Bad Girls and Fallen Women: Chronic STD Diagnoses as Gateways to Tribal Stigma

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This article uses women’s firsthand experiences as the basis from which to explore how social constructions of sexual disease and feminine morality merge to threaten women’s sexual selves during sexually transmitted disease (STD) diagnostic interactions. Constant comparative analysis of interview data reveals how forty-three women made sense of this stage in their moral careers. Adding to interactionist literature on gender and chronic illness, this article expands discussions of tribal stigma to the intrapersonal realm. The data show how these women learned to view herpes and human papillomavirus (HPV) as symbols of impurity, antithetical to feminine ideals of sexual morality. Socialized to fear a caste system that divides women according to perceptions of moral transgression, the women viewed official medical diagnoses as having the potential to brand them not only as diseased but also as immoral. Tribal stigma provides the theoretical framework for analyzing why and how STD diagnostic interactions may be the catalysts for women to symbolically redefine themselves as bad girls and fallen women.

Every year in the United States, health care practitioners diagnose millions of patients with chronic sexually transmitted diseases (STDs). Among female patients, these medical interactions often trigger frightening and even socially stigmatizing redefinitions of their sexual selves. From a public health perspective, estimates of genital human papillomavirus (HPV, the virus that causes genital warts) in the United States range from as low as 1 out of 8 (CDC 2000) to as high as 3 out of 4 adults (ASHA 2000b). However, rates of genital herpes infections are consistently estimated at 1 out of every 4 adults (ASHA 2000a; CDC 2000). Though rarely fatal, these viral STDs are treatable but not curable, often have long periods of latency, and are spread via skin-to-skin contact that can occur even with the proper use of latex condoms.

Given the globally devastating impact of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), the majority of social-psychological
studies of sexual health have focused on individuals living with HIV and AIDS (Fernando 1993; Matthews 1988; Plumridge 1998; Ray 1989; Sandstrom 1996). This field of study has produced invaluable findings about the symbolic interaction among gender norms, sexual identity, and illness stigma. My research builds on this body of work and scholarship on identity and gender in chronic illness (see Charmaz 1994) to explore the psychosocial consequences for women living with HPV and genital herpes in the United States.

This article explores the meaning-making processes and initial challenges to the women’s sexual selves that occur during one “turning point moment” (Strauss 1959) in the illness narratives of these women: the diagnostic encounter. During this encounter, women may experience new and negative definitions of their moral characters that shape revisions of how they view themselves as sexual beings. Understanding women’s experiences with STD stigma requires a conceptual expansion of how diagnostic encounters affect their moral standings and self-definitions. My analysis demonstrates the significance of expanding our conceptual grasp of such pivotal turning points to contextualize the conditions under which many women degrade the value of their sexual selves and moral characters.

Previous studies of individuals infected with herpes have neglected to analyze sociologically the ramifications to self of patients receiving a morally stigmatizing diagnosis (Reiser 1986; Rosenthal et al. 1995; Swanson and Chenitz 1993). In contrast, medical research has determined that “the most common and usually the most devastating problem of having genital herpes is its psychological impact” (Bettoli 1982:925). In the case of HPV, most studies of infected individuals have focused on cognitive evaluations of risk and consequential risk-taking behaviors (e.g., Ford and Moscicki 1995). One clinical study (Keller, Egan, and Mims 1995) advises practitioners to be aware of the “psychosocial” aspects of HPV when delivering diagnoses but neglects to analyze HPV diagnostic encounters as psychosocial challenges for the patients.

I explore these psychosocial challenges by analyzing the illness narratives of women with herpes and HPV within the framework of a moral career (Goffman 1959). Hughes (1958) conceptualizes “career” as a process that entails periodic redefinitions of self. Goffman’s (1959) expansion of this concept to mental patients reveals the dual nature of their “moral careers”: patients experienced both interpersonal adjustments to different stages and intrapersonal reevaluations of self and identity. This article focuses on one specific juncture in the moral careers of women with chronic STDs, the diagnostic encounter, and explores the ways in which this interaction threatens their sexual selves with stigmatizing redefinitions.

CONCEPTUALIZATION OF STD STIGMA

To analyze the diagnostic encounter stage in the moral career of women with STDs, I drew on Goffman’s (1963:4) three types of stigma: “abominations of the body[,] . . . blemishes of individual character[,] . . . tribal stigma.” I found evidence of all three
in my research. The first type of stigma, which Goffman assigns to the presence of “physical deformities,” was readily apparent: more than 75 percent of the women used the adjective “dirty” to describe how they felt about their genitalia immediately following diagnosis. With regard to “blemish of character,” STDs have been socially constructed as symbols of moral corruption in that risk of infection has been linked to promiscuity (Brandt 1987). Evidence of this second type of stigma was more prevalent: analysis of the women’s reported emotions during their diagnostic encounters revealed the presence of blame and dread: sexual transmission evoked self-blame; fear of being contagious evoked dread. Weitz (1991) argues that the presence of these emotions in ill individuals can signify damage to their moral character.

Had I restricted my analysis to bodily and character stigma, I would have added little to the findings of previous research on the aspects of non-HIV STD stigma (e.g., Balshem et al. 1992; Fox and Edgely 1983). Constant comparative analysis of the data led me to believe that a unique application of tribal stigma might allow for a more nuanced analysis of STD diagnostic stigma.

Testing for the presence of tribal stigma among women with STDs required a theoretical expansion of Goffman’s (1963) conceptualization. His definition limits the scope of tribal stigma to “race, nation, and religion, these being stigma that can be transmitted through lineages and equally contaminate all members of a family” (Goffman 1963:4). Tewksbury and McGaughey (1997) broadened the definition to include not only tribes organized around ascribed traits but also those organized around achieved traits. They argue that those infected with HIV may experience tribal stigma because the disease has been associated with membership in deviant subcultures (e.g., intravenous drug users, prostitutes, and men who have sex with men). In both instances, tribal stigma has remained in the interpersonal realm, limited in definition to stigma that are transmitted via lineage or group membership. In this article, I argue that a thorough analysis of women’s experiences with STD diagnostic stigma remains incomplete without a conceptual expansion of tribal stigma to the intrapersonal.

