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## **damaged goods: women managing the stigma of STDs**

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This article uses interview data to explore how 28 women diagnosed with chronic sexually transmitted diseases (STDs) managed the impact of stigma on how they saw themselves as sexual beings. Constant comparative analysis reveals the ways in which they manage the stigmatized sexual health status of genital herpes and human papillomavirus infections. Findings from this study indicate that the women engaged in a three-stage process of reconciling their spoiled sexual selves. First, the majority of them passed for healthy; some covered by lying about what was happening to their bodies. Second, almost all used stigma transference to deflect the blame onto real and imaginary others. In the end, all of the women preventively or therapeutically disclosed to intimate others. The data suggest, through a narrative model of the self, that the women viewed their sexual selves as "damaged goods" yet prevented the stigma from infecting their core self-narratives.

The HIV/AIDS epidemic has garnered the attention of researchers from a variety of academic disciplines. In contrast, the study of other sexually transmitted diseases (STDs) has attracted limited interest outside of epidemiology and public

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health. In the United States, an estimated three out of four sexually active adults have human papillomavirus infections (HPV—the virus that can cause genital warts); one out of five have genital herpes infections (Ackerman 1998; Centers for Disease Control and Prevention [CDC] 1998a). In contrast, the nationwide rate of HIV infection is approximately 1 out of 300 (CDC 1998b). Current sociological research on the interrelationships between sexual health, stigma, and the self has focused overwhelmingly on HIV/AIDS (Sandstrom 1990; Siegel and Krauss 1991; Weitz 1989).

The social psychological perspective has addressed the role of social learning and psychological factors on shaping the meaning and practice of sexuality in different cultures and on developing sexual orientations and identities with regard to choice of sexual partners (Strong, DeVault, and Sayad 1996). A research focus has been psychosexual development: "factors that form a person's sexual feelings, orientations, and patterns of behavior" (Kelly 1998:157). Symbolic interactionist accounts of sexuality have addressed "the process of becoming sexual—something that is learnt and negotiated in a complex sequence of events" (Walby 1990:114). However, there has been a lack of theory building around the question of how individuals' conceptions of themselves as sexual beings exist in relation to their core or overall self-concepts.

This article focuses on how the sexual self-concept is transformed when the experience of living with a chronic STD casts a shadow of disease on the health and desirability of a woman's body, as well as on her perceived possibilities for future sexual experiences. The term *sexual self* means something fundamentally different from *gender identity* or *sexual identity*. Invoking the term *sexual self* is meant to conjure up the innately intimate parts of individuals' self-concepts that encompass how they think of themselves with regards to their experienced and imagined sensuality. Components of a sexual self may include the following: level of sexual experience, emotional memories of sexual pleasure (or lack thereof), perception of one's body as desirable, and perception of one's sexual body parts as healthy.

Prior studies have found that adolescents and adults use emotion-focused coping strategies for health problems (Folkman and Lazarus 1980; Spirito, Stark, and Williams 1988). These studies have drawn on social psychological theories of the self that offer insights on components of coping with various ill-

nesses. Pioneers in researching the connection between self-conception and sexual health, Swanson and Chenitz (1993) used qualitative methods to examine the relationship between herpes infections and a "valued" self. Although these researchers theorized a three-stage model of regaining a valued sense of self after a herpes diagnosis, the findings of this study indicate a more complex process. In a related psychological study, researchers used quantitative methods to analyze the coping strategies of adolescent girls with STDs (Rosenthal et al. 1995). Although their findings highlight a typology of coping strategies, the authors concluded by emphasizing the need for further research into how young women cope with STDs as both a medical and an interpersonal problem.

To understand the individual-level experience of living with a chronic STD, it is important to take into account how these infections are symbolically constructed in American culture. The meanings that Americans give to being infected with an STD are intersubjectively formed during interactions. Individuals' experiences of health, illness, and medical care "are connected to the particular historically located social arrangements and the cultural values of any society" (Conrad and Kern 1994:5). Present American social values reflect the longstanding connections between sexual health and morality: Interactions with medical practitioners and lay people are the conduit through which the stigma of STDs is reinforced (Brandt 1987). Pryce (1998) pointed to a critical gap—the "missing" sociology of sexual disease—and asserted that this application of sociology should focus on the social construction of the body as central in the medical and social iconography of STDs.

In answer to Pryce's (1998) challenge, this research expands on the work of Swanson and Chenitz by sociologically analyzing the impact of genital herpes and HPV on women's sexual selves. This study adds to this research area by examining sexual self-transformation, starting from the point of how individuals' sexual selves are transformed by the lived experiences of being diagnosed and treated for chronic STDs. Beginning from a premise that the majority of people grow up feeling sexually invincible, a variety of traumas have the capacity to disrupt a positive sexual self-concept (e.g., molestation, rape, and illness). Social-interactional traumas also transmit messages that can damage sexual selves: Some physical bodies are undesirable; some sexual preferences are unacceptable; some levels of sexual experience are immoral.

This article addresses the process of how women manage the stigma of having an STD. First, I describe the research setting and methods. Second, I develop a conceptual framework for understanding the relationship between stigma management strategies and sexual self-transformation. Then, I analyze the women's self-narratives to evaluate both internal and interactional processes: (a) nonacceptance of stigma, (b) deflection of the stigma onto scapegoats, and (c) reflexive dynamics of stigma acceptance through disclosure. Finally, I conclude by exploring how their stories highlight the adaptation of individual stigma management strategies to a form of deviance that neither takes over core identities nor opens the door to social networks of collective stigma management. The connection between stigma management and identity transformation is explored by applying a narrative metaphor for the self to the women's struggles to keep their core self-concepts insulated from the stigma of STD infections.

