender roles than their patients even though both groups agreed that promiscuous women should be blamed for spreading STI. This difference played out not only in attitudes towards patients, but also in patients’ awareness of how much they should disclose to clinic workers (e.g., in terms of naming sexual partners, or in presenting fictional rather than actual sexual histories). Chambliss (1996) has noted that power differentials between staff and patients are often expressed in terms of moral judgments about the appearance and behavior of patients. “Morality gaps,” of the sort described by Chambliss, were evident in the different interpretations of what constituted a “proper” sexuality for women

(e.g., partner sharing was tolerated by most patients, but not by clinic workers who were women) and in clinic workers’ beliefs about the virtues of church attendance in protecting against sexual promiscuity and STI.

The Battelle Report (1998) has cited moral conservatism, negative moral judgments and punitive attitudes toward patients as barriers to health care for STI in the South. The differences between staff and patients in the focus groups did not emerge in such absolutist dimensions, but it was clear that moral conservatism defined understandings about STI-related stigma and that patient interactions with staff were shaped accordingly. Moral judgments were not only expressed in the attitudes of health workers or patients, but, as reported by the patients, in the teachings of church and community leaders who strongly equated STI with sexual promiscuity and sin. The local moral world was therefore produced and enacted within the African-American community without obvious reference to the social values of white society. However, it should be recognized that this local world was framed against a backdrop of broader understandings about STI-related stigma, race and poverty in the US, and that status anxiety may have contributed to how staff and patients constructed STI-related stigma in terms of moral absolutes.

## Conclusion

Stigma is a powerful social-psychological barrier to the screening and treatment of STI. This phenomenon in itself may be a major contributor to both the high incidence and prevalence of STI. Reducing these barriers in the socially conservative Deep South is probably an unrealistic goal, at least in the short term. Other measures, such as adapting health clinic practices and arrangements to meet the privacy needs of patients, and offering multi-purpose health services for at-risk men could be more achievable for preventing screening and treatment delays. These measures would provide better access to STI treatment and screening, particularly for low-income and uninsured patients who have limited health care options. As this focus group study has shown, stigma-related barriers are not only powerful in the American Deep South, but they also vary according to gender, ethnicity, and age. Further studies should investigate the links between STI-related stigma and barriers to STI screening and treatment more precisely, especially in the Southeastern US where STI/HIV rates, are highest. The lack of generalizable data on STI-related stigma represents a critically important gap in the research literature. It would be timely to investigate this topic on a broader scale with comparative regional data so that the epidemic of STI in the US can be reduced in keeping with the nation’s stated public health goals.



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