Contemporary feminist scholars attest the resilience and strength of gender norms: “despite the impact of feminism and deconstruction, gender has not been abolished, but continues to be reinscribed in our identities, desires and thought” (Thomson and Holland 1997:2). Whereas gender norms are contextualized (i.e., they intersect with norms of race, sexuality, age, etc.), women’s intrapersonal negotiations of self and identity are created in reference to and measured against salient gender norms. Each woman’s conception of gender norms shapes her view of the “tribe” of womanhood of which she is expected to be a member. As in other tribes, norms are communicated interactionally—interpersonally transmitted, symbolically created by mass culture, and institutionally reinforced by policies and practices. Drawing on Hughes’s (1945) conceptualization of “master status,” if being a woman is one’s master status, then one is expected to meet stereotypical expectations of femininity, including norms of sexual morality and behavior. Patriarchal views of femininity

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have highlighted socially meaningful categories of women at both ends of the sexual morality spectrum: "God's police" are posed in opposition to "damned whores" (Summers 1975).4

Research on adolescents' commentaries about sex found that one ideology dominated among both young men and young women: "the gender ideology linked with the 'double standard' in which males are morally elevated by multiple sexual encounters while females are morally demeaned" (Eyre, Davis, and Peacock 2001:13). My data confirm the significance of this ideology for women trying to make sense of STD diagnoses. Sexual health scholars agree that the traits our society associates with contracting other STDs—"indiscriminate promiscuity, pollution, and uncleanness" (Lawless, Kippax, and Crawford 1996:1371)—are incongruous with cultural definitions of feminine "goodness." Historically, medical views have posited the female body as "unclean, weak, and ill," justifying the representation of women "as the source of sexually transmitted diseases, a view which served to validate the sociocultural image of woman as dangerous" (Leonardo and Chrisler 1992:2). For example, syphilis was symbolized by the image of "the corrupt female" (Gilman 1988:254).

In this vein, physicians constructed a spectrum of STD culpability: "innocent patients" at one end, "problem girls" at the other (Davidson 1994). STD epidemiology viewed "problem girls" as having contracted these diseases willfully and serving as the "major vectors of disease" by virtue of low morals and promiscuous behavior. The moral division between respectable and disreputable women came to be represented through medical metaphors of sexual disease.

To claim that the receipt of an STD diagnosis can be a stigmatizing experience for women is to claim that women perceive a unique relationship between the attribute, a chronic STD, and the negative stereotype, the promiscuous bad girl or fallen woman. In this article, I explore how the good girl/bad girl dichotomy can be conceptualized as two "tribes" of femininity. I argue that women with chronic STDs are often viewed by others and by themselves, via Cooley's "looking glass self" ([1902] 1964), as members of the bad girls tribe. Easily identifiable members are prostitutes, porn stars, and exotic dancers. However, implicit membership extends to the variety of girls and women who have been interactionally labeled as some variation of "slut" or "tease." Conceptually, this tribe emerged from grounded theory analysis of women's initial constructions of meaning in STD diagnostic interactions. The data show that membership in the good girls tribe is fragile, requiring strict adherence to gender norms of sexual morality. Downward mobility into the bad girls tribe can be accomplished with startling ease. This article demonstrates how contracting herpes or HPV more than qualify as serious transgressions and threaten women with tribal stigma at the diagnostic stage in their moral careers as STD patients.

Drawing on illness narratives of forty-three women living with genital herpes and/or HPV, this article addresses the following six questions: How do women come to learn the sexual and moral criteria of feminine "goodness" and "badness"? What are the gendered lessons they learn about the status implications of contracting an
STD? How do women make sense of being diagnosed with a chronic STD? How does a woman’s prediagnostic view of herself as a sexual being serve to contextualize her experiences of diagnostic stigma? What intrapersonal challenges are posed by internalizing diagnostic stigma? Finally, what are the macrolevel public health implications for socially constructing and interactionally reinforcing the idea that STD-infected girls and women are “bad”? In exploring these questions, this article illuminates important facets of stigma, with a focus on diagnostic encounters as the beginnings of event series that will ultimately shape the women’s redefinitions of their sexual selves and social relationships.

SETTING AND METHOD

While a professional sexual health educator, I began to question how infected individuals managed the challenges of living with chronic STDs. Having conducted survey research that found women to have strong preferences for maintaining confidentiality of sexual health statuses, I determined that in-depth interviews were best for obtaining valid data. The challenge was to locate myself as researcher in the “same critical plane as the overt subject matter” (Harding 1987:8). In this way, I viewed my values and actions as empirical knowledge that might either support or weaken my findings.

Semistructured or unstructured interview designs have been favored by ethnographers because they produce “non-standardized information that allows researchers to make full use of differences among people” (Reinhart 1990:19). During the interviews, I used researcher self-disclosure of my own STD status to create and maintain rapport, and I included self-reflexive reporting of the interview process as part of the transcribed data I analyzed (Reinhart 1990). In keeping with Oakley’s (1981) feminist critique of interview methodology, I did not rule out answering questions asked by participants. Rather, I incorporated a reciprocal intention and communicated my willingness to answer sexual health questions (e.g., modes of transmission, diagnostic procedures, treatment options) after the conclusion of our “official” interview.

I was required to protect participants’ confidentiality by using pseudonyms and not directly recruiting participants. Rather, subjects had to approach me, usually after hearing my presentation on sexual health, seeing my flyers, or hearing about my research from other participants. The criteria for participation included being at least eighteen years of age, having been diagnosed with genital herpes and/or HPV, and a willingness to talk in depth about their illness experiences. As has been the case with many studies of individuals living with HIV and AIDS (Cranson and Caron 1998; Grove, Kelly, and Liu 1997; Sandstrom 1996), I employed a convenience sampling method because of the sensitive nature of the topic. Once interview subjects contacted me, I gained entrée and acceptance via my status as a sexual health educator and a “complete member” (Adler and Adler 1987): at age twenty, I had been diagnosed with a cervical HPV infection. I concluded interviews with requests
to the participants to mention my study to other women who might be interested. In this way, I used snowball sampling to generate interviews (Biernacki and Waldorf 1981). In keeping with grounded theory, I aimed to sample for theory construction rather than for representativeness (Charmaz 1995). The end sample size results from ethical restrictions on subject recruitment: I could not obtain a list of all the women who met the sampling criteria and then create a random sample.