### SETTING AND METHOD

The motivation for this study stems from my personal experience with STDs. My "complete membership role" (Adler and Adler 1987) stems from legitimacy and acceptance by other women with STDs as a member of this unorganized and stigmatized group. At 20, sexual health became the center of my world when I was diagnosed with mild cervical dysplasia, the result of an HPV infection. I began an informal self-education process that helped me manage the stress of my treatments. My commitment to managing my sexual health status would become the foundation for this research project and provide me with the personal insights needed to connect with others facing STDs and the clinical knowledge necessary to be a sexual health researcher.

As a campus sexual health educator, I began to question what sexual health services were not provided. Seeing that women and men were being diagnosed and treated for STDs without receiving follow-up education and counseling, I developed a women-only support group for individuals dealing with STDs. Because of the topic's sensitive nature, I chose a gender-segregated approach to the support group and, ultimately, to the research. Contemporary gender scholars have demonstrated that sexuality "is socially organized and critically structured by gender inequality" (Walby 1990:121).

Unfortunately, only one woman used the support group. Initially disheartened, I began to question why people flocked to other support groups that were based on shared stigma (e.g., eating disorders and alcoholism) but failed to use this sexual health support group. Even persons living with HIV and AIDS used support groups to collectively manage their stigma. Clearly, I was a member without a group.

To investigate the failure of this support group, I conducted a survey among patients using a local women's health care clinic. During a month chosen at random, clinic staff gave each patient who came in for an appointment an anonymous survey about a new service being offered: a women's sexual health support group. In all, 279 completed surveys were collected ( $N = 279$ ). Owing to the population from which the sample was drawn, generalizability is restricted to the population of women who receive women's health care services from this clinic. Further, the survey instrument was self-administered, thereby eliminating the possibility of participants getting clarification of confusing wording and so forth. Thirty-nine surveys contained missing data on one or more of the variables and were excluded from analysis.

I performed a multiple regression analysis on the data, the results of which supported the hypothesis that a person who has been diagnosed with a STD is less likely to be interested in a sexual health support group. The standardized coefficient ( $-.149971$ ) reflects a moderately strong, negative relationship, significant at the .05 level. One of the most revealing findings was that only 23.3 percent of the women were definitely interested ("yes") in a sexual health support group. Of those who answered no (31.5 percent) or maybe (30.5 percent), most commented on their desire to keep sexual health matters private—even to the exclusion of others living with similar STDs. These findings lessen the effectiveness of a focus-group method for data collection.

I interpreted this finding to reflect that the stigma of having an STD is so severe that the perceived cost of disclosing this sexual health status to strangers outweighs the possible benefits. Because there has yet to be a moral entrepreneurial campaign to destigmatize STDs in our society, the norm remains secrecy (Brandt 1987). Therefore, to attend an STD support group is to make semipublic what the affected individuals strive to keep secret.

On the basis of these findings, I determined that in-depth interviews were my best chance for obtaining valid data. I constructed my research methods to reflect a reciprocal intention: As the women gave their stories to me, I would offer my support and resources as a sexual health educator. The challenge was to locate myself as a researcher on the "same critical plane as the overt subject matter" (Harding 1987:8). In this way, my values and actions as the researcher were viewed as empirical knowledge that might either support or weaken my findings.

My first hurdle was to achieve approval from the campus Human Research Committee. Their main concern was the participants' confidentiality. Because of the confidential nature of individuals' STD diagnoses, I was not allowed to directly recruit participants. Rather, they had to approach me, usually after hearing about my research project from other participants or women's health care practitioners with whom I had consulted. Once interview participants contacted me, I gained entrée and acceptance through my status as a sexual health peer educator and a complete member. In this way, I used snowball sampling to generate interviews (Biernacki and Waldorf 1981).

Many researchers have gone against traditional methods of interviewing that emphasize distance, instead answering participants' questions, providing important educational information during interviews, and maintaining friendships with participants long after studies reached completion (Nielson 1990). Semi-structured or unstructured interviewing has been favored by many feminist researchers because it "produces non-standardized information that allows researchers to make full use of differences among people" (Reinharz 1990:19). During the interviews, I used researcher self-disclosure to create and maintain rapport, and I included self-reflexive reporting of the interview process as part of the transcribed data that I analyzed (Reinharz 1990).

I conducted 28 conversational, unstructured interviews with consensual participants, who ranged in age from 19 to 56. The interview gave each woman the opportunity to discuss with me, one on one, her unfolding experiences with specific sexual health issues. I conducted the interviews in participants' preferred locations: their homes, my home, or other private settings. The interviews lasted from 1 to 2 hours and were tape recorded with the participants' permission. When appropriate, I concluded the interview with offers to provide sexual health

information and resources, either in the form of health education materials or referrals to resources.

I then analyzed the data according to the principles of grounded theory (Glaser and Strauss 1967). Using constant comparative methods developed by Glaser and Strauss (1967; Glaser 1978), I analyzed the interview data by adjusting analytical categories to fit the emerging theoretical concepts. Over time, I verified these categories as similar patterns from previous interviews reappeared. On the basis of introspection (Ellis 1991), I began by hypothesizing stages of the transformation process of the sexual self as affected by the diagnosis and treatment of an STD. With each interview, I started to cluster participants' experiences around particular stages to check the validity of my initial model. The six stages of sexual self-transformation, in chronological order, are as follows: sexual invincibility, STD suspicion, diagnostic crisis, damaged goods, healing/treatment, and integration. Each of these stages had subcomponents that detailed the impact on the women's sense of sexual self from one part of the process to the next. I then looked through my field notes and transcriptions of interviews for illustrations of these stages and their properties, examining each example to further check the validity of my conceptualizations.

