NEGOTIATION PROCESSES IN NON-VISIBLE STIGMA: THE CASE OF VENEREAL DISEASE

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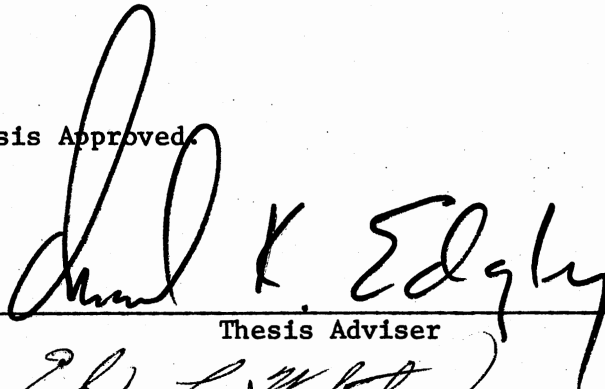

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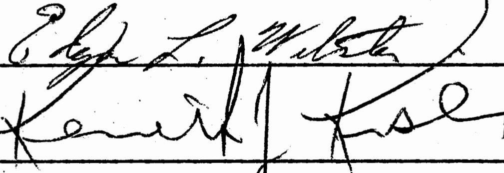

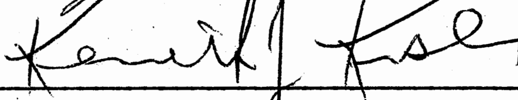

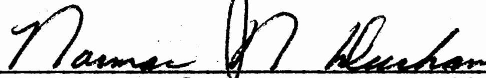

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PREFACE

This study is concerned with the negotiation processes involved in non-visible stigma. The primary objective of this study is to understand the methods of information control utilized by persons experiencing a potentially stigmatizing situation during social interaction. A qualitative analysis of the self-reports of individuals infected with venereal disease is used to ascertain any prevalent generic processes associated with stigma negotiation.

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CHAPTER I

THEORETICAL ORIENTATION

Introduction

Goffman (1963:2) states that the term stigma is used in reference to a perceived attribute that is deeply discrediting. A stigma then is a facet of an individual which has the capacity of generating a negative response, a response which usually results in differential treatment. The words response and treatment should cue the reader to the social nature of stigmatization. Stigmatization is conceived and executed entirely within a social framework; it does not stand apart from interaction. As Goffman (1963:3) explains, "a language of relationships, not attributes, is really needed to describe stigmatization as a process." This language of relationships, however, is derived from the meaning of the attribute as it arises in the process of interaction between the people.

> The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person (Blumer, 1969:4).

Thus, when one refers to an attribute as being stigmatizing or potentially stigmatizing, reference is not made with the assumption that the attribute is a viable entity, for indeed it is not. It is simply a pragmatic means of referring to the interaction changes which occur as a result of the meanings people create and then attach to the attribute.

Just as an individual cannot be conceptualized apart from the social interaction which brings him into existence, neither can a characteristic be used to refer to any conceptualization which separates the characteristic from the social response it generates.

Most people are well acquainted with the effects of stigma. As Goffman (1963:32) suggests,

> The stigmatized individual learns how normal people (those without a stigma) view the possession of the stigma, and then learns he, himself, possesses this stigma, with the accompanying knowledge of the stigma.

One does not necessarily have to be stigmatized himself in order to have some understanding of the differential treatment accorded those with a stigma. Simple observation of interaction between those possessing and those not possessing a stigma should be a sufficient educational tool in a majority of interactions.

Stigmas arise from a variety of sources. Some stigmas are inherent from birth and the consequences of such possession cannot be avoided. The physically handicapped are a prime example of potentially unavoidable stigmatization, although birth into a segment of the population which is considered socially inferior in some manner is also an unavoidable stigmatizing possession. Others acquire their stigmatizing possession later in life, quite possibly through the performance of acts judged deviant by a viewing audience.

Stigmas, as a consequence of their origin, may be either visible or non-visible, that is, overt or covert. Whether the characteristic that gives rise to the stigma is visible, such as obvious birth defects and public recognition of deviant acts, or is non-visible, such as concealable flaws in physical appearance and in social identity, the actual process of stigmatization is generic and the resulting loss of the

social identity is predictable. The difference between overtness and covertness, or visibleness and non-visibleness, lies in the ability of the person to take an active part in negotiating the strength of the stigma. Some stigmatizing characteristics cannot be concealed, so must necessarily assume the responsibility for generating negative response. Other stigmatizing characteristics are more easily concealed and, depending upon the ingenuity of the person, control of the response to the offending possession is possible by managing the visibleness of the characteristic.

Thus far, two specific types of stigma have been identified. The first, that consisting of overt possessions, is readily apparent to the casual observer, and as such, is incorporated into the interaction between people. This overt characteristic, at least as it is established in interaction, contributes to the form and style the interaction will follow.

The second type of stigma, that consisting of concealable flaws, is not readily apparent to the participants in an interaction, and as such, will not necessarily have influence in an encounter with another person. The existence of a covert characteristic does not have to be acknowledged, and if not, its existence is not brought into play during interaction and thus, in effect, does not exist. A stigmatizing characteristic has no life of its own apart from interaction and its ability to generate social response. The uniqueness of a non-visible stigmatizing possession lies in its ability to either generate a social response or have no effect at all, depending entirely upon the acknowledgement of its existence.

Acknowledgement of the existence of a non-visible characteristic often lies solely with the possessor. The possessor has the ability to bring this discreditable aspect of himself into interaction only if he so desires. Often he does not desire the acknowledgement of its existence as he is aware of the resulting differential treatment which will be accorded him if he chooses to do so. The strategies an individual with a non-visible stigmatizing possession employs to prevent the acknowledgement of his possession have been termed information control, a concept utilized consistently by Goffman (1963).

The focus of this study will deal specifically with information control in non-visible stigma. Venereal disease was chosen to represent a non-visible stigmatizing possession. The study will attempt to discover the strategies employed by individuals with venereal disease as a process of preventing acknowledgement of their discreditable information. However, this specific investigation into the information control strategies cannot be separated from the meanings of the disease social interaction establishes with regard to the information.

Investigation into the management of a stigma involves a study of interaction processes, with selfhood as presented by the participants and received by the audience being the initiating factor. The review of the theoretical orientation of this thesis will deal with the concept of self in terms of several phases of interaction associated with stigmatization and will be presented in several segments, these being: 1) the nature of the self, 2) appearance and the self, 3) stigma as social deviance, 4) societal reaction to stigma, 5) negotiation of deviant labels, 6) information control and stigma, and 7) accounts and disclaimers.

The Nature of the Self

When two people first encounter one another, an exchange of information between the two persons is necessary. Each person must understand the particular type or category of person the counterpart in the interaction is claiming to be before a sustained discourse may ensue, as interaction can only be sustained through utilization of this information for guidance on the form and style of the interaction.

According to Goffman (1963:2),

> Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories . . . The routines of social intercourse in established settings allow us to deal with anticipated others without special attention or thought. When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his social identity. We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands.

In short, we present to others a self, a social identity, which guides all participants in interaction with regard to expected behavior and performance. Not only is interaction sustained through the acceptance of our presented claims but the social self as presented by the participant is validated. We become what our social audience validates or agrees that we are. If the social identity claimed is not validated by the audience, then, for the duration of that interaction, we do not exist within the framework of our claims. Thus, we can state that social identity is established and sustained only through interaction.

There appears to be an obligatory aspect to the nature of validation of social identities as claimed. We are, in a sense, obligated to accord all rights and privileges generally associated with a particular social identity until a verification occurs that the self is not what it

claims to be. This very obligation is the basis for uninterrupted interaction, interaction which is based on responses to socially defined expectations for each category.

Validation of claimed social identities is of primary concern for the person inasmuch as self-esteem can be linked to the sustaining of interaction. According to Brissett (1972), one aspect of self-esteem is the process of self-evaluation. Self-evalutation is used to refer to the process of making a conscious judgement regarding the social importance or significance of one's self. Most often this judgement is rendered upon one's identity. Thus, if a claimed social identity is validated by the viewing audience and interaction is sustained, then the self-evaluation by the claimant is positive and the person may experience enhanced self-esteem. On the other hand, if social claims are not validated, then self-evaluation may be negative in nature resulting in a lowered self-esteem. Self-esteem, then, may be seen as a consequence of social interaction.