The subjects ranged in age from nineteen to fifty-six: thirty-eight were Caucasian (including Jewish, Greek, and Persian ethnicities), three were Latino, one was African American, and one was Native American. Socioeconomically, they ranged from working class (9) to upper class (1), with the majority identifying themselves as lower middle (5), middle (18), or upper middle (10) class. The respondents represented a wide variety of religious upbringings and current practices, including Buddhists, Christians, Jews, Muslims, Pagans, Protestants, and Southern Baptists. The largest religious representation was Catholic (12), although fourteen said they had been raised with no religion and nineteen said they were currently nonreligious. In terms of sexual identity, the majority (37) identified as heterosexual, five identified as being bisexual, and one identified as a lesbian.

The interview gave each woman the opportunity to discuss with me her experiences with specific sexual health issues. I conducted the interviews in private locations of the subjects' preference. The interviews lasted from forty-five minutes to two hours and were tape recorded with the permission of the subjects. Single interviews have been criticized for providing a glimpse into a life rather than the whole story (Rubin and Rubin 1995). However, the sensitivity of the subject matter (willingness to participate was dependent on only having to talk once) and transitory nature of the sample (approximately 75 percent undergraduate or graduate college students) made it difficult for me to conduct follow-up interviews with participants. Inherent in the inability to conduct follow-up interviews with participants, I was also unable to receive input on my final analysis from all participants. However, six participants remained in contact with me after being interviewed. I asked for and received their comments on preliminary drafts of articles from this study.

In all, I conducted forty-three conversational, semistructured interviews with consensual subjects. When I had interviewed approximately thirty women, I reached a point of initial saturation: the emerging conceptual categories of my analysis had begun to gel, and each new interview served to confirm rather than to create new categories. However, in acknowledgment of the self-selection bias of my sample and lack of representativeness with regard to race or ethnicity, class, age, and sexual identity I continued to accept new invitations to interview. I hoped to expand the diversity of my sample as much as possible and further test the validity of my analytic coding. A few of the new interviews allowed me to refine coding categories, and with the conclusion of my forty-third interview I reached the point of saturation.5

I analyzed the data according to the principles of grounded theory, using constant comparative methods to adjust analytic categories to fit emerging theoretical concepts (Glaser 1978; Glaser and Strauss 1967). Initially, I used introspection
(Ellis 1991) to hypothesize stages of how the sexual self was transformed by a chronic STD. Over time, I verified some categories and discarded others as data patterns reappeared. With each interview, I clustered subjects' experiences around particular stages to assess the validity of my initial model. The resulting evolutionary analysis was what Wiseman (1970) called a “total pattern”—a sequence of events that held true for the group studied. The six stages of sexual-self transformation developed as follows: sexual invincibility, STD anxiety, diagnostic crisis, stigma management, healing and treatment, and reintegration. This article focuses on the women's creations of meaning during diagnostic encounters, “a realm that has special meaning, and in which a particular language of reality is binding” (Radley 1994:99).

STD DIAGNOSES: GATEWAYS TO TRIBAL STIGMA

When asked to describe their diagnostic encounters, the women first recalled different degrees of “diagnostic shock” (Charmaz 2000), depending on whether they had noticed symptoms before the medical visit. They then described the emotional impact of finding out that something was seriously wrong with their bodies. Similar to the chronically ill men studied by Charmaz (1994), diagnoses triggered “identity dilemmas” for the majority of the women. What kind of women were they to have contracted an STD? How did they now feel about themselves as sexual beings? What were the social implications of their new sexual health statuses?

At this point in their moral careers, most of the women could be categorized as fairly discreditable (Goffman 1963): by virtue of patient confidentiality, each woman was only explicitly discredited to her practitioner. My analysis, however, hinges in on their perceptions of stigma, “what the putatively stigmatized think others think of them and ‘their kind’ and about how these others might react to disclosure” (Schneider and Conrad 1981:212). As the women entered the diagnostic crisis stage, many had their worst fears confirmed and began the process of defining the meanings and consequences of now “official” STD statuses.

Prediagnostic Lessons: Cultural Messages about STDs

The social history of sexual disease in the United States reflects a tradition not only of assigning moral responsibility to those infected with STDs but also of differentially assigning moral stigma on the basis of gender, race, and class (e.g., Brandt 1987; Luker 1998). The social hygiene movement of the Progressive Era saw physicians and female moral reformers combine forces to more explicitly shape the moral boundaries of sexual behavior under the justification of public health. However, these boundaries were gendered with regard to venereal disease. A doctrine of physical necessity justified men's forays into promiscuity. In contrast, “the cowardly and cruel theory of innate depravity has been industriously disseminated as applying to ‘fallen women’...[M]en, the stronger, have remained free from blame; women, the weaker, have lived under a curse” (Dock 1910:60).
Following a modified life history format for interviews, I asked the women to discuss when they had first learned about sex in general and STDs in particular. I also asked them to relate any sexual or STD-related gossip, rumors, or jokes they had heard before their own STD diagnosis. My goal was to discover the processes through which each of them had learned to think about sexual norms and values and how they learned to assign symbolic meanings to girls and women who contracted STDs. "Since definitions of illness are ultimately cultural products, their meanings are influenced by social attitudes and cultural stereotypes" (Grove, Kelly, and Liu 1997:318). To analyze the intrapersonal impacts of STD diagnoses on these women, I had to first understand their prediagnostic heuristics.

"Suzy Rottencrotch" and Other Members of the Tribe

When I asked each woman to reflect on what she had learned about sexually diseased women, all conveyed similar imagery. Analytically, I conceptualized this pattern as the definitional building blocks for a gendered experience of tribal stigma. The women's stories of how they learned to think about women with STDs served to construct a stigma theory, "an ideology to explain [the stigmatized individual's] inferiority and account for the danger [that individual] represents" (Goffman 1963:5). According to the data, the women assigned auxiliary traits of promiscuity, dirtiness, low class, and irresponsibility to the "type" of woman who would contract an STD. As Goffman (1963) noted, stigma theory often incorporates rationalizations of animosity toward stigmatized individuals based on status differences, such as social class.