Once certain stages emerged, I began to ask about them more specifically in interviews, checking for the boundaries and variations as applied concepts. I also searched for connections between different stages and subcomponents, searching to understand how these conceptualizations interacted with each other. When particular stages emerged as more dominant themes in interviews, I began to delve into them further and to center my thinking around them as key analytical concepts. By this time, I had discarded some of the preliminary conceptualizations that appeared less relevant or theoretically inconsequential. The result of this evolving analysis was what Wiseman (1970) called a "total pattern," a sequence of events that held true for the group studied. I followed this plan of data collection and analysis to maximize the validity of my findings.

### **STIGMA AND THE SEXUAL SELF**

For all but 1 of the 28 women, their STD diagnoses radically altered the way that they saw themselves as sexual beings. Facing both a daunting medical and social reality, the women

used different strategies to manage their new stigma. Each stigma management strategy had ramifications for the transformation of their sexual selves.

### **Stigma Nonacceptance**

Goffman (1963) proposed that individuals at risk for a deviant stigma are either "the discredited" or "the discreditable." The discrediteds' stigma was known to others either because the individuals revealed the deviance or because the deviance was not concealable. In contrast, the discreditable were able to hide their deviant stigma. Goffman found that the majority of discreditable were "passing" as nondeviants by avoiding "stigma symbols," anything that would link them to their deviance, and by using "disidentifiers," props or actions that would lead others to believe they had a nondeviant status. Goffman (1963) also noted that individuals bearing deviant stigma might eventually resort to "covering," one form of which he defined as telling deceptive stories. To remain discreditable in their everyday lives, 19 of the women used the individual stigma management strategies of passing and/or covering. In contrast, 9 women revealed their health status to select friends and family members soon after receiving their diagnoses.

### ***Passing***

The deviant stigma of women with STDs was essentially concealable, though revealed to the necessary inner circle of health care and health insurance providers. For the majority, passing was an effective means of hiding stigma from others, sometimes even from themselves.

Hillary, a 22-year-old White college senior, recalled the justifications she had used to distance herself from the reality of her HPV infection and to facilitate passing strategies.

At the time, I was in denial about it. I told myself that that wasn't what it was because my sister had had a similar thing happen, the dysplasia. So, I just kind of told myself that it was hereditary. That was kinda funny because I asked the nurse that called if it could be hereditary, and she said "No, this is completely sexually transmitted"—I really didn't accept it until a few months after my cryosurgery.

Similarly, Gloria, a Chicana graduate student and mother of four, was not concerned about a previous case of gonorrhea she had

cured with antibiotics or her chronic HPV "because the warts went away." Out of sight, out of her sex life: "I never told anybody about them because I figured they had gone away, and they weren't coming back. Even after I had another outbreak, I was still very promiscuous. It still hadn't registered that I needed to always have the guy use a condom."

When the women had temporarily convinced themselves that they did not have a contagious infection, it was common to conceal the health risk with partners because the women themselves did not perceive the risk as real. Kayla, a lower middle-class White college senior, felt justified in passing as healthy with partners who used condoms, even though she knew that condoms could break. Cleo, a White 31-year-old mother of a toddler, had sex with a partner after being diagnosed with HPV.

So at the time I had sex with him, yes, I knew but, no, I hadn't been treated yet. That gets into the whole "I never told him," and I didn't. Part of me thought I should, and part of me thought that having an STD didn't fit with my self-concept so much that I just couldn't [disclose].

Francine, a White 43-year-old professional and mother of a fourth grader, had never intended to pass as healthy, but she did not get diagnosed with herpes until after beginning a sexual relationship with her second husband.

I think there was all the guilt: What if I bring this on you? So, I felt guilt in bringing this into the relationship. Because he had not been anywhere near as sexually active as I had. So, I started feeling remorse for having been so sexually active during the period of time between marriages. So, I think I always felt a little more guilty because I might have exposed him to something through my actions.

Similarly, Tasha, a White graduate student, found out that she might have inadvertently passed as healthy when her partner was diagnosed with chlamydia. "I freaked out—I was like, 'Oh my God! I gave you chlamydia. I am so sorry! I am so sorry!' I felt really horrible, and I felt really awful." Sara, a Jewish upper middle-class 24-year-old, expressed a similar fear of having passed as healthy and exposed a partner to HPV. "Evan called me after we'd been broken up and told me he had genital warts. And, I was with another guy at the time, doing the kinda-sorta-

condom-use thing. It was like, 'Oh, my gosh, am I giving this person something?'" Even if the passing is done unintentionally, it still brings guilt to the passer.

The women also tried to disidentify themselves from sexual disease in their attempts to pass as being sexually healthy. Rather than actively using a verbal or symbolic prop or action that would distance them from the stigma, the women took a passive approach. Some gave nonverbal agreement to putdowns of other women who were known to have STDs. For example, Hillary recalled such an interaction.

It's funny being around people that don't know that I have an STD and how they make a comment like "That girl, she's such a slut. She's a walking STD." And how that makes me feel when I'm confronted with that, and having them have no idea that they could be talking about me.