Appearance and the Self

Persons claiming certain rights and privileges due to a clearly presented social identity may or may not actually possess all the attributes associated with the claim. This inability to credential everything that is claimed is irrelevant for sustaining interaction as long as the audience for the claimed social identity is unaware of the discrepancy between that which is claimed and that which is possessed. Participants in interaction will continue to validate a social identity, proceeding on the assumption that the presented social identity is all which others assume it to be; thus, the appearance of possessing the

attributes generally associated with a particular social identity is a sufficient framework for generating an interaction based on socially defined expectations.

In this sense, an attribute can be conceptualized as information being held by the audience which is attributed to a social identity. Without this process of attributing by the audience to a social identity a quality which is assumed to be possessed by the social identity, there is no actual possession. Attributes then are the basic contruction blocks of social identities. They are qualities inferred by the audience and claimed by a social self which help in identifying the social identity for sustaining interaction.

Interaction becomes interrupted at the point in time when it is discovered that a presented self is not all that it claims to be, for at that time, previously claimed social identity is destroyed and the interaction has no guidance until new definitions are enacted. Upon discovery of a lack of credentials in association with a presented social identity, confusion is evidenced and necessitates a recategorization of the participants. This recategorization is usually negative in quality.

> When evidence is presented that an individual possesses an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind--in the extreme, a person who is quite thoroughly bad, dangerous, or weak. He is reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive (Goffman, 1963:3).

For Goffman, the discredited individual is one whose stigma is obvious to viewers, or has already been subject to public scrutiny, thus denying the stigmatized individual the opportunity to hide his negative possession. The individual with the discreditable attribute is in a unique

position, for he will not necessarily be forced to undergo the effects of a destroyed social identity if he is successful in preventing the knowledge of his negative characteristic from becoming well known. The difference between the discredited and the discreditable then, lies in the relationship between the person and his audience. One is discredited, stigmatized, only if the audience is aware of the negative information about the individual. For the discreditable individual, the situation can only be termed potentially stigmatizing, for stigmatization cannot exist independent of audience awareness.

Thus, when one talks about discrediting or discreditable attributes, one is actually engaging in a discussion of information held by the viewing audience regarding a social identity. If no discreditable information becomes available to those engaging in interaction with the social identity, then the audience accords it the rights and privileges generally associated with that particular social identity. Interaction is sustained. However, if information is available which acquaints the audience with the knowledge that the identity is not all that is claimed, then the social identity is discredited and validation of that identity is not forthcoming from the audience. The self experiences a kind of social death.

Stigma as Social Deviance

Upon discovery by the viewing audience that a person does not possess all the attributes associated with a claimed social identity, a reassessment of the person may be instigated. The viewing audience may judge him to be inadequate in some manner and if so reassessed, then in a sense, he is deviant, for the individual deviates from socially

defined assumptions. One must understand that the stigma process is an activity which is based on the relationship between a presented social self and a responding social audience. Thus, the nature of deviance in association with the concept of stigma is not a clearly defined thing, but an elusive process situationally dependent upon the interaction between the actor and audience. This view of deviance has been termed a labeling perspective, a perspective which applies itself to the process of stigma investigation very successfully. With the labeling perspective, the problematic nature of deviance is directed toward the viewing audience of the deviant act; the act itself is not considered inherently deviant.

Kutsuse (1962) lists three prerequisites for the conceptualization of deviance as a process. These include: 1) the interpreting of certain behaviors as deviant by members of a group, 2) the labeling of persons who so behave as deviant, and 3) the accordance of treatment considered appropriate for such deviants. Becker (1963) stresses the collective action required in the creation of deviance. He states that deviance is not a quality which lies in behavior itself, but rather lies in the interaction between the person who commits an act and those who respond to it (Becker, 1963:9). Deviance, then, is dependent on the actions of others who view it and then so define such behavior as deviant. Erickson (1962:248) emphasizes this point in his discussion of deviance.

> Deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audiences which directly or indirectly witness them. Sociologically, then, the critical variable in the study of deviance is the social audience rather than the individual person, since it is the audience which eventually decides

> whether or not any given action or actions will become a visible case of deviation.

According to Becker (1963), the labeling of behavior is the result of activities which have broken rules; social rules which are the creation of specific social groups. Becker differentiates between behavior which is simply rule-breaking and reserves the term deviant for those labeled as deviant by some segment of society. Mankoff (1971:207) addresses the problem of societal reaction to deviance with regard to rule-breaking behavior more specifically. He considers as separate phenomenon, two types of rule-breaking behavior.

> Ascribed rule-breaking occurs if the rule-breaker is characterized in terms of a particular physical or visible impairment. He does not necessarily have to act in order to be a rule-breaker. By contrast, achieved rule-breaking behavior involves activity on the part of the rule-breaker, regardless of his positive attachment to a deviant way of life.

The ugly and the physically disabled can be considered ascriptive rule-breakers, simply due to a freak of nature. The embezzler who attempts to conceal his rule-breaking behavior; no less the regular user of drugs who freely admits his transgression, has had to achieve rule-breaking, at least to some extent, on the strength of his own actions. Thus, achieved rule-breaking is initiated on the part of the person, and unless circumstances arise which bring to light these rule-breaking activities, the labeling process does not come into play.

Societal Reaction to Stigma

When an individual possesses a negative attribute and his viewing audience is aware of it, a transformation of the individual's social identity is enacted. This transformation results in a lowered position in the social scheme. Garfinkel (1956) refers to this process as

successful degradation ceremonies. A successful deviant label or stigma is invasive to the whole identity of the individual because the deviant act is tied directly by his audience, not to the act, but the actor. Garfinkel (1956:421) illustrates the importance of this concept in his description of the outcome of a successful degradation ceremony.

> The work of the denunciation effects the recasting of the objective character of the perceived other: the other person becomes in the eyes of his condemners literally a different and new person. It is not that the new attributes are added to the old nucleus. He is not changed, he is reconstituted. The former identity at best, receives the accent of mere appearance. In the social calculus of reality representations and test, the former identity stands as accidental: the new identity is the 'basic reality'. What he is now is what, 'after all', he was all along.

Thus, when deviant roles are compared with other roles, the difference lies in the extent to which the role is identified with the person rather than the act.

The individual who has been stigmatized by his audience receives mortal blows to his social identity, an identity which he may wish to retain. Goffman (1952:453) addresses the problem of identity in relationship to societal reaction with regard to social roles specifically.

> A person is an individual who becomes involved in a value of some kind--a role, a status, a relationship, an ideology--and then makes a claim that he is to be defined as someone who possesses the value or property in question. The limits to his claims, and hence the limits to his self, are primarily determined by the objective facts of his social life and secondarily determined by the degree to which a sympathetic interpretation of these facts can bend them in his favor. Any event which demonstrates that someone has made a false claim, defining himself as something which he is not, tends to destroy him . . . If the person can keep the contradiction a secret, he may succeed in keeping everyone but himself from treating him as a failure.

Thus, stigmatization processes have the ability to nullify a previously defined social identity. Stigmatization creates an ahistorical

situation for the deviant individual. All that he was is no longer relevant, the presiding identity remaining after labeling effects have been evoked is the only social identity which will be utilized by the audience for interaction. As Goffman (1963:132) explains, "painfullness of sudden stigmatization comes not from confusion about identity, but from knowing too well what he has become."

Negotiation of Deviant Labels

One must bear in mind that the role of the deviant in stigmatization processes is not solely passive or reactant.

> Often the deviant takes an active part in the labeling process: they initiate self-definitions. They insist that others define them in preferred ways, and the strategies they choose to negotiate and settle labeling issues vary with the social contact in which such labeling occurs (Levitin, 1975:549).

This active negotiation of deviant labeling has been studied by Davis (1961, 1963) on several occasions through investigation into negotiation processes utilized by visibly handicapped persons. According to Davis, visibly handicapped persons are also visibly deviant persons and it is of extreme social importance to the individual to become engaged in the process of stigma negotiation, a concept which Davis refers to as deviance-disavowal. He defines this term as the ways in which the individual attempts to reduce the reaction of his audience to his deviance and thus, negotiate the strength of the labeling process (1961:125). In deviance-disavowal, the deviant may: 1) accept normal standards and wish to be viewed in these circumstances--a process termed passing, 2) make light of the differences and try to bring forth qualities for concentration--normalization, or 3) relinquish normal standards--disassociation. The various strategies utilized by deviant individuals

engaging in deviance-disavowal may be referred to as aspects of moral careers (Goffman, 1963; Davis, 1961, 1963).