Historically, public opinion and public health campaigns have targeted sexually active, working-class, and racial or ethnic minority women as the "vectors and vessels" of sexual disease (Davidson 1994; Luker 1998; Mahood 1990). For example, those in the lower economic classes, particularly women, have been viewed as transmitters of disease to wealthier classes. Several of the women described racial and socioeconomic dimensions of the bad girls tribe. Rhonda, a twenty-three-year-old Cuban American working-class administrative assistant, described how she had conceptualized women with STDs before her first herpes outbreak. She painted a picture of poverty and substance abuse: "She'd be dirty. . . . I guess I would picture somebody who's really skinny, like sickly skinny, and just not clean. She'd probably have cold sores . . . like a crack-head." Jasmine, a twenty-year-old white upper-middle-class undergraduate had the perspective of a privileged upbringing and added an educational component to tribal membership: "People [who get STDs] are dirty or just not as intelligent. You know, not smart enough to be safe." Haley, a twenty-two-year-old white upper-middle-class undergraduate, added irresponsibility as a tribal trait. She had learned to assume that a woman who contracts an STD "isn't responsible, just going out and partying, and just not really caring about what they're doing and not watching out for themselves[,] . . . someone who doesn't even know what they're doing half the time." Monica, a twenty-one-year-old white
middle-class undergraduate, added a racial dynamic to the social construction of this social class of women. Her high school health class featured "teenage mothers" as guest speakers to educate girls about the price of female sexuality. All of these teen moms were African Americans or Latinas from economically disadvantaged areas. As a white teenager from a middle-class home, Monica remarked that she felt "removed" from the risk of joining their ranks because these girls were "different in all those ways."

The age at which moral meanings became attached to STDs was fairly consistent among participants. While a few of the women recalled overhearing others' comments about STDs during childhood, all cited junior high or middle school as the time when their sexual health ideologies took shape. When asked what ideas they had about people with STDs during junior high and high school, all of the women described a consistent stereotype. Cleo, a thirty-one-year-old white middle-class graduate student, remembered how her high school health teacher had presented STDs as "awful" and "bad," so she "thought that only bad people had STDs." Kayla, a twenty-two-year-old white working-class undergraduate, told of having learned myths about the character blemishes of dishonesty and treachery embedded in stories about sexually diseased women who lied to their partners about their sexual health statuses and risked infecting them.

Because of religious lessons about sex, many of the women had learned to associate premarital sex and promiscuity with sin. For example, all twelve of the women who described themselves as having been raised Catholic recalled learning that STDs were connected to deficiencies in spiritual "goodness" that are manifested as "bad" behavioral choices. As an adolescent, Francine, a forty-three-year-old white middle-class health educator, remembered her Catholic school showing a sex education movie that gave her "the message that there's something very bad about having sex." She recalled, "That film showed sexuality being a temptation of the devil." In her social construction of sexuality, STDs became the mark of the sinner. Ingrid, a twenty-three-year-old white middle-class undergraduate, had learned from a nun, her Catholic school teacher in seventh grade, that she "didn't have to worry about STDs because [she was] a good Catholic." Implicit in this lesson was the message that those who contracted STDs were lacking in piety and moral fortitude. Such lessons were not limited to Catholicism: all of the remaining thirty-one women, raised in variety of faiths, used derogatory adjectives to describe the explicit and implicit lessons from their childhood and adolescence about people with STDs.

The women's agreement on the trait of promiscuity was unanimous. Before contracting HPV, Cleo, thirty-one years old, had believed that "you had to be really promiscuous to get an STD." In high school, Ingrid learned the connection between being a bad girl and having an STD when she befriended a girl who had been "forced into prostitution at age eleven and had contracted several STDs, including syphilis and gonorrhea." In college, Tanya, a twenty-seven-year-old white upper-middle-class graduate student, also learned to connect STD status with being a woman who "slept around a lot." When rumors got out that a female student (named
Dee) had herpes, she and others mocked this woman by calling her “ST. Dee or V. Dee” and by ostracizing her from their social group. Being excluded from desirable social groups was another price to pay for being labeled a bad girl.

Tasha, a thirty-year-old white middle-class graduate student, clarified the gendered aspect of promiscuity when recounting the myths she had learned: men contracted STDs “from wanton women,” not vice versa. Diana, a forty-five-year-old African American upper-middle-class professional, had had a similar attitude as a teenager: “I didn’t think that I would ever be around anybody who would have something like that. You know, just kind of scum-of-the-earth people had it . . . like, men who hung out with prostitutes.” Hence, the double standard of STD morality: good men can be infected, but any woman with an STD is a bad woman. Ingrid, twenty-three years old, confirmed the inequity evident in standards of sexual morality. She recalled one female classmate in junior high who was not known to be sexually active but “was considered a slut just because she grew boobs.” Thus this classmate served as a tease to the unrequited desires of her male peers. Highlighting the gendered nature of this category, she talked about a boy of the same age who was sexually active and positively regarded by peers as “the shit.”

One woman described how military institutions clarify the rules of membership for this tribe. Chris, a forty-year-old white professional, recounted a tale of the infamous “Suzy Rottencrotch,” a fictional character created by the military to exemplify the sexually diseased woman. Her former husband had shared with her his experiences with U.S. military programs on STD prevention. According to him, the programs relied heavily on the legend of Suzy, a loose woman/prostitute who would tempt men on leave to stray from their “good wives” who were faithfully chaste (and “clean”) back home. This example clarifies how Suzy and her kind represent a different breed of women, the polar opposite in a moral dichotomy of female tribes: the “bad” versus the “good.”

Contemporary U.S. ideologies of feminine sexual morality shaped interpersonal interactions in which the women learned symbolic meanings and consequences of STD infection for girls and women, in contrast to that of boys and men. Bad girls and fallen women were described as having gained their stigmatized affiliation by breaking the feminine moral code of their antithesis, the good girls or women. “The stigma attached to venereal disease then is generated not by who the person is, but rather by what the person no longer is” (Fox and Edgely 1983:70). Is a woman with an STD no longer “good”? This question would become personal and highly relevant in the context of receiving herpes and HPV diagnoses.

Patient-Practitioner Interactions

The diagnosis itself is key to the moral careers of women with STDs because it can be taken as “evidence” that they possess attributes that differentiate them from other women, other good women. As Frank (1998) noted, “deep” illness experiences can trigger alterations in identity, and Kelly (1992) connected awareness of
illness not only to identity transformation but also to social status degradation. Chronic and serious illness increases the possibility for affected individuals to become self-aware "that these differences are undesirable in themselves and likely to be appraised by others as undesirable" (Kelly 1992:397).