Others kept silent about their status and tried to maintain the social status of being sexually healthy and morally pure. Kayla admitted to her charade: "I guess I wanted to come across as like really innocent and everything just so people wouldn't think that I was promiscuous, just because inside I felt like they could see it even though they didn't know about the STD." Putting up the facade of sexual purity, these women distanced themselves from any suspicion of sexual disease.

### ***Covering***

When passing became too difficult, some women resorted to covering to deflect family and friends from the truth. Cleo summed up the rationale by comparing her behavior to what she had learned growing up with an alcoholic father. "They would lie, and it was obvious that it was a lie. But I learned that's what you do. Like you don't tell people those things that you consider shameful, and then, if confronted, you know, you lie."

Hillary talked to her parents about her HPV surgery, but never as treatment for an STD. She portrayed her moderate cervical dysplasia as a precancerous scare, unrelated to sex. "We never actually talked about it being a STD, and she kind of thought that it was the same thing that my sister had which wasn't sexually transmitted." When Tasha's sister helped her get a prescription for pubic lice, she actually provided the cover story for her embarrassed younger sister. "She totally took control, and

made a personal inquiry: 'So, how did you get this? From a toilet seat?' And, I was like, 'a toilet seat,' and she believed me." When I asked Tasha why she confirmed her sister's misconception, she replied, "Because I didn't want her to know that I had had sex." For Anne, a 28-year-old lower middle-class graduate student, a painful herpes outbreak almost outed her on a walk with a friend. She was so physically uncomfortable that she was actually waddling. Noticing her strange behavior, her friend asked what was wrong. Anne told her that it was a hemorrhoid; that was only a partial truth because herpes was the primary cause of her pain. As Anne put it, telling her about the hemorrhoid "was embarrassing enough!"

### ***Deception and Guilt***

The women who chose to deny, pass as normal, and use dis-identifiers or cover stories shared more than the shame of having an STD—they had also told lies. With lying came guilt. Anne, who had used the hemorrhoid cover story, eventually felt extremely guilty. Her desire to conceal the truth was in conflict with her commitment to being an honest person. "I generally don't lie to my friends. And I'm generally very truthful with people and I felt like a sham lying to her." Deborah, a 32-year-old White professional from the Midwest, only disclosed to her first sexual partner after she had been diagnosed with HPV; she passed as healthy with all other partners. Deborah reflected, "I think my choices not to disclose have hurt my sense of integrity." However, her guilt was resolved during her last gynecological exam when the nurse practitioner confirmed that after years of "clean" pap smear results Deborah was not being "medically unethical" by not disclosing to her partners. In other words, her immune system had probably dealt with the HPV in such a way that she might never have another outbreak or transmit the infection to sexual partners.

When Cleo passed as healthy with a sexual partner, she started "feeling a little guilty about not having told." However, the consequences of passing as healthy were very severe for Cleo:

No. I never disclosed it to any future partner. Then, one day, I was having sex with Josh, my current husband, before we were married, and we had been together for a few months, maybe, and I'm like looking at his penis, and I said, "Oh, my goodness!"

You have a wart on your penis! Ahhh!" All of a sudden, it comes back to me.

Cleo's decision to pass left her with both the guilt of deceiving and infecting her husband.

Surprisingly, those women who had unintentionally passed as being sexually healthy (i.e., they had no knowledge of their STD status at the time) expressed a similar level of guilt as those who had been purposefully deceitful. Violet, a middle-class, White 36-year-old, had inadvertently passed as healthy with her current partner. Even after she had preventively disclosed to him, she still had to deal with the guilt over possibly infecting him.

It hurt so bad that morning when he was basically furious at me thinking I was the one he had gotten those red bumps from. It was the hour from hell! I felt really majorly dirty and stigmatized. I felt like "God, I've done the best I can: If this is really caused by the HPV I have, then I feel terrible."

When using passing and covering techniques, the women strove to keep their stigma from tainting social interactions. They feared reactions that Lemert (1951) has labeled the *dynamics of exclusion*: rejection from their social circles of friends, family, and, most important, sexual partners. For most of the women, guilt surpassed fear and became the trigger to disclose. Those who had been deceitful in passing or covering had to assuage their guilt: Their options were either to remain in nonacceptance, disclose, or transfer their guilt to somebody else.

### **Stigma Deflection**

As the women struggled to manage their individual stigma of being sexually diseased, real and imaginary social interactions became the conduit for the contagious label of damaged goods. Now that the unthinkable had happened to them, the women began to think of their past and present partners as infected, contagious, and potentially dangerous to themselves or other women. The combination of transferring stigma and assigning blame to others allowed the women to deflect the STD stigma away from themselves.

### **Stigma Transference**

I propose the concept of stigma transference to capture this element of stigma management that has not been addressed by

other deviance theorists. Stigma transference is not a specialized case of projection that "in a psychoanalytic context describes the unconscious process in which the individual attributes to others his or her own emotions and impulses—a common defense mechanism, used by the ego to control unacceptable feelings, thereby helping to reduce anxiety" (Marshall 1994:421). Stigma is neither an emotion nor an impulse; rather, it is a formal concept that captures a relationship of devaluation (Goffman 1960). Although the participants attributed their devalued relationship with sexual health ideals to real and imaginary others, they were not controlling unacceptable feelings. Rather, stigma transference manifests as a clear expression of anger and fear, and the women did not connect this strategy to a reduction in their levels of anxiety; in fact, several discussed it in relation to increased anxiety.

Cleo remembered checking her partner's penis for warts after her doctor told her that she could detect them by visual inspection. It became a habit for Kayla to check her partner for any visible symptoms of an STD. Gloria was more careful about checking future partners and asking if they had anything. Tasha explained, "I just felt like I was with someone who was dirty." In all four cases, the women were only sure of their own STD infections, yet in their minds these partners had become diseased.