For the person who has publicly undergone a successful degradation ceremony (Garfinkel, 1965), the moral career of the stigmatized individual may be limited. Only certain modes of stigma negotiation are available, generally some form of normalization. However, for the individual who has not yet been successfully labeled, other routes are available and his entire lifestyle may consist of episodes of stigma negotiation during which he attempts the strategy of passing.

Information Control and Stigma

What becomes crucial to the deviant who is attempting to pass is information control. In order to prevent the process of stigmatization, he must successfully prevent the knowledge of his deviance from being brought forth during interaction. If he is successful in this attempt, his social claims will be honored and he will be accorded all the rights and privileges associated with his claimed social identity. The deviant who is attempting passing is confronted with the potential situation of what has been referred to by Lyman and Scott (1970) as defensive face games, a game in which a player seeks to protect his own identity from damage or spoilage. Successful information control is of course dependent upon the obviousness of the deviance to the social audience. The physically handicapped may be able to engage in passing only to a certain extent, the limit of that extent being dependent upon physical capabilities (Davis, 1961). Individuals whose deviance assumes the form of deviant acts which leave no overt signs of deviancy are in a better position to continue in a moral career of passing. In this situation,

the ability to pass is dependent on the ability of the deviant to control information of deviancy. If he chooses not to bring forth the knowledge of his deviancy for interaction, then his deviancy does not, in effect, exist. Deviance is not independent of the social audience. Thus, stigmatization of the deviant with a non-visible negative possession is not a mandatory process. It is contingent on the ability of the deviant to control discreditable information.

Accounts and Disclaimers

There may be times in the moral career of the individual who is attempting to pass when he finds it necessary to disclose his discreditable information. During situations when information control is not possible and the person is forced into revealing his stigmatizing characteristic, he will most likely relate this discrediting information in such a manner as to reduce its labeling effect.

Lyman and Scott (1970:112) define an account as a linguistic device employed whenever an action is subjected to valuative inquiry. Accounts are routinely expected when activity falls outside the domain of expectations. Accounts may assume the form of one or two types: excuses and justifications. Excuses are socially approved vocabularies for mitigating or relieving responsibility when conduct is questioned and full responsibility for the act is denied, whereas justifications are accounts in which one accepts responsibility for the act in question, but denies its consequences (114).

Excuses may include one or more of the following categories described by Lyman and Scott (1970:121): appeal to accidents, appeal to defeasibility, appeal to biological drives and scapegoating.

Justification categories include denial of injury, denial of the victim, condemnation of the condemners, appeal to loyalties, sad tales and self-fulfillment. The important difference between excuses and justifications lies in the acceptance of normative expectations of behavior. The individual who employs excuses when called upon to give an account of his behavior will readily acknowledge the supremacy of normative expectations and his desire to fulfill those expectations as they apply to him. His argument lies not with what is expected of him but with forces beyond his control which influenced his behavior and prevented him from fulfilling his normative obligations. The individual who employs justifications when called upon to give an account of his behavior will not necessarily acknowledge the supremacy of normative expectations. He will instead attempt to show just cause as to why, in this very special circumstance, normative expectations should not be applied to his behavior. His request, then, is for alteration of normative expectations.

The account given may or may not be honored, and if not honored the degradation ceremony as described by Garfinkel (1956) may commence and the individual may find it necessary to forego passing and attempt normalization or disassociation as strategy for dealing with his stigmatizing situation.

Closely associated with accounts is a concept known as the disclaimer. A disclaimer is a verbal device employed to ward off and defeat in advance, doubts and negative typifications which may result from intended conduct (Hewitt and Stokes, 1975). Disclaimers are used to define a forthcoming conduct as not relevant to the kind of identity-challenge such conduct would usually generate. In the case of an

individual possessing an attribute which is potentially stigmatizing, a disclaimer may be used to set the stage for the forthcoming admission of the deviant act.

Accounts and disclaimers are used as tools to prevent re-evaluation of social identity when action is interrupted. Accounts and disclaimers may be utilized in an analogy with pillows, the purpose of which is to cushion the blow to the social identity. Socially defined expectations regarding behavior and performance in association with particular social identities are used as guidelines during interaction. Obviously, when one views the amount of deviation from these guidelines, it becomes apparent that a wide variety of behavior is possible, thus rendering these guidelines suggestive but not totally directive. However suggestive they may be, people generally attempt to establish interaction initially on the basis of these guidelines and when individual behavior places them in situations where interaction is disrupted as a result of confusion regarding social identities, strategies for explaining away the confusion is attempted, for not to do so is to have one's social identity rendered deviant, a process which results in a negative evaluation of the self offered for interaction--a stigma.

CHAPTER II

RESEARCH PROBLEM AND METHODOLOGY

The Research Problem

Goffman (1963:147) argues that:

> stigmatized persons have enough of their life situations in common to warrant classifying all these persons together for purposes of analysis. . . . What remains in each of the traditional fields could then be re-examined for whatever is really special to it, thereby bringing analytical coherence to what is now purely historic and fortuitous unity.

Each type of stigmatizing situation then is open to inquiry. It is true that the capacity to generate the process of stigmatization is shared by all pieces of discreditable information. It also appears to be true that each separate piece of discreditable information must have some aspect to it which is generic to itself alone.

The topic of investigation of this thesis is the stigmatizing process associated with venereal disease. Venereal disease can be considered a covert or non-visible discrediting attribute. As such, individuals possessing this attribute can be effective in negotiating the stigmatizing process through control of the knowledge of the existence of venereal disease. It has been hypothesized by one public health official that part of the reason for the epidemic proportions of growth of the disease is due to the refusal of individuals with the disease to admit to themselves that they have the disease, to name sexual contacts from whom they may have contracted the disease, or to

seek active medical treatment for the disease. Sociologically, all these activities can be viewed as attempts to negotiate the strength of a stigmatizing possession. Others, besides the diseased themselves, appear to aid the inflicted with this negotiation process. A recent pamphlet published by the Department of Health states that only one out of every nine physicians actually reports all cases of venereal disease treated (1972). The Department of Health, in recent years, appears to have gained understanding of this phenomenon inasmuch as it has launched a media advertising program in an effort to convince the population that "VD is for Everyone", perhaps hoping to reduce the stigmatizing effect of the disease and thus aid in its eradication by making victims more willing to seek treatment.

As a potentially stigmatizing piece of information, individuals with venereal disease can, to a certain extent, avoid allowing their attribute to generate a stigmatizing situation. The extent to which the attribute is controlled is the extent to which they prevent others from gaining knowledge of their possession of venereal disease. The focus of this study is management of information control among individuals with venereal disease.

An area of general concern will be to discover the extent to which venereal disease is considered a stigmatizing possession by those inflicted with the disease. This question should be answered through an understanding of the extent to which individuals attempt to hide the knowledge of the existence of venereal disease. It would appear that persons who reveal their venereal disease freely should not fear possible damage to their social identity as intently as those who elect to tell no one of the existence of venereal disease. This assumption leads

one to question the reason for various approaches to the problematic nature of having venereal disease. Perhaps the degree to which an individual is threatened by the acknowledgement of his possessing venereal disease is dependent on his strategies for coping with the potentially stigmatizing situation.

The basic questions being explored by this investigation into individuals with venereal disease are:

1. What is the social nature of stigmatization?
2. What are the social consequences of being stigmatized?
3. How do individuals possessing a potentially stigmatizing characteristic negotiate the strength of the labeling effect?

These questions will be studied as a function of the stigmatizing effect of venereal disease.

Methodology

The theoretical framework utilized in this research conceptualizes stigma as a process based on interaction. Without interaction, there is no stigma. While it would be possible to construct an instrument which has the capacity to measure adequately some aspect of social interaction as experienced by the viewing audience which occurs as a result of stigma, it would be impossible to construct an instrument which has the capacity to aid the researcher in quantifying all aspects of the stigma process as it is experienced by the stigmatized person. Investigation into the process of stigma as it develops meanings which alter interaction for the individual so stigmatized is necessarily dependent upon the stigmatized individual's report of the changes in interaction and relationships which occur as a consequence of the stigmatizing or

potentially stigmatizing situation. For this reason the writer has assumed a methodological approach which is qualitative and dependent upon the reports offered by those individuals engaged in the process of stigma.