**Medical Meanings of Diagnoses**

Few studies examine microlevel interactions in sexual health services, especially from patients’ perspectives. Such studies have the potential to illuminate issues at the interface between medical practitioners and patients, such as the prevalence of "moral evaluations" of patients (Roth 1972). All of the women studied viewed their practitioners’ deliveries of their diagnoses as formative in how they initially processed medical and symbolic meanings of their STDs. The content and style of practitioners’ diagnostic presentations varied and, in different ways, served to exacerbate or diminish the women’s perceptions of stigma.

A key factor that shaped the medical meanings of the diagnosis was whether the practitioner had presented accurate information about transmission, treatment, and prognosis. During interviews, the women assessed their practitioners’ degree of accuracy in retrospect, as most had researched their diseases or sought out second opinions after receiving their initial diagnoses. In all, twenty-four women reported feeling initially devastated by the physiological implications of how STDs had permanently harmed their bodies. Practitioners had reinforced their concerns that their infections meant permanent damage. For example, Summer, a twenty-year-old Native American working-class clerical worker, remembered the exam when she was diagnosed with genital warts. For her, the most horrible part was her practitioner explaining to her that it was not curable. Several of these women asked their practitioners directly to clarify the chronic nature and the implications of their diagnoses. In one case, Gita, a twenty-three-year-old Persian American middle-class professional, admitted that she “freaked out” when she was diagnosed with genital warts. She asked her practitioner, “Is this a lifetime thing? Am I gonna have another [outbreak]? I felt very unsure.” Implicit in the incurable nature of these diseases was the long-term responsibility of being contagious. Haley, twenty-two years old, also remembered being more upset by the idea of infecting others than by the fact that HPV was incurable. When her practitioner told her that she could transmit genital warts to sexual partners, Haley recalled feeling “bad”: “What made me feel worse than knowing that I had it was that I had the capability of giving it to somebody else.”

In contrast to the above women, the other nineteen women in this study left their diagnostic interactions feeling less stigma of bodily abomination because their practitioners had helped them to see that their chronic STDs were, to some degree, manageable physical conditions. Sandy, a twenty-one-year-old white middle-class undergraduate, saw a practitioner who told her that her cervical HPV infection was not only treatable but also statistically “normal”—a fact she found very comforting.
Elle, a thirty-two-year-old white working-class graduate student, had a doctor who helped her to understand that although herpes may not be curable, the outbreaks may decrease in severity and duration over time. Her practitioner also detailed treatment options that could alleviate symptoms and shorten the length of outbreaks.

Other practitioners in this subgroup fostered a lack of knowledge that served equally (if not genuinely) well in minimizing health fears. Many of the women felt calm after receiving STD diagnoses because their practitioners had not fully explained the chronic nature of the infections. In a few cases, practitioners gave significantly incorrect information about the contagious aspects of the STDs in their diagnostic interactions with patients. Helena, a thirty-one-year-old Greek American middle-class graduate student, received incorrect and incomplete information about HPV and “almost felt like [the practitioner] was going to treat the warts, and then everything was going to be fine . . . because nothing else was really explained.” Several practitioners left their patients with similar false senses of well-being; they told the women that their HPV infections were not serious because the virus could not be transmitted to male partners. Previous health research has found that many HPV patients “were initially informed that they had a ‘virus’ or ‘condyloma.’ The sexual route of transmission and the implications of the disease were not even mentioned” (Keller, Egan, and Mims 1995:358). My data confirm this finding and reveal that in such cases this lack of information reduced the women’s initial perceptions of diagnostic stigma.

Moral Meanings of Diagnoses

Analyses show that while practitioners played important roles in shaping the medical meanings of STD diagnoses, they had less affect on the symbolic meanings. Not even the most compassionate and knowledgeable practitioner succeeded in undoing the years of socialization that had shaped their patients’ perceptions that STDs were associated with the lower social caste of immoral and promiscuous women. However, sixteen of the women reported having received diagnoses from practitioners who acted in ways that exacerbated the women’s fears of being seen as less than or worse than “good” women.

For this subgroup, the demeanor, actions, and language of their practitioners revealed judgment and condemnation of female patients with STDs. Diagnostic interactions with moralizing practitioners generated an immediate realization of the demoralizing interpersonal implications of having an STD. In some cases, the participant perceived general disgust and revulsion toward them on the part of practitioners. For example, Chris, a forty-year-old who had scheduled a gynecological appointment because of a painful first herpes outbreak, described her doctor’s interactions with her as if he were a car mechanic assessing a vehicle whose irresponsible owner had created a horrible problem. “He just looked at my crotch and said, ‘Yep, that’s herpes,’ and sort of slammed my knees back together, like. Let’s close this back up, like a car—slam the hood down! Don’t want to see anymore of
this one.” In another case of perceived tactile communication of disgust, Julia, a fifty-year-old white middle-class professional, observed her doctor “pulling back” when he examined her, “like he didn’t really want to touch my leg, like I was contaminated merchandise.”

Practitioners also expressed negative feelings verbally about the women to whom they delivered news of a serious shift in health status. Louise, a twenty-eight-year-old white middle-class graduate student, received a harsh HPV diagnosis over the telephone. “He was very accusatory, like now I was this big pain in the ass for having a bad pap smear. . . . I got him on the phone, and he’s like, You have cancerous growth all over your cervix: it’s everywhere. It’s probably HPV. You probably picked it up from some guy.” Not only had her doctor described a very significant part of her body as ravaged by cancer, but he had also marked her as promiscuous. Her case illustrates how swiftly a woman can first face the stigma of bodily abomination and then rapidly feel the stain of blemished character and tribal stigma.

In some of these cases, the women perceived their practitioners as doubting both their morality and their intelligence. Such encounters left the women feeling like their characters had been doubly tarnished. When Jasmine, twenty years old, saw a gynecologist for her first outbreak of external genital warts she recalled her doctor asking, “Well, you’ve had unsafe sex?” She remembered: “[I felt] like I wanted to pull out my SAT scores and tell her, ‘Just look—I’m not stupid!’” Looking back on her diagnosis, she admonished, “Someone in the health field should be objective about it and should be there to help you and to answer questions and not say, ‘You’ve done the wrong thing.’” When Violet, a thirty-five-year-old white engineer, was given an HPV diagnosis, her nurse reprimanded, “You should use condoms.” In response to Violet’s disclosure that she had many casual partners whose STD status she did not know. Violet, whose nurse had labeled her promiscuous and stupid for not practicing safer sex, resented the nurse’s choice to go “off on a moralistic trip.” Essentially, these practitioners encouraged their patients to reduce their moral identities to those of women neither good enough nor smart enough to avoid getting spoiled by STDs. Violet’s and the other women’s concerns of being viewed as women of poor character reflect larger fears of being socially “reclassified” as belonging to a different and lesser category of women.