Transference of stigma to a partner became more powerful when the woman felt betrayed by her partner. When Hillary spoke of the "whole trust issue" with her ex-partner, she firmly believed he had lied to her about his sexual health status and that he would lie to others. Even though she had neither told him about her diagnosis nor had proof of him being infected, she fully transferred her stigma to him.

He's the type of person who has no remorse for anything. Even if I did tell him, he wouldn't tell the people that he was dating. So it really seemed pretty pointless to me to let him know because he's not responsible enough to deal with it, and it's too bad knowing that he's out there spreading this to God knows how many other people.

Kayla also transferred the stigma of sexual disease to an ex-partner, never confronting him about whether he had tested positive for STDs. The auxiliary trait of promiscuity colored her view of him: "I don't know how sexually promiscuous he was, but I'm sure he had had a lot of partners." Robin, a 21-year-old

White undergraduate, went so far as to tell her ex-partner that he needed to see a doctor and "do something about it." He doubted her ability to pinpoint contracting genital warts from him and called her a slut. Robin believed that he was the one with the reputation for promiscuity and decided to trash him by telling her two friends who hung out with him. Robin hoped to spoil his sexual reputation and scare off his future partners. In the transference of stigma, the women ascribed the same auxiliary traits onto others that others had previously ascribed to them.

In a different twist, Anne did not transfer her stigma to her partner, as they both felt that he had been betrayed by his ex-girlfriend.

He felt terrible about his own infection—he was angry at the woman who infected him because she didn't tell him. They had a verbal agreement that they were having a monogamous relationship, and then she was not monogamous with him. She infected him with a sexually transmitted infection. And he was just really upset and felt like he didn't want to pass that on. He didn't want to continue that cycle. So then when he infected me, he felt horrible.

Anne's partner had revealed his herpes status to her before they had become sexually intimate. His disclosure, "being so up front—before he even kissed me," ended up preventing him from being the target of stigma transference.

In all cases, it was logical to assume that past and current sexual partners may also have been infected. However, the stigma of being sexually diseased had far-reaching consequences in the women's imaginations. The traumatic impact on their sexual selves led most to infer that future, as yet unknown partners were also sexually diseased. Kayla summed up this feeling: "After I was diagnosed, I was a lot more cautious and worried about giving it to other people or getting something else because somebody hadn't told me." They had already been damaged by at least one partner. Therefore, they expected that future partners, ones who had not yet come into their lives, held the threat of also being damaged goods.

For Hillary, romantic relationships held no appeal anymore. She had heard of others who also had STDs but stayed in non-acceptance and never changed their lifestyle of having casual, unprotected sex:

I just didn't want to have anything to do with it. A lot of it was not trusting people. When we broke up, I decided that I was not having sex. Initially, it was because I wanted to get an HIV test. Then, I came to kind of a turning point in my life and realized that I didn't want to do the one-night-stand thing anymore. It just wasn't worth it. It wasn't fun.

At this stage in her sexual self-transformation, Hillary imagined the world of possible partners having been polluted with contagion.

Anne's lesbian friends introduced her to a theory about which future partners should be suspected of being dangerous. One friend claimed that her secret to sexual health was to only have sex with female partners. In a therapeutic disclosure to another lesbian friend, Anne recalled her friend's reaction. "Those rotten men! You should just leave them alone. It's clear that you should be with women, and it's safer and better that way. Women don't do this kind of thing to each other." Her friends' guidance was an overt attempt to encourage Anne to believe that only potential male partners bore the stigma.

Instead of going by gender, Gloria, a self-identified Chicana, made a distinction based on ethnicity as a predictor of sexual health status:

Now, if it was a White man, I made 'em wear a condom because I got it from a White man, and so I assumed that there had to be something with their culture—they were more promiscuous. But, one thing I do know culturally and with the times is that Chicano men were more likely to have a single partner.

These women felt justified in their newfound attitudes about sexual partners. What was only supposed to happen to "bad" women had happened to them. Overall, these women transitioned from blaming their own naiveté to blaming someone else for not being more cautious or more honest.

### ***Blame***

The women's uses of stigma transference techniques were attempts to alleviate their emotional burdens. First, the finger of shame and guilt pointed inward, toward the women's core sexual selves. Their sexual selves became tainted, dirty, damaged. In turn, they directed the stigma outward to both real and fictional others. Blaming others was a way for all of the

women to alleviate some of the internal pressure and turn the anger outward. This emotional component of the damaged goods stage externalized the pain of their stigma.

Francine recalled how she and her first husband dealt with the issue of genital warts. "We kind of both ended up blaming it on the whole fraternity situation. I just remember thinking that it was not so much that we weren't clean, but that he hadn't been at some point, but now he was." Francine's husband had likely contracted genital warts from his wild fraternity parties: "We really thought of it as, that woman who did the trains [serial sexual intercourse]. It was still a girl's fault kind of thing." By externalizing the blame to the promiscuous women at fraternity parties, Francine exonerated not only herself but also her husband.

Similarly, Sara found a way to blame the other woman. In the process of internalizing her new stigmatized sexual reality, she wanted to set the blame away from herself, and even away from her ex-partner because she was contemplating getting back together with him:

So, then I thought, oh, he was with that floozy, dirty woman before we got back together: the last time. And, then I thought, [the genital warts] could be latent—for up to 18 months. I'm like, that falls within the 18-month guideline; it was definitely her. So, I decided it was her who gave it to him, who gave it to me.