Description of the Respondents

When the research project was first initiated, the objective was to use a sample of subjects from two health facilities. The cooperation of a university student health facility and the local Department of Public Health was secured. Medical personnel at each health facility agreed to pass out a cover letter to each newly diagnosed venereal disease patient. Repeated checks at each health facility reassured the researcher that the agreement was being honored by medical staff. However, a period of six weeks passed during which no volunteers for participation in the research project materialized. A possible explanation for the lack of volunteers from these sources will be discussed in the final chapter of this thesis.

Alternative respondents were secured by the following techniques: 1) placement of an ad in the university newspaper, 2) placement of a handbill on the bulletin board of each floor in each dormitory on campus, and 3) eliciting the cooperation of individuals known to the researcher to have had venereal disease. The majority of the respondents were obtained through the ad in the university newspaper and from the handbills in the dormitories.

Initial contact with respondents was made by telephone. At that time more detailed explanation of the research project was given. Much assurance of confidentiality was necessary on the part of the researcher

during the initial telephone contact in order to secure participation in the research project. Twelve males and five females were interviewed by the researcher (N=17). Table I is a summary of the socio-demographic backgrounds of the respondents.

Data Collection

All of the interviews were conducted in one of three locations. The locations were the home of the researcher, the home of the respondent, or the office of the researcher. The location of each interview was varied according to the desires of the respondent. Confidentiality was the primary objective guiding the respondent in choice of location.

Appointments for interviews were made over the telephone, and again the date for the interview was scheduled with the convenience of the respondent in mind. Half of the interviews were scheduled for the day after the telephone contact, while the other half of the interviews generally were performed within an hour of the telephone conversation. Seven appointments were made with possible respondents who never kept the appointment.

The interviews were basically unstructured and open-ended questions were asked. All but five of the interviews were tape-recorded and later transcribed. Those interviews not tape-recorded were recorded by taking notes during the interview. Taking notes was necessary as each of these five interviews were held spontaneously, and a tape-recorder was not immediately available. Several specific points were probed. These included: 1) the type of venereal disease and the manner of diagnosis, 2) the specific number of individuals the respondent chose to tell of the venereal disease and the relationship of these people to the

TABLE I

SOCIO-DEMOGRAPHIC INFORMATION

Variable	Sex	
	Male	Female
Marital Status:		
Married	3	0
Single	9	5
Education Level:		
No College	0	0
Some College	9	5
Completed College	3	0
Age at Time of Infection:		
18-24 Years Old	6	3
25-30 Years Old	4	2
31-36 Years Old	2	0
Type of Venereal Infection:		
Gonorrhea	12	5
Syphillis	0	0
Manner of Diagnosis:		
Private Physician	2	2
Health Clinic	10	3

respondent, 3) the changes in relationships which the respondent perceived to be a result of venereal disease, 4) the manner and method utilized by the respondents during the process of informing others about venereal disease, and 5) the manner and method utilized by the respondent during attempts to keep from informing others about the venereal disease.

At the completion of the interviews, an analysis of the self-reporting by all the respondents was undertaken. Commonality of response were sought, and if found, were assumed to be generic to the interactional processes which resulted as a consequence of the stigma generated by venereal disease.

Limitations

When attempting to generalize from the findings reported in this thesis to the society at large, one must bear in mind that the sample is not representative of the entire population. The sample utilized in this research consisted of young adults ranging in age from 18 to 36 years old. All of the respondents were either in the process of completing a college education or had already achieved this goal. The majority of the respondents were raised in Oklahoma and classified themselves as being primarily from rural backgrounds.

CHAPTER III

ANALYSIS OF DATA

Introduction

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

It appears that people in society today are somewhat aware of the social consequences that will arise as a result of being stigmatized as a possessor of venereal disease, at least to the extent that venereal disease is an illness no one wishes to contract. Venereal disease may often be the topic of nervous jokes but seldom is it the subject of discussion at formal dinner parties. In short, it appears that most people are aware that venereal disease is a problem which can result in

differential treatment by social peers. The attachment of a stigma to venereal disease is readily acknowledged, but until an individual is actually faced with having to deal with the consequences of possessing the disease, it is doubtful that many people could adequately verbalize the specific characteristics that this stigma implies.

Goffman (1963) suggests that a language of relationships rather than attributes should be used to describe the process and effects of stigmatization. Given the social nature of stigmatization, that is, its total dependence upon a social origin, the study of stigmatization should necessarily be the investigation of interaction variations as a result of social response to a negative characteristic. The discrediting characteristic by itself has no meaning. It only begins to assume form and have effect when meanings are attached to it by a viewing audience. The viewing audience then responds to the attached meanings, thus generating variations in interaction processes and relationships.

The study of the stigmatizing effect of venereal disease is the study of the effects on interaction and relationships that meanings attached to the disease will generate. A distinction is being presented by the author between interaction and relationships, while in truth, no distinction exists. A relationship is an interaction. However, for purposes of analysis of the stigmatizing effects of venereal disease, this distinction is necessary. A relationship will be used to describe the interaction process between the individual infected with venereal disease and those people he chooses to tell of his discrediting characteristic. This attribute will modify meanings attached to the interaction between the infected individual and those with knowledge of his

infection, thus changing the relationship, the previously negotiated ways of interacting, which existed between the two participants.

Most people are aware of relationship changes which might occur as a result of the social knowledge of the infection. Perhaps these persons could not verbalize explicitly the amount of change, but certainly they have the capacity to understand the quality of the changes in interaction brought about by venereal disease. The effect of stigmatization by venereal disease can then also be studied by investigating the ways in which individuals with venereal disease attempt to hide the knowledge of the existence of the discrediting information in order to prevent the relationship changes which would occur as a result of social knowledge of infection.

The study of the effects of stigmatization by venereal disease which will be discussed in the following pages will assume two forms. The first being the changes in relationships which occur as a result of stigmatization and the second being the study of the ways in which people go about preventing the changes which they perceive might occur as a result of stigmatization. The initial question to be asked then, is, "what is the stigma attached to venereal disease?"

The Stigma of Venereal Disease

Venereal disease must be viewed as illness which occurs to people in relationship with other people and never as a singular effect on an individual alone. Respondents in the study perceived their disease as a social condition, not as an individual response to a physical change in the body. Most of the respondents, when asked to explain their initial reactions to the realization that they were infected with venereal

disease, expressed devaluations of their social identity. "I felt plagued," or "I felt as if I had leprosy", were common assertions. The respondents appeared to regard themselves as no longer quite suitable for social interaction. They felt somehow spoiled. Reference to such concepts as "plagued" and "leprosy" implied the social nature of certain qualities considered necessary for interaction, qualities which the respondents felt venereal disease deprived them of possessing. One young man stated, "I felt as if I should wear a bell around my neck to warn people I was dirty."

After a brief period of twelve to twenty four hours the respondents related anxiety arising as a result of the damage venereal disease might inflict on their bodies. This concern was generally evidenced only after the infected individual had the opportunity to consider the social changes which would occur as a result of the disease, and this concern with potential damage by the disease was always in association with the changes in possible future interactions. Respondents expressed concern over possible sterility or the inability to achieve erection as a function of the disease. Again, even the damage of the disease was considered only within a social context, inasmuch as the concern over damage was actually concern with its ability to prevent future social interactions of a specified nature--that of sexual intercourse or of giving birth. One young woman, when asked if her immediate concern when told of her infection was one of social consequences or damage to her body, stated the point precisely.

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

> telling someone I wanted to marry that I couldn't have kids because I had the clap.

It appears then that social interaction requires certain capacities on the part of the individual. These capacities are necessary for forming relationships and sustaining interaction. Venereal disease forces the individual to relinquish the possession of these clean, unplagued characteristics and thus changes the way the individual so infected views himself. He no longer considers himself an appropriate candidate for interaction. He becomes devalued in his own estimation because he is lacking in some qualitative manner what everyone else who does not have venereal disease enjoys, that is, an unblemished reserve of social interaction capacities.