The interactions of these sixteen women with practitioners magnified concerns they already had about how others would react on learning about, seeing, or feeling their STD symptoms. This subgroup of women logically concluded that if a medical practitioner, whose training presumably stressed objectivity, could blithely assassinate their characters, then those beyond the walls of the examination room might dole out even harsher judgments. We must note that twenty-seven women described their practitioners as ranging from “kind” to “matter-of-fact” and did not feel that their practitioners actively reinforced the negative stereotypes of promiscuity or immorality. However, prediagnostic lessons about bad girls and fallen women provided the contextual backdrop for all of the women’s sexual-self assessments during the diagnostic stage of their moral careers.
Contexts of Diagnostic Meaning

Previous research asserts that STD stigma “represents a total social identity, an identity devoid of qualities which would attract desirable persons” (Fox and Edgely 1983:70). Receiving medical results and confirmation of an official diagnosis, these women faced the challenge of whether to revise their actual social identities into that of fallen women. Though 75 percent of the women described feeling that their newly diagnosed bodies were “dirty,” each woman’s unique sexual-historical framework served to filter the amount of tribal stigma she internalized.

Romantic Relationship Status

Although practitioners served the role of the first “other” who discredited their STD statuses, most of the women’s immediate stigma management concerns shifted from the real interactions with their practitioners to the imagined interactions with significant others. Relationship status—whether the women were single, casually dating, or in a committed romantic relationship—affected how they imagined their STDs might affect their social status. They described how they began to evaluate internally potential ramifications in the medical office, after the practitioners had presented the diagnosis. The women employed a process of self-reflexivity and began to imagine how others, especially current and future sexual partners, might view them in light of their new STD status.

The women in committed intimate relationships felt buffered from the full effect of shame and fear of moral condemnation. For almost half of the women, long-term and monogamous relationships acted as shields from judgment, easing the moral shock of an STD diagnosis. Amelia knew that she could “talk about anything,” including her cervical HPV diagnosis, with her fiancé because he was “very sexually secure.” Similarly, Sierra, a twenty-three-year-old white administrative assistant, felt that having a boyfriend tempered her genital warts diagnosis: “I think I’m really fortunate in that I’m in a relationship right now that’s absolutely amazing. . . . I also feel like he and I are pretty long term.” Robin, a twenty-one-year-old white undergraduate, remembered her boyfriend as having a positive attitude: “I was really lucky to be with someone that was secure in how he felt about me. . . . And I think he was like ‘we both have it,’ it wasn’t like one person did and one person didn’t.” She was grateful to have his support at the time of her diagnosis. By having partners reaffirm their worth, these women felt absolved from moral condemnation to some extent.

A few of the women expressed relief that they had not been dating casually at the time of diagnosis because that allowed them to delay the additional stress of being morally judged by a new partner. Sandy, at twenty-one, was “glad to be single” and did not plan on dating any time soon because she wanted to get treated and put the STD “behind” her without having to deal with possible rejection. Mary, a fifty-one-year-old white lower-middle class widow, had “not had sex” since her diagnosis
with genital warts. She wanted to avoid the “humiliation” of talking about her STD. Being single and celibate seemed to provide less of an immorality “buffer” than having a committed relationship. However, the women perceived celibacy as offering less risk of moral scorn than casual dating. These findings speak to high levels of concern about the social ramifications of possibly being perceived by others as a bad girl or fallen woman.

**Prediagnostic “Good” Girl Status**

The culture had taught these women to evaluate the moral status of other women through assessments of their sexual behaviors. Hence they found themselves struggling to ascertain the relevancy of prediagnostic tales about the type of women who contracted STDs. They described looking to their unique sexual narratives for answers to how they had come to “earn” this mark of immorality. Thirty-five of the women saw themselves as having far too limited levels of sexual experience and, in turn, far too high sexual morality to “deserve” their infections. Examples of these women were Monica, twenty-two, who contracted external HPV as a “technical” virgin (i.e., skin-to-skin transmission occurred without penetrative intercourse), and Ingrid, twenty-three, who contracted cervical HPV from her first sexual partner.

A few of the women verbalized the question Why me? when they struggled with STD stereotypes of immorality. Helena, thirty-one, recalled postdiagnosis emotions and questions: “I just came home from the doctor, and I felt so dirty—why was this happening to me?” Rebeeca, a fifty-six-year-old white upper-middle-class professional, was shaken when she was diagnosed with herpes: “All of a sudden, it did have something to do with me—my first reaction was, ‘Who, me?’”

Several of the women recalled their earlier conceptions of bad girls and fallen women as they tried to discern what their diagnoses meant for their symbolic status as women. Louise, twenty-eight years old, related that she received her cervical HPV diagnosis over the telephone and immediately thought that this meant she was a “slut.” However, she was conflicted about this: “I haven’t had that many sexual partners. I’ve been fairly careful. . . . Who could I have gotten it from?” Likewise, Hillary, a twenty-two-year-old white middle-class undergraduate, could not believe that she had contracted HPV: “I just thought [STDs] happened to promiscuous, slutty people.” Haley, twenty-two years old, also diagnosed as an undergraduate, described feeling jarred and distracted during her diagnostic encounter as she struggled with the contrast between who she thought she was and the type of people she thought got STDs: “I was pretty overwhelmed. . . . I have this disease, but I never thought I would get it. I never thought I would be one of those people. And here I am.” In contrast to Haley’s surprise, Jenny, an eighteen-year-old white upper-middle-class undergraduate, described how receiving her cervical HPV diagnosis caused her to reflect on how she could have been so naïve as to have believed she was one of the “good girls.” As the practitioner delivered the diagnosis, “Well, I kinda felt like a slut. . . . I wasn’t thinking that when I got to ten, or however many
people I had sex with, that I would look back and be like, Oh, my god—I’ve had sex with ten people!” Anne, a twenty-eight-year-old lower-middle-class graduate student, expanded on the dissonance she experienced:

I feel kind of slimy sometimes when I think about it. Like only slimy people get things like that, and I don’t think of myself as slimy. So it’s—yeah. It kind of doesn’t fit, in a way, with my whole conception of myself. I never thought of myself as someone who would get a sexually transmitted infection and I definitely didn’t—still it doesn’t sit well with my image of myself.