For Violet, it was impossible to neatly deflect the blame away from both herself and her partner.

I remember at the time just thinking, "Oh man! He gave it to me!" While he was thinking, "God, [Violet]! You gave this to me!" So, we kind of just did a truce in our minds. Like, OK, we don't know who gave it—just as likely both ways. So, let's just get treated. We just kind of dropped it.

Clearly, the impulse to place blame was strong even when there was no easy target.

Often, the easiest targets were men who exhibited the auxiliary traits of promiscuity and deception. Tasha wasn't sure which ex-partner had transmitted the STD. However, she rationalized blaming a particular guy. "He turned out to be kind of huge liar, lied to me a lot about different stuff. And, so I blamed him. All the other guys were, like, really nice people, really trust-

worthy." Likewise, when I asked Violet from whom she believed she had contracted chlamydia, she replied, "Dunno, it could've been from one guy, because that guy had slept with some unsavory women, so therefore he was unsavory." Later, Violet contracted HPV, and the issue of blame contained more anger:

I don't remember that discussion much other than, being mad over who I got it from: "Oh it must have been Jess because he had been with all those women." I was mad that he probably never got tested. I was o.k. before him.

The actual guilt or innocence of these blame targets was secondary. What mattered to the women was that they could hold someone else responsible.

### **Stigma Acceptance**

Eventually, every woman in the study stopped denying and deflecting the truth of her sexual health status by disclosing to loved ones. The women disclosed for either preventive or therapeutic reasons. That is, they were either motivated to reveal their STD status to prevent harm to themselves or others or to gain the emotional support of confidants.

### ***Preventive and Therapeutic Disclosures***

The decision to make a preventive disclosure was linked to whether the STD could be cured. Kayla explained,

Chlamydia went away, and I mean it was really bad to have that, but I mean it's not something that you have to tell people later 'cause you know, in case it comes back. Genital warts, you never know.

Kayla knew that her parents would find out about the HPV infection because of insurance connections. Before her cryosurgery, Kayla decided to tell her mom about her condition.

I just told her what [the doctor] had diagnosed me with, and she knew my boyfriend and everything, so—it was kind of hard at first. But, she wasn't upset with me. Main thing, she was disappointed, but I think she blamed my boyfriend more than she blamed me.

Sara's parents also reacted to her preventive disclosure by blaming her boyfriend: They were disappointed in their daughter, but angry with her boyfriend.

Preventive disclosures to sexual partners, past and present, were a more problematic situation. The women were choosing to put themselves in a position where they could face blame, disgust, and rejection. For those reasons, the women put off preventive disclosures to partners as long as possible. For example, Anne made it clear that she would not have disclosed her herpes to a female sexual partner had they not been about to have sex. After "agonizing weeks and weeks and weeks before trying to figure out how to tell," Diana, a 45-year-old African American professional, finally shared her HPV and herpes status before her current relationship became sexual. Unfortunately, her boyfriend had a negative reaction: "He certainly didn't want to touch me anywhere near my genitals." In Cleo's case, she told her partner about her HPV diagnosis because she wasn't going to be able to have sexual intercourse for a while after her cryosurgery. Violet described the thought process that lead up to her decision to disclose her HPV status to her current partner:

That was really scary because once you have [HPV], you can't get rid of the virus. And then having to tell my new partner all this stuff. I just wanted to be totally up front with him: We could use condoms. Chances are he's probably totally clean. I'm like, "Oh my god, here I am tainted because I've been with, at this point, 50 guys, without condoms. Who knows what else I could have gotten?" [long pause, nervous laugh] So, that was tough.

For Summer, a 20-year-old Native American administrative assistant, and Gloria, their preventive disclosures were actually a relief to their sexual partners. Summer decided to disclose her genital warts to a new boyfriend after they had been "getting hot n' heavy." Lying in bed together, she said, "I need to tell you something." After she disclosed, he lay there, staring at the ceiling for a couple of minutes before deeply exhaling, "I thought you were going to tell me you had AIDS." Similarly, one of Gloria's partners sighed in relief when she revealed that she had herpes; he thought she was going to say she was HIV positive.

Many of the therapeutic disclosures were done to family members. The women wanted the support of those who had known them the longest. Finally willing to risk criticism and shame, they hoped for positive outcomes: acceptance, empathy, sympathy—any form of nonjudgmental support.

Tasha disclosed to her mother right after she was diagnosed with chlamydia.

My family died—"Guess what, mom, I got chlamydia." She's like, "Chlamydia? How did you find out you got chlamydia?" I'm like, "Well, my boyfriend got an eye infection." [laughter] "How'd he get it in his eye?" [laughter] So, it was the biggest joke in the family for the longest time!

In contrast, Rebecca, a White professional in her mid-50s, shared her thought process behind not disclosing to her adult children.

I wanted to tell my younger one—I wanted very much for him to know that people could be asymptomatic carriers because I didn't want him to unjustly suspect somebody of cheating on him—and I don't believe I ever managed to do it—it's hard to bring something like that up.

The women often unburdened their feelings of shame and guilt onto their close friends. Cleo shared her feelings with her roommate: "I told her that I was feeling weird about having had sex with this second guy, knowing that I had an STD." Kayla's therapeutic disclosure was reciprocal with her best friend. "At that time, she was also going through a similar situation with her boyfriend, so I felt okay finally to talk about it." Lily, a 41 year-old white mother of a teenage son, disclosed to a male friend and found relief, as she could share her fear about what was happening to her. He was able to be emotional and supportive. Deborah only disclosed to a handful of female friends, never to any male friends. In Anne's case, her therapeutic disclosure to a friend was twofold: both to seek support and to apologize for initially having used the hemorrhoid cover story. Anne explained to her friend that she had felt too uncomfortable to tell the truth. "I remember later when I did tell her the truth, I was embarrassed and said, 'I need to tell you that I wasn't completely honest with you before.'"