Contracting venereal disease appeared to the respondents as one of the mystical tragedies such as fires and auto accidents, which always occur to others but never themselves. All of the respondents were aware of the prevalence of venereal disease but with two exceptions, no one considered venereal disease as an illness they would personally contract. As one respondent stated, "VD is for everyone but not for me." The devaluation of the social identity of the individual so infected by venereal disease appears to be partially a consequence of this attitude of invincibility to venereal disease.

To have contracted venereal disease carries with it the implication that the individual was lacking in attributes necessary for the prevention of its contraction. As one respondent explained,

> I was really ashamed. I'll tell you why. I couldn't believe it. I figured, you know, I was kept cool . . . had, you know, the precautions, the whole thing, and here I end up with it anyway and I couldn't believe it.

It would seem that to contract venereal disease is to be considered lacking in judgement, to be not wise. The respondents stated that they had assumed that if one showed a certain amount of judgement, such as in choice of sexual partners or in the use of prophylactics, then venereal disease would never occur to them. Contracting venereal disease then was somehow equated with showing a lack of judgement on the part of the individual, and this lack of judgement added to the devaluation of the self-concept of the infected person. Not only was the individual blemished because he had contracted venereal disease, but the fact that the blemish was the result of his own stupidity contributed to the conceptualization of the individual as unclean or unfit for social interaction.

The two exceptions to the belief that one would never personally contract venereal disease were individuals who had either contracted their disease from a prostitute or a one night stand. The rationale of the young man who had contracted his infection from a prostitute was, "That's what you get when you use whores." The other exception was a young man who tended bar and had a tendency to pick-up tipsy young ladies for sexual encounters after the bar closed. He assumed that his style of sexual encounters would naturally result in venereal disease at some time. "When you play you gotta pay," was his approach to the contraction of venereal disease. The blemish on personal qualities necessary for social interaction was present in both of the two exceptions, although the blemish of possessing a lack of judgement was not as strong. They appeared to have relieved themselves of this particular meaning attached to the contraction of venereal disease prior to engaging in sexual intercourse simply by the acceptance of venereal

disease as a consequence of their chosen style of sexual encounters, although it is entirely possible that this conceptualization was made after having contracted the disease as a means of coping with the devaluation it caused in their self-concept.

The stigma of contracting venereal disease does not appear to lie with the means of contracting the disease, that is, engaging in sex, but lies rather with the quality of the sexual encounter. All the respondents appeared to associate the stigma of venereal disease with the particular type of individual one contracted it from, that is, from loose individuals who routinely engaged in one night stands or frequented bars looking for sexual encounters.

For all of the respondents, contracting venereal disease was a consequence of association with a particular social world. A superficial glance at the above statement would allow one to make the assumption that venereal disease is associated with a particular type of undesirable persons and that the stigma attached to venereal disease is due to the association with those undesirable persons. However, the implications to social identity are far more pervasive than simple guilt by association.

Thus, for the respondents, an individual who contracted venereal disease was assumed to be the type of individual who was not capable of sustaining a lasting relationship with one particular person. This inability to attract a partner for a sustained interaction, for the formation of a sexually exclusive relationship, was a natural consequence of the lack of possession of the qualities usually found in those who were capable of such feats; that is, the unblemished and the wise. Contraction of venereal disease was used to generalize to the overall

life style of the infected person. The entire life style was conceptualized as one fleeting encounter after another, totally lacking in substance, relating directly to the incapacity of the individual to interact with others on a sustained level. As explained by one respondent,

> Well, I think they might think that I had never had any kind of serious emotional and sexual relation with somebody. They might think that I was the guy that haunted bars and . . . they might fear that they would get VD from me themself.

Venereal disease should not be seen simply as the stigmatization which results from an association with an undesirable person, but rather as a representation of the entire social attributes and identity of the individual, a social identity lacking in substance and basic qualities normally utilized in a sustained relationship. Thus, one could say that the stigma attached to venereal disease is not a case of stigmatization as a result of what a person does, or who he associates with, but rather represents a total social identity, an identity totally devoid of qualities which would attract desirable persons. The stigma attached to venereal disease then is generated not by who the person is, but rather by what the person is not.

The Consequences of Stigmatization on Relationships

Prior to beginning a discussion of the consequences of being stigmatized, one must have a clear understanding of the concept of relationships as utilized by the respondents. There appear to be several types of relationships, with each type assuming different social interaction obligations. The first of these relationships is described as

being a lasting relationship, however, the duration of the relationship has little to do with whether or not it is regarded as lasting since lasting may imply any amount of time from two weeks to a year or more. Sustained interaction of some sort is expected when two people engage in what they term a lasting relationship, that is, the two participants are obligated to spend a certain amount of free time together and expected to be supportive of each other with regard to such matters as career or school achievements. The primary criteria for describing a relationship as lasting is the negotiated sexual exclusiveness between the two partners. The two partners agree to engage in sex only with each other.

A casual relationship is another type of interaction the respondents utilize in describing the various types of interactions. This type of relationship may be subdivided into two separate categories. The first is the casual relationship one engages in with a friend. Again, specific social interaction obligations are assumed when one enters into a casual friendship with a partner. A certain amount of free time is expected to be spent together, although this amount of time is considerably less than that expected in the lasting relationship. Mutual support is another characteristic, although one is not expected to support the partner in the relationship to the extent that is expected in the lasting relationship. Participation in sex together is a negotiated aspect of the relationship although sexual exclusiveness is not expected. The primary differences between the lasting and the casual-friend relationships are the sexual exclusiveness and the amount of time one is obligated to spend in a sustained interaction.

The second category of casual relationships is that of the very casual. Little else besides engaging in sex is expected from any

interaction between the two participants, and neither of the participants are obligated to perform supportive roles outside that of sex partner. Engaging in sex together at some future time when it is convenient for both partners, is implied in this relationship. This assumption of future sexual interaction is the fine distinction between the very casual relationship and the one night stand. The interaction negotiated between participants of a one night stand is strictly for sexual purposes at that time, and future sexual activity is not implied. However, the one night stand, if encountered accidently a second or third time may become a very casual or casual-friend, by classification of interaction together. Seldom does the partner in a casual or one night stand rise from the ranks to full participation in the lasting relationship.

It appears that a great deal of self-esteem is tied to the type of relationships one engages in. One can judge oneself to be a person capable of attracting others to sustained interaction if one can participate in a lasting relationship, that is, be a participant in a sexually exclusive interaction. Prestige is not lost if one engages in sex with friends, because it is assumed that one is capable of sustained interaction, but simply has not discovered the right partner yet. Prestige among peers, and consequently self-esteem, is low if one cannot at any time be the participant in a lasting relationship. One is considered lacking in certain basic qualities necessary for sustained interaction if one has never experienced a lasting relationship. Prestige among peers is almost totally lacking if one is thought only to be able to obtain sexual partners among the prostitutes or one night

stands. Thus, self-concept can be directly related to social interaction of a sexual nature.

Becoming stigmatized by venereal disease represents to the individual a process whereby he is recategorized by himself and others, as lacking in basic interpersonal skills which are utilized in the formation of lasting relationships. The next question to be considered is the results of this recategorization as it applies to social interaction. According to the analysis of the data, the results are usually dependent upon the nature of the sexual encounter in association with whatever type of social relationship the individual is engaging in at the time of contraction. The nature of the sexual encounters studied include several types. These are: 1) contraction from a prostitute or a one night stand while not engaged in a lasting relationship, 2) contraction from an outside sexual source while engaged in a lasting relationship, and 3) contraction from a partner in a sexually exclusive or lasting relationship.

The first social reaction to the stigmatization of venereal disease to be discussed is that reaction generated by contraction from a prostitute or a one night stand. Two of the respondents interviewed contracted their infection from one of the two above categories. The first respondent to be discussed contracted his infection from a prostitute while serving in the military overseas. At that time there were few if any women available for forming an enduring relationship and seeking sexual outlets among prostitutes was a common practice. This respondent did not feel threatened by possible stigmatization due to the geographical circumstances of his environment. He perceived his sexual activity as a normal response in a harsh situation and assumed acceptance by his

peers of his sexual choices. He felt so confident of peer acceptance that when he first began experiencing symptoms of gonorrhea, that is, a urinary drip, he showed the drip to several fellow soldiers for their diagnosis prior to going to a physician for confirmation. However, he did state that since that time he is very much afraid of his wife finding out about that particular incident in his life, for he knows the circumstances have changed and he will no longer find peer acceptance of venereal disease.