For this subgroup of women, previous “good” moral identities clashed and created intrapersonal conflict over the potential shift to the lesser status of being “bad” and immoral. Having learned consistent messages about STDs equaling promiscuity and promiscuity equaling bad girl or fallen woman, the women perceived their diagnostic encounters as unwarranted and unexpected threats. The curse of two tribes assumed sudden relevance, and the idea of being demoted from good girl to “Suzy Rottencrotch” horrified them.

**Prediagnostic “Bad” Girl Status**

In contrast to the majority, eight of the women perceived their diagnoses as minimally stigmatizing with regard to social identity because they had already experienced the initial shame and loss of status when previous sexual traumas had, in effect, barred them from viewing themselves as “good.” For example, Violet, thirty-five, had survived incest and several sexual assaults that had led her to see herself as “totally tainted” before her HPV was diagnosed. She also saw herself as an “awful slut” who had spent her undergraduate years “sport-fucking,” a term she defined as “making guys beg for casual sex.” Similarly, Julia, fifty, viewed “getting raped” as making her “feel a little looser about having intercourse.” She had thought that trying to view her sexual self as good had no point, “‘cause I’ve been raped and I’m not a virgin anymore.” Having come of age in the early 1960s, she had learned that being a “good girl” required virginity. Violet’s and Julia’s stories exemplify the double bind for women: whether she sees herself as the object or subject of sexual trauma the resulting blow to social identity remains the same.

Several women claimed agency and contended that they had earned tribal stigma before being diagnosed with herpes or HPV. Rhonda, twenty-three, saw herself through her Cuban mother’s judgmental eyes as a daughter who had done a “series of bad things,” including the Catholic sin of terminating a pregnancy—a crisis that she believed held far greater moral and emotional consequences. She reiterated the stereotype of the “promiscuous slut” and confirmed, “I guess I did see myself that way.” Likewise, Amelia, twenty-six, reflected on her days as the “school slut” who was always worried about getting pregnant and was not surprised to find out she had contracted an STD. Natasha, a twenty-year-old white middle-class undergraduate, also saw herself as fitting the STD stereotype of “someone who’d slept around with a lot of people” and felt she “deserved” her genital warts infection. All women
in this subgroup viewed their past social identities as completely congruous with being at risk for contracting an STD. As these women had judged themselves as promiscuous and sexually unhealthy before receiving an official STD diagnosis, their diagnostic encounters did not add a tribal stigma but merely confirmed their preexisting membership.

**Prediagnostic Rejection of the Tribal Dichotomy**

One exception to either of the aforementioned subgroups is Elle, the thirty-two-year-old white working-class graduate student. She did not describe her herpes diagnosis as having threatened her sexual self with tribal stigma. Although she had described being aware of the stereotype that women with STDs were “skanks,” she had come to view STDs as “a probability issue” for anybody having sex. She viewed her practitioner as “very normalizing and very optimistic.” She credited her positive perception of the moral and health implications of genital herpes to the kind nature and educational stance of her practitioner. Theoretically, her case exemplifies the context of entering the STD diagnostic encounter having already embraced a deviant belief system with regard to gendered norms of sexual conduct.

Goffman (1963:6) noted, “It seems possible for an individual to fail to live up to what we effectively demand of him, and yet be relatively untouched by this failure; insulated by his alienation, protected by identity beliefs of his own, he feels that he is a full-fledged normal human being, and that we are the ones who are not quite human.” While Elle’s herpes diagnosis signifies that she has failed to meet the normative standards for feminine “goodness,” she represents the special type of individual described above. She revealed in her interview that she identified as “queer,” reported bisexual experiences, and identified as a member of a sadomasochistic subculture. Elle had insulated herself from the STD-related tribal stigma by having embraced membership in deviant tribes that rejected mainstream norms of sexual morality.

Her example points to an important question: Is it possible to immunize female patients from the threat of tribal stigma? The answer might lie in (1) socializing girls and women to reject the double standard of sexual morality and (2) training sexual health practitioners to explicitly destigmatize STDs and affirm patients’ self-worth during diagnostic interactions. The challenge of investigating this theory would be to generate a sizable sample of women with STDs who meet the criteria.

**CONCLUSION**

Taking a firsthand, experiential perspective, this qualitative research fills some gaps in understanding the gender discourses and interactional processes at work in shaping symbolic meanings and psychosocial consequences of STD diagnoses for women. Through STD diagnostic interactions, these women experienced the fragility and fluidity of the female sexual self. Although Goffman (1963) does not distinguish
tribal stigma as one that applies to gender “tribes,” my data suggest that STD tribal stigma affects women at the intrapersonal level during diagnostic encounters.\textsuperscript{9} Cultural scripts of femininity structure a tribal dichotomy that defines what it means to be a sexual woman. Deviation from the “good girl” script threatens demotion to an unsavory social caste. Tribal stigma can result from a relatively discrepantible STD diagnosis because maintaining the good girl status is inherently unstable.

Invoking Goffman’s (1963) differentiation between the discredited and the discrepantible, the only arena in which the women I studied were explicitly discredited was in the doctor’s office, where their records contained documentation of diagnoses, treatments, and follow-up exams. The women with internal or cervical HPV could “pass” for healthy even when naked and engaged in sexual intercourse. The women with external HPV and genital herpes could pass whenever they were asymptomatic. Given the potential to remain discrepantible in most relationships, why did they experience blemished characters and feel threatened by tribal stigma? I attribute these differences to the specific sociohistorical construction of non-HIV STDs such that women, rather than gay men or intravenous drug users, are posited as the root of these diseases.

Expanding tribal stigma to intrapersonal realms frames my analysis of why and how women with chronic STDs may be vulnerable to its effects. Medical sociologists have not typically found evidence of tribal stigma in individuals whose disorders are easily hidden. In reference to individuals with discrepantible conditions such as Parkinson’s disease, urinary or bowel incontinence, Charmaz (2000:285) found that “guilt and shame increase when chronically ill people view themselves as socially incompetent.” Women with chronic STDs do not exhibit public signs of bodily abomination; yet many experienced feelings of social incompetence in that they fear having jeopardized their status as “good” women.