### ***Consequences of Disclosure***

With both therapeutic and preventive disclosure, the women experienced some feelings of relief in being honest with loved ones. However, they still carried the intense shame of being sexually diseased women. The resulting emotion was anxiety over how their confidants would react: rejection, disgust, or betrayal. Francine was extremely anxious about disclosing to her

husband. "That was really tough on us because I had to go home and tell Damon that I had this outbreak of herpes." When asked what sorts of feelings that brought up, she immediately answered. "Fear. You know I was really fearful—I didn't think that he would think I had recently had sex with somebody else—but, I was still really afraid of what it would do to our relationship." Hillary's anxiety over her deviant status getting leaked almost prevented her from taking advantage of a sexual health support group.

I think one of the biggest fears for me was walking into a support group and seeing someone that I knew there. But then I turned it around and decided that they were just as vulnerable as I was—But, I think the biggest part was just having people find out about what I had somehow.

Even though the other women in the support group would have been strangers, each participant represented a potential gossip.

Overall, disclosing intensified the anxiety of having their secret leaked to others in whom they would never have chosen to confide. In addition, each disclosure brought with it the possibility of rejection and ridicule from the people whose opinions they valued most. For Gloria, disclosing was the right thing to do but had painful consequences when her partner's condom slipped off in the middle of sexual intercourse.

I told him it doesn't feel right. "You'd better check." And, so he checked, and he just jumped off me and screamed, "Oh fuck!" And, I just thought, oh no, here we go. He just freaked and went to the bathroom and washed his penis with soap. I just felt so dirty.

The risk paid off for Summer, whose boyfriend asserted, "I don't ever want to be *that guy*—the one who shuns people and treats them differently." He borrowed sexual health education materials and spent over an hour asking her questions about various STDs. Even in this best-case scenario, the sexual intimacy in this relationship became problematized (e.g., having to research modes of STD transmission and safe-sex techniques). Disclosures were the interactional component of self-acceptance. The women became fully grounded in their new reality when they realized that the significant people in their lives were now viewing them through the discolored lenses of sexual disease.

## CONCLUSION

The women with STDs went through an emotionally difficult process, testing out stigma management strategies, trying to control the impact of STDs on both their self-concepts and on their relationships with others. In keeping with Cooley's ([1902]1964) "looking glass self," the women derived their sexual selves from the imagined and real reactions of others. Unable to immunize themselves from the physical wrath of disease, they focused on mediating the potentially harmful impacts of STDs on their sexual self-concepts and on their intimate relationships.

Ironically, most of the women first tried to deny this deviant health status—one that was virtually secret through the protection of doctor–patient confidentiality laws. Although many used passing and covering techniques that relied on deceiving others, self-deception was impossible to maintain. The medical truth began to penetrate their sexual self-conceptions as soon as they fabricated their first lie. To strategize a successful ruse, it was necessary to know the scope of what they were trying to hide.

When guilt caught up with them, making it hard to pass as healthy, their goal shifted to stigma deflection. Those who engaged in stigma transference imagined forcing blamed others to look into the same mirror of judgment in which they had been forced to look into. However, this only delayed the inevitable—a deviant sexual self that penetrated the women's prior conceptions of their sexual selves.

After mentally transferring their stigma to real and imaginary others, all of the women finally accepted their tainted sexual health status through the reflexive dynamics of disclosure. Voluntary disclosure to intimate others took their sexual health status out of the doctor's office and into their lives. Each time they told their story to a friend, family member, lover, or ex-lover, they revised the story of who they were as sexual beings. The new stories gained veracity in the verbal and nonverbal responses of the trusted few. The women's sexual selves moved along a deviant career path by means of the interactive dynamics of their stigma management strategies.

One model of deviant identity formation treats the process as involving three distinct linear stages: primary, secondary (Lemert 1967), and tertiary deviance (Kitsuse 1980). The women began the move into primary deviance when they engaged in the initial act of deviance: contraction of a sexually transmitted

disease. However, the actual moment of STD transmission was imperceptible and did not result in a deviant label. Rather, in private interactions, medical practitioners named the deviance through STD diagnoses, thus completing the women's transitions into primary deviance.

Movement into secondary deviance began as the women contemplated how they would manage the stigma of sexual disease in their "real" lives, beyond the sterile doors of the examination rooms. As the women made choices on which stigma management strategies to use, they grappled with the ramifications of internalizing this new label. Choosing passing and covering techniques meant they could remain in non-acceptance and put off stigma internalization. When they deflected the stigma onto others by means of stigma transference, the women glimpsed the severity of an STD stigma as reflected in the presumed sexual selves of real and imaginary others. Finally, the women's disclosures confirmed the new story of their tainted sexual selves.

For the women with STDs, the stigma penetrated only the portions of their self-concepts that addressed sexuality. They were forced to reconcile new, "dirty" sexual self-concepts with their prior conceptions of unspoiled sexual health. However, all of them succeeded in compartmentalizing the deviant identity of being sexually diseased into the sexual part of their self-concepts, never making the complete transition to secondary deviance. Their experience of partial secondary deviance significantly differs from Lemert's (1967) conception, in which the deviant identity becomes fully integrated into one's core self-concept. Unlike the people in ethnographic studies of other medically deviant groups (Herman 1993; Karp 1992; Sandstrom 1990), the women in this study learned to accept a tainted sexual self but did not end up with an internalized deviant identity that spoiled their entire self-concepts.