The second respondent contracted his venereal disease from a young woman he picked up in a bar. He had never met the woman prior to the sexual encounter and he never saw her subsequently. This young man stated that the confirmation of venereal disease created self-doubt on his part. He began to question his entire life style and wondered if he were capable of forming a lasting relationship with anyone. He had not, up until that time, been interested in a steady relationship, but due to the anxiety generated by the infection, he felt compelled to initiate that type of relationship with someone. He stated:

> I was going through the whole scene of cruising around and picking people up . . . going home with people and people forgetting your name and you never see them again. I wanted a more pat relationship than that . . . a true and loving relationship.

This respondent needed to assure himself that he was capable of forming a lasting relationship, in other words, that he possessed qualities for sustained sexual interactions.

When an individual is in a sexually exclusive relationship and must inform his partner that he has contracted venereal disease from an outside source, it tends to destroy the relationship. There is an immediate loss of trust between the two partners since obviously there has

been outside sexual contact. This loss of trust results in a death of the intimacy previously experienced by the partners. The infected individual, upon informing his partner of his disease, is immediately re-evaluated by his partner. It is at this point that guilt by association appears to have an effect. The uninfected partner no longer feels the infected partner is capable of sustaining a lasting relationship, and if the uninfected partner elects to continue the relationship, then possible doubts will be cast on the interaction capabilities of the uninfected partner. As one lady stated,

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

Thus, in order to maintain the social identity as the type of individual who can indeed form lasting relationships, it is necessary to end the interaction with the individual who is not capable of the same, that is, the infected partner.

Women may be infected with gonorrhea and not be aware of symptoms, thus they may be infected for extended periods of time lasting over several intensive relationships. Three of the women respondents found themselves in this position. Two of the women respondents visited a doctor for treatment of what they had considered a bladder infection which in fact was gonorrhea, and the other woman was diagnosed during a health clinic visit for a yearly pap test. Each of these women were engaged in a lasting relationship at the time of diagnosis. None of the women had participated in sexual encounters outside of the relationship and each of the relationships had been in existence for more than three weeks. When first told of the infection, the women remembered undergoing the feelings of being unclean and plagued, as described earlier,

although these feelings rapidly gave way to anger. The anger was directed toward the respective partners in the relationship under the assumption that the partner was the source of contamination.

The final conclusion by all partners in the relationships was that the female had carried the infection with her into the present relationship and that no party was guilty of extracurricular sexual activity. With this understanding, the relationships were somewhat repaired for the time being, although at the time of the interview, only one of the three respondents was still engaged in a sexually exclusive relationship with the same partner. The women perceived the infection as having little or no affect on the quality or duration of the relationship. As one woman explained, "He didn't hold against me what I did before we met." It should be noted however, that two of the male partners in the relationship had themselves been infected with venereal disease some time prior to engaging in the present relationship.

Due to the uniqueness of the physical symptons of gonorrhea in males, no male respondent carried the infection unwittingly into a new relationship. This appears to be a situation to which only women are subjected. While it is exceedingly difficult to attempt a generalization from such a small number of respondents, perhaps it could be surmised that the usual devaluation of an individual's interaction capabilities is not initiated if contamination from outside sexual contacts is not present and the individuals involved have proved themselves capable of sustained relationships prior to knowledge of the infection.

The amount of anger experienced toward the source of infection, in general, appears to be dependent on the nature of the relationship

between the two partners. If an individual is engaged in an intensive relationship and contamination comes from an outside source, then anger is inevitable. If the relationship between the two partners is not serious, or rather casual, then little if any anger is evidenced, and the general attitude is one of benign understanding. In other words, if sustained interaction were not expected from the encounter, then little anger was associated with the sexual contamination as it related directly to the source. However, devaluation of the individual's interaction capability was always evidenced. Anger was always evidenced toward the source of contamination when the assumption was that sustained interaction and sexual exclusiveness had been negotiated.

In summary, it appears that people derive a great deal of their self-esteem from their relationships. When a person is engaging in an idealized type of relationship, he will judge his interaction capabilities positively and the self-evaluation he assesses upon his social identity will also be positive. Self-esteem will be maintained. He will thus value his social identity because that particular social self is effective in sustaining interaction. Lowered self-esteem will be the consequence of a social identity which is not capable of successfully sustained interaction. The self-evaluation rendered upon the social identity which is not acceptable for sustained interaction will be negative in nature and result in a lowered self-esteem. Any social identity which results in a lowering of self-esteem will generate devaluation of the person by the person.

Venereal disease devalues the person and whatever relationship he is involved in at the time. Contracting venereal disease from a source outside that of a sexually exclusive relationship tends to destroy the

lasting relationship. Guilt by association is implied. If sexual exclusiveness and sustained interaction have not been negotiated between the partners as a basis for their relationship, then less self-concept is tied to the relationship and the interaction between the two participants will not necessarily be destroyed.

Notifying Contacts

When an individual is first informed by a health agency that he is infected with venereal disease, he is usually given the option by that health agency of informing his sexual contacts of possible infection himself or allowing the agency to render him this service. This option is always accompanied by a brief lecture by medical personnel regarding the dangers of untreated venereal disease in an effort to highly motivate the infected individual to actually contact sexual partners to inform them of possible infection. This brief lecture must be effective in motivating infected patients to actively inform sexual partners for the health agency has no way of forcing the patient to perform this act. The brief lecture presents the nature of the dire consequences to the human body if venereal disease is left untreated. The health personnel interviewed during this research felt confident that they were capable of instilling altruistic motivations in the newly infected patients, that is, the patients would inform their contacts in a spirit of love for fellowman. Interviews with patients proved this to be not the only, nor the most important reason for seeking out sexual contacts for purposes of informing them of possible infection.

Individuals with venereal disease will be motivated to seek out sexual contacts for a variety of reasons, most of them having to do

primarily with concern for the patient himself and seldom totally for altruistic concerns alone. The patient, when approached with a choice in the available options, will generally choose to inform the sexual partners himself, or at least, he will agree to do this while still in interaction with health personnel. However, whether he will or not is dependent totally on the type of relationship he was involved in at the time he contracted his infection.

Contraction from a prostitute almost always insures that an active effort to seek out and inform sexual contacts will not take place. With one exception, none of the male respondents attempted to inform the prostitute from whom he contracted venereal disease that she was infected, although each respondent did agree to do this during the time of diagnosis by health personnel. The respondents appeared to consider this additional interaction with the prostitute not necessary. The negotiation between the patient and the prostitute included only interaction for the duration of the sex act and the additional interaction, which informing the prostitute would necessarily involve, was not felt to be appropriate considering the circumstances of the relationship. The one exception to this general behavior pattern was an individual who felt it necessary to cure the infection before he resumed a paying relationship with the lady, inasmuch as he was a regular customer. It would appear then, if there is no negotiation for further interaction past the sex act, then the customer is under no obligation to inform his contact of the spread of the infection. The general assumption is that the prostitute is already aware of the infection and for financial reasons, failed to inform the customer prior to intercourse. None of the respondents appeared greatly angered by this alleged attitude of

the prostitute. They appeared to consider it simply economically sound business management on the part of the prostitute and the contraction of venereal disease a consequence of paying for sex on their part.

Women who contracted venereal disease from a previous sexual partner and carried it with them into a new relationship have already been discussed. With regard to informing sexual contacts of infection, this particular category of respondents were quite adamant with regard to their decision on the need to inform the contact of venereal disease. As a whole, this category of respondents never made any effort to inform the contact at all. They, like the males who contacted from a prostitute, also considered the contacts as being aware of the infection; the difference between the two groups lies in the amount of anger this purported awareness generated.

Anger was evoked from what was considered a grossly negligent act on the part of the male contacts. The women respondents considered this negligence a desecration of the past relationship. The women as a whole commented that the incident, that is, the belief that the male contacts were aware of the disease and had neglected to tell them, spoiled the memory of the relationship. As one woman stated, "I felt cheapened. It made me feel that what we had wasn't what I thought it was." An interesting point was made during the interview when each woman questioned whether males were always aware of gonorrhea. It was as if each respondent was seeking reassurance that her hostility toward the male contact was valid. One woman stated the attitude quite precisely,

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

With the exception of contacting the male partners believed to be responsible for the infection, the female respondents informed all sexual contacts of possible infection. Unlike the male respondents, the females did, in certain circumstances, go to great lengths to do so. One of the women respondents had sexual intercourse with a contact who was married, and in order to inform him of possible infection, sent a registered letter to his house asking him to call her. She felt so compelled to relay this information to him that she risked creating possible marital difficulties for her contact.

With the exception of contraction from a prostitute, men are also inclined to inform contacts of possible infection. Certainly, the matter of risk to the body of the female contact is a crucial point in the decision to tell, however, other factors are also just as vital. If the male respondents are involved in an intensive relationship, they may feel compelled to tell their partner in order to force the partner to seek treatment. The newly infected individual who is engaged in a lasting relationship must inform the partner of the supposedly sexually exclusive relationship or risk reinfection. As one young man stated,

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

If the contact with venereal disease occurs within a relationship that is considered casual rather than intensive and no sexual exclusiveness is implied or negotiated, then risk of reinfection is not pertinent and other connotations come to light. In dealing with informing casual relationships, a more personal basis than fear of reinfection is evoked.

As one patient stated,

> Now, I think, well, if I had relations with someone, it would be more a . . . less a sexual thing, more of a . . . I mean there would be some kind of other communication between us. We'd at least have to be friends, and you know, I'd want them to know, because when you see a girl often enough, you know, someone else could get the same condition I got. You know, if you know someone who's got leprosy and they don't know about it, you ought to tell them.

With regard to informing sexual contacts in casual relationships, all the respondents considered the need to inform as an obligation stemming from the negotiated relationship. As long as the sex partners were not prostitutes, the respondents appear to have equated participation in intercourse, even on a one-time basis with no future encounters planned, as being the basis for an interaction which called forth the type of relationship that necessitated the informing.

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

When the actual method of informing contacts is discussed, it appears that if the relationship is casual then the telephone provides

an adequate means. However, if the contact is a partner in a lasting relationship with the newly diagnosed individual, then only face-to-face interaction is acceptable.

If the need to inform arises and the contact is someone with whom no future sexual encounters are expected, then the infected individual appears not to feel an obligation to explain the circumstances of the contraction. One young man called his casual contact on the telephone,

> I gave the poor girl a call and told her she should . . . We, I said I don't know where I got it, I used a little tact there because I knew I got it from her. But I said, 'I really don't know how to explain this and I doubt if you're involved, but you really ought to get checked out. It's only fair to tell you that I've caught a case of the clap and I might have given it to you or possibly someone else might have before we got together.'

If an individual is involved in an exclusive relationship with a contact or perceives that intercourse might possibly occur at some future time, then absolute honesty appears to be the motto.

> It was hard to get the nerve up. I thought about what I was going to say. I felt open about it inside, I wanted to say it inside but to say it openly was hard, I'm not used to talking about stuff like that. There was more of a need to tell her because of what may go wrong, what may happen to her. You know, I weighed the consequences of if I didn't tell. But, then, if I did it would be all cleared up so I went ahead and told the truth.

One young man related the fact that he conceived several stories which he thought might be more acceptable to his girlfriend but elected at the last minute to tell the truth. "Well, I just told her the absolute truth that I had been to Norman and I got right into this girl up there and I had to tell her, she had to go get treatment."

However, there are certain circumstances which necessitate lying. One male respondent admitted to lying to his contacts when informing them of possible infection. "I didn't tell them I caught it from a

hooker. It might make them feel bad about themselves to think that they had been with a man that uses hookers." It would appear that this respondent was acutely aware of the devaluation which would occur in both the relationships he was engaging in and in the self-esteem of the participants in those relationships if knowledge of his use of prostitutes became available.

In summary, unless the infection was contracted from a prostitute, generally most males will inform sexual contacts of possible infection. With the exception of contact from a previous relationship to whom knowledge of infection is alleged, women will always inform contacts of possible contraction of venereal disease. When informing contacts in a casual relationship, no obligation to explain the circumstances of the contraction is felt, however, should the infected person be participating in a lasting relationship, then nothing but the entire truth is considered acceptable. Perhaps the need to tell the entire truth is a means of salvaging some remnants of the social identity of the infected person which was offered for interaction prior to the devaluation which occured at the moment of confession. If this need to tell the truth is viewed as a disclaimer, then one can perceive the act as an attempt on the part of the individual to prevent total destruction of his social identity. In essence, he may be attempting to prove that he is not totally devoid of qualities necessary for sustained interaction because he is capable of one of the requirements, that of honesty.

Passing

In an effort to prevent the stigmatizing process from occurring, most individuals with venereal disease employ a strategy which Goffman

(1963) refers to as passing. Passing is utilized in the attempt to prevent the larger society from becoming aware of the discrediting attribute. In short, it is a means of concealing the attribute. Passing may assume several forms. The individual may simply avoid situations where he must reveal his attribute, that is, the existence of venereal disease, or he may simply lie and deny its existence. All the respondents in the study played a passing role at some time.

The most common form of passing occurred with social groups during leisure time activities. All the respondents reported being in a group at some time during which venereal disease was discussed in a joking manner. None of the respondents admitted to the group that they had been victims of the disease, nor did any of the respondents go so far as to announce that venereal disease is no joking matter. In the majority of cases, the respondents stated that they simply laughed at the appropriate times and waited for someone to change the subject. No respondent reported brining up venereal disease as a subject for discussion. As one patient stated "If someone brings it up, I just look the other way." However, one respondent did report joining in the joking in an aggressive manner. As he explains,

> I can joke about ovens over in Germany, you know. That doesn't mean I would operate one, but I can be pretty cold blooded in a good joke. I'm not squeamish; I'll go ahead and joke about it if the occasion were to arise.

Another example of passing is described in the restrictions respondents placed on themselves immediately after diagnosis. Each respondent was informed by his physician to avoid sexual encounters for a period of two weeks. For those individuals who were not involved in a lasting relationship where disclosure of venereal disease was forced,

alternative means of preventing disclosure were employed. Those individuals altered their lifestyle for the short period during which they were not to engage in intercourse by avoiding social encounters where such activity might presumably take place. As one respondent explained, "When the weekend came along, I just didn't go out partying. I just didn't ask anyone out and I just cooled it."

Another form of attempting to pass revolved around filling out job applications. Most job applications include a section for the applicant to fill out concerning past illness. Venereal disease is often listed as one of the illnesses the applicant is to check if he has ever been exposed. Not all the respondents had filled out such an application since contracting venereal disease, but of those who had, all but two respondents lied and stated they had never contracted venereal disease. The two exceptions stated that they admitted to having venereal disease because they thought their health records would be made available to the company. They admitted weighing the consequences of being caught in the lie with telling the truth, and decided to tell the truth. They felt they would appear more honest by admitting to the discrediting information they thought the company was capable of obtaining.

One respondent was quite verbal regarding his decision to lie on a job application. He stated,

> I'm not going to discuss my personal life with a computer or someone who looks over papers as if he were a computer. If he wants to discuss personal things with me, he can look me in the eye. I'll lie and I'll sign that lie, too. If they want to know me, they'll get to know me. If they want to know my paper, they can look at it all they want.

Another form of passing is engaged in when the individuals become involved in relationships with new partners. Again, the choice is not

to tell the partner that venereal disease is an aspect of their past. None of the respondents felt an obligation to inform new partners in relationships of past episodes of venereal disease, although, most spouses were informed. Perhaps the marriage situation implies a commitment which includes honesty, which another type of involved relationship does not, although it is entirely possible that the respondents felt the partner might discover the information by himself.

With regard to passing, it appears that respondents will conceal or lie about discrediting information if at all possible. If the situation arises where it is felt that concealment is no longer possible, then individuals with venereal disease will attempt to inform before they are discovered. This may be viewed as an attempt on the part of the individual with the discrediting attribute to salvage some aspect of a credible social identity.

It is felt that the newly discovered knowledge of venereal disease will blemish the social identity, so individuals will attempt to bring forth other social qualities for the interaction which are not discredited. In short, when passing is no longer feasible, normalization will occur. Individuals will attempt to salvage some aspect of credible social identity by brining forth honesty as a quality upon which to focus interaction.

Motives for Self-Identification

All the respondents were asked why they chose to come forth and identify themselves as having contracted venereal disease. Each respondent, with the exception of one, identified himself as being motivated by altruism. Common responses to the question of motivation

ranged from, "I wanted to help you out because I knew how hard it must be for you to get anyone to talk to you," to "I know how difficult this was [having VD] for me and I want to make it easier for someone else and I thought your research would help other people." The one exception was a young woman who had recently contracted her infection. She had confided in only one other person that she had contracted venereal disease and frankly admitted that she was motivated to talk to the researcher by a need to discuss the episode of infection with someone she felt would not be judgmental and with whom she would not have further interaction past the interview.

The young lady who admitted her need to talk about venereal disease had undergone her episode of venereal disease just three months prior to the interview. She was the most recent recipient of venereal disease among the respondents. Although letters requesting interviews had been passed out at the local health clinics to newly diagnosed venereal disease patients, none of the newly diagnosed consented to participation in the research. It appears that the length of time involved since an episode of venereal disease accounts for a willingness to participate in research concerning venereal disease as well as accounting for the reasons given by those respondents who did participate.

With regard to stated motivations by respondents for participation in research, assertions regarding aid to the researcher were associated with infections six to eighteen months old. Assertions regarding aid to humanity were associated with infections more than eighteen months old.

Those respondents in the six to eighteen month period attempted to personalize the interview situation by asserting a personal concern for the researcher as motivation for participation, that is, wishing to aid

the interviewer. Those whose episodes were more distant stated greater concern for humanity at large, that is, a desire to aid others in the same situation and a more personalized interaction with the researcher was not attempted. These time categories correlated with the number of additional people informed of the venereal disease by the respondents outside those individuals involved directly in the informing of contacts process. Those whose infections were more recent had told a lesser number of additional people, as shown in Table II.

TABLE II

NUMBER OF PEOPLE INFORMED BY THE RESPONDENTS

Time Since Infection	Male	Female
0-03 months	0 (N=0)	1 (N=1)
4-06 months	5-07 (N=2)	2-3 (N=2)
7-12 months	5-10 (N=3)	5 (N=1)
13-18 months	8-12 (N=5)	6 (N=1)
18 months and longer	7-15 (N=2)	0 (N=0)
	12	5

Perhaps it can be surmised that the shorter the time span since the infection the greater the desire on the part of the individual to present more personalized motivations to the interviewer, that is, the greater the desire on the part of the respondent to establish a more

personal one-to-one relationship. With the length of time since the contraction of venereal disease expanded, the respondents did not need to personalize the interview situation as greatly and wished to present themselves as more concerned with humanity. It may be that with the lesser number of additional people told, the respondents had a greater need to participate in a more intimate interaction, while on the other hand, those who had previously informed a larger number of additional people had had the greater opportunity to engage in more direct interactions during which venereal disease was the subject of discussion.

For those respondents still stunned by the spoiled social identity generated by the disease, a more personal relationship is necessary, perhaps as a means of proving to themselves that they are still capable of interaction. For those whose venereal disease episode was further in the past, interaction capabilities had already been tested and found acceptable. The social identity as presented by the respondents, when viewed in the context of stated motivations for participation in the research project, can be concluded as being dependent upon the length of time since contraction of venereal disease.

Altruistic motivations as stated by the respondents with regard for the researcher or humanity at large can be viewed as another example of normalization by the recipients of venereal disease. Each respondent may be attempting to bring forth an alternative quality for concentration during interaction, that quality being concern for fellowman, and should thus have this interaction viewed as an attempt to salvage some aspect of a presentable social identity.

CHAPTER IV

CONCLUSION

The theoretical framework utilized throughout this thesis has conceptualized stigma as consisting of three major components, these being 1) that stigma is used in reference to a perceived attribute which is deeply discrediting, 2) that the consequence of possessing the discrediting attribute will be manifested in interaction, and 3) that a stigma cannot exist apart from interaction. Possessing the attribute of venereal disease can appropriately be termed a stigmatizing attribute as defined in the theoretical framework inasmuch as it cannot be conceptualized independent of the operational definition of stigma utilized in this thesis.

However, given the nature of venereal disease, that being its non-visibleness, it does possess a certain unique quality that sets it apart from other types of visible stigmatizing attributes. While it is true that the effects of social response to some stigmatizing attributes must be experienced in a social situation of interaction before the possessor of the attribute is aware of the interactional changes that occur which label the possession as stigmatizing, venereal disease is an attribute which people are aware of as implying a spoiled identity prior to the offering of that social identity for interaction. Individuals have the capacity to attach meaning to venereal disease prior to actually experiencing venereal disease. This is evidence in the immediate changes

in self concept experienced by newly diagnosed patients. Prior to experiencing venereal disease personally, people conceptualized venereal disease as stigmatizing inasmuch as they relate themselves as being unclean or dirty at the moment their social identity is fused with the attribute of venereal disease. In other words, meaning is previously attached to the possession of venereal disease and at the time of diagnosis, people simply include themselves into the previously defined meaning of venereal disease and in essence, become in their own minds, spoiled due to the inclusion of their identity with venereal disease.

It is essential that one understands that the immediate fusing of the social identity with the spoiling attribute is not independent of social interaction. These previously constructed meanings of venereal disease were derived from interactions which occurred during earlier social encounters. The changes in self concept which occur with individuals infected with venereal disease, of course, are dependent on the process of interpretation by the individual. It is possible for venereal disease to have no stigmatizing meaning for an individual so that the possession of the attribute will not result in lowered self-esteem. This process of interpretation is interactionally based. This point is evidenced in the young soldier who contracted his venereal disease overseas. The meaning attached to venereal disease at the time of his contraction was not one that generated stigmatization, although, as he stated, it would be stigmatizing at this time and point. His social environment for interaction had changed with his return home, and in conjunction, so did the meaning he attached to venereal disease.

Due to the immediate changes in self-esteem which occur as a result of venereal disease, interaction is also changed for the individual even without the awareness of the viewing audience of the negative attribute. People have the capacity to make objects of themselves in their minds, to engage in interaction with themselves, and to visualize the consequences of their own performances. It is this unique ability to conceptualize social reaction which provides incentive for people to engage in interactional changes which occur as an effect of the possession of the stigmatizing attribute. People project a viewing audience in their minds and will initiate interaction variations as a consequence of their perceptions of possible viewing audience response. An example of this is the young man discussed in chapter three who felt motivated to seek out a lasting relationship as a consequence of contracting venereal disease. He understood the implications venereal disease carried with regard to social identity. He was able to create a social response to the venereal disease conceptually because of the possible responses such an attribute would generate in an actual physical social interaction, thus he was compelled to seek a lasting relationship. He had not actually experienced the process of being labeled by a viewing audience as being incapable of securing a lasting relationship. He had simply attached the meaning he felt the viewing audience would project to his attribute should an awareness be created in the social audience and acted accordingly in an attempt to salvage part of his not yet spoiled social identity.

Goffman explains that a language of relationships should be used to describe the stigmatizing process. This point is essential to the understanding of venereal disease as a discrediting attribute.

Individuals infected with venereal disease appear to perceive themselves in association with their illness only in terms of social relationships. For the individual so infected, venereal disease represents changes in relationships exclusively. Venereal disease can be described totally in terms of relationship changes which occur as a consequence of the disease. Even the physical effects the disease may evoke in the body are viewed in terms of relationship to future interactions. The concern expressed by the respondents was not simply that they may be left impotent or sterile, but rather how they should explain this physical condition to others. The meaning attached to venereal disease was generalized to future interactions.

Directly related to the description of the effects of venereal disease as a stigma in association only with relationships is the negotiation of these relationships which is generated by venereal disease. The study of venereal disease as a stigmatizing process is actually the study of the negotiation of relationships. One must understand that to possess venereal disease is to possess a spoiled social identity. The social identity is spoiled not only for the individual but also for the viewing audience. This spoilage is the result of activity on the individual's part which resulted in a failure to meet normative expectations. The failure in meeting normative expectations lies in the inability of the individual to form lasting relationships since venereal disease should not be an aspect of a lasting relationship. The stigma generated by venereal disease produces a recategorization of the entire social identity of the individual, or in Garfinkel's terms, a degradation ceremony begins. The individual with venereal disease is placed

in the position of attempting to negotiate the strength of the labeling effect generated by the degradation ceremony.

Generally, when socially defined assumptions are