The master status of gender interacts with STD stereotypes to magnify the experience of STD stigmata for women. In a society that ideologically structures women as a tribe divided over sexual morality, a master health status of being STD infected stigmatizes a woman both morally and socially. Is there a function served by this ideology? If one views sexuality as “socially organized and critically structured by gender inequality” (Walby 1990:121), then a gender-based ideology of double standards for sexual morality functions to legitimate the social-sexual power of men. Researchers studying the gendered implications of STD infections have confirmed that women experience greater degrees of stigmatization and ostracism than do men (Pitts, Bowman, and McMaster 1995). Many cultures construct male promiscuity as evidence of positive masculine traits: “Popular ideas about STDs suggest little stigma is attached to male infection. Having an STD is almost regarded as a rite of passage into manhood, proof of sexual activity: ‘A bull is not a bull without his scars’” (Bassett and Mhloyi 1991:143).

This study points to the fact that this ideology also has an impact on practitioner-patient sexual health interactions. My research supports Lock’s (2000:266) idea that medical agents often act in the best interest of the socially dominant: “It is with
special emphasis on ethnicity and gender differences, that the well-being of some individuals may be exploited in any given society for the sake of those with power.” Feminist scholars have long criticized Western medicine as a significant contributor to sexist ideologies (e.g., Delaney, Lupton, and Toth 1988; Ehrenreich and English 1973). This research highlights how the majority of male and female sexual health practitioners do not work to dismantle an ideology that promotes gender inequality. A comparable study of men with chronic STDs would be able to test the hypothesis that the gender of the patient correlates with the degree to which the patient perceives an STD diagnosis as stigmatizing.

STD stigmata are not born within clinic walls. Public health efforts to destigmatize STDs must address the prevalence of an ideology of sexual morality that promotes a gendered double standard. Research on this ideology proposed that if it “is mobilizing a great deal of rhetorical and self-justificational energy, then sexual behavior is likely also to be affected by that ideology since sexual behavior is itself a major asset/liability in moral self-presentations” (Eyre, Davis, and Peacock 2001:14). My research demonstrates how this ideology influences women’s experiences of chronic STD diagnoses interactionally such that tribal stigma threatens their moral self-presentations. Future research on the experiences of men and women with chronic STDs should examine the potency of gender norms on individuals’ experiences of stigma and identity dilemmas, especially with regard to tribal stigma.

From an applied standpoint, this study adds the sociological dynamic of stigma to clinical research on STD diagnostic encounters. The data confirm that women were often emotionally distraught during diagnostic encounters. One study on the clinical needs of HPV patients found that patients who experience the diagnosis as a threat to not only their health but also their morality and sexual self-conception have impaired abilities to absorb vital medical information:

> These emotional responses can block an individual’s ability to take in further information about the disease and its treatment. . . . The content of any counseling and education intervention depends partly on the needs expressed by the client. Thus, it is very important to assess the meaning the individual assigns to the infection. (Keller, Egan, and Mims 1995:359)

The data illustrate this point by showing how patients can be overwhelmed by illness stigmata during diagnostic encounters.

From a public health perspective, the protocol of STD diagnostic interactions, including health education, should reflect interactionist understandings of issues that relate to society’s ideology of sexual morality. To address a newly diagnosed woman’s concerns about social status, practitioners, health educators, and health education materials must explicitly address the gendered conceptualization of sexual morality that maintains a bad girl/good girl dichotomy. Public health campaigns should focus on exposing and subjecting this ideology to critical analysis. Protocol for patient care should reflect research findings on the emotional impact of diagnoses. Successful STD public health campaigns, interventions, and practitioner
guidelines must address the ways in which patients assign meanings to their illnesses and assess both intra- and interpersonal ramifications.

Acknowledgments: I wish to thank Patti Adler, Stephen Marks, Lora Lempert, José Marichal, and Jen Vineyard for their support and advice throughout this article’s evolution and the editor and anonymous reviewers of this journal whose comments strengthened this piece. I am grateful to the Society for the Study of Symbolic Interaction’s 2001 Blumer Award Committee for their critique and encouragement of an earlier draft. Earlier versions of this article were presented at the 2001 annual meeting of the American Sociological Association and the 2000 annual meeting of the Society for the Study of Social Problems.

NOTES

1. The disparity in HPV statistics can be traced to the fact that many infected individuals remain asymptomatic or experience warts that are so small and painless that infected individuals are unaware they have contracted the disease and do not seek medical attention.

2. Though relatively harmless, some types of HPV cause cervical cancer. In the United States each year, about 14,000 women are diagnosed with cervical cancer, causing the deaths of 5,000 (ASHA 2000b). Medical research has also found that contracting one STD increases an individual’s likelihood of contracting others, including HIV (CDC 2000).

3. A previously published article addresses postdiagnostic stigma management (Nack 2000), and a forthcoming manuscript explores how their sexual selves transform and reintegrate throughout individualized experiences of treatment and healing.

4. Contemporary feminist critiques caution against reifying “either-or” categories (see Wilton 1997). “Bad” versus “good” girls and women could be viewed as reifying a sexist double standard of morality. I take this risk to push the theoretical implications of Goffman’s (1963) tribal stigma and intend my analysis to help dismantle an ideology of double standards for sexual morality rather than to perpetuate “woman-as-victim” discourse.

5. A similar study with ethical and practical allowances to organize a larger and randomly selected sample may reach different analytic conclusions.

6. Because of the chronic nature of both viral infections, many patients perceived their physical symptoms as permanent during diagnostic encounters. A forthcoming manuscript addresses how these perceptions often changed after treatments eliminated or lessened symptoms.

7. A woman may be infected with more than one strain of HPV, such that diagnosis of a cervical infection does not rule out the possibility of having a future outbreak of external warts or transmitting the infection to a male partner.

8. As practitioner-patient interactions often magnified STD stigma, I allude to “do’s and don’ts” of practitioner interaction style. This is, however, the focus of a forthcoming article.

9. A forthcoming manuscript explains how the majority of the women overcome STD tribal stigma through critical self-analysis and antisezist re-visioning of an ideology of sexual morality.

REFERENCES