These data highlight the limitations of this three-stage model for explaining the process of deviant identity development for women with STDs. The fragmented nature of the women's movement into secondary deviance stems from the situational nature of the STD stigma. Unlike the stigma of HIV/AIDS—which carries the threat of life-changing illness, death, and contagion beyond the scope of sexual behaviors—the STD stigma lends itself to compartmentalization. The women were able to hide their shame, guilt, and fear (of further health complications,

of contaminating others, of rejection, etc.) in the sexual part of their self-concept. They recognized that this part of their self-concept did not have to affect their entire identity. Medically speaking, an STD need only affect the decisions and interactions connected with sexual and reproductive behavior. If the impact of the STDs on their sex lives ever became too emotionally painful, the women could always decide to distance themselves from this role: choosing temporary or permanent celibacy.

The "narrative metaphor" for self (Hermans 1996) views the self as multivoiced. Historically, James ([1890]1902) and Mead (1934) discussed the distinctions between the objective and subjective self. Whereas the subjective self engages in self-reflexivity to negotiate an identity, information provided through interactions with external others continues to shape the objective self. In this way, the externally constructed self mediates internal conversations about identity. During these dialogues between the "I" and the "me," one's negotiated identities become incorporated into the self-concept.

James ([1890]1902) posited the distinction between "I" and "me." However, Mancuso and Sarbin (1983) and Sarbin (1986) posited an interpretation of James ([1890]1902) and Mead (1934) that frames the I-Me distinction as a narrative of the self. From a narrative perspective, I is the author of the story about Me, the protagonist of the story being constructed about the self. The ability to construct such a narrative comes from the I's ability to reinvent the past, hypothesize the future, and describe her- or himself as the actor (Crites 1986). In this way, the construction of self-narratives becomes the means by which people organize experiences, behaviors, and their accounts of these events (Sarbin 1986).

A narrative model of the self proposes that personal myths create the self and become "the stories we live by" (McAdams 1996:266). I propose that we seek to understand the significance of the stories we choose not to live by. Personal STD "stories" are rarely told in American mass culture. McAdams (1996:22) proposed that "carrying on affairs in secret"—maintaining a discreditable stigma—is a way to keep stigmatizing stories from occupying center stage in people's personal myth. However, these data suggest that individuals manage identity transformations, especially transformations into deviant identities, by constructing and sharing self-narratives through disclosure interactions. Although the women do not maintain secrecy,

they do keep their STD stories from center stage.

When the distasteful or spoiled self can be contained to the private sphere (such as the sex life), the I uses stigma management strategies that protect the core self from the spoiled part of the self. To accomplish this, the I authors a peripheral narrative about the deviant aspect of the Me. Disclosures are the telling of this peripheral narrative. This type of narrative is connected, yet fails to contaminate, the core narrative, in which the Me, as protagonist, is insulated from the stigma contained in the peripheral narrative.

The incompleteness of the women's transitions into secondary deviance is explained by their choice to incorporate the stigma into a peripheral rather than core self-narrative. Although this strategy enables them to protect their core self-narrative from stigma, the women face challenges in maintaining this compartmentalization. Whereas celibacy is an obvious aid in using this stigma management strategy (three participants were celibate), the norm of sexual activity repeatedly makes the sexual self a salient part of women's self-concepts. In modern American culture, "heterosexual activity is seen not only as desirable but also as necessary for a 'normal' healthy life, [and] the pressures on women to marry or cohabit with a man, with all the consequent forms of servicing, are increased" (Walby 1990:127).<sup>1</sup>

In many ways, the creation of a deviant peripheral self-narrative may be the ultimate stigma management strategy. The apparent effectiveness of this particular stigma management strategy would seem to appeal to all individuals who struggle with deviant stigma. The rarity of its use can be explained by the organizational complexity of those who share a particular deviant stigma. The existence of a deviant subculture promotes secondary deviance by implying membership requirements: acceptance of deviant norms, values, social support, and so forth. (Best and Luckenbill 1980). Deviant subcultures also allow for the existence of collective stigma management groups that may encourage individuals to move into tertiary deviance and embrace their deviant identities (Kitsuse 1980). The inclusion of stigmatized individuals into deviant subcultures exposes them to others who have rewritten their core self-narratives to reflect

<sup>1</sup> The next phase of this study will focus on men living with chronic STDs and compare the gendered dimensions of this experience.

their deviant identities. Such groups function to remove the negative connotation of the deviance by offering inclusion to their deviant circles (Lemert 1951). However, micro-level interactions between deviant individuals and collective stigma management groups encourage the incorporation of the stigmatized label into core self-narratives.

These data on how women manage the stigma of chronic STDs have significant implications for the study of isolated deviants and the study of self-transformation of deviants in general: They highlight the role of isolation in protecting a core self-narrative from stigma. Individuals, such as women with STDs, remain loners because their deviant labels do not provide them with membership to deviant subcultures (Lowery and Wetli 1982) and, possibly, to collective stigma management groups. When society constructs a type of deviance as "loner," affected individuals need not enter complete secondary deviance and internalize the deviant label into their core self-narrative. Isolated in their experience of this stigma, these individuals have greater flexibility in their decision to rewrite their deviant transformations into either core or peripheral self-narratives. Further research on loner deviants would be helpful in testing the efficacy of peripheral self-narratives for managing stigma.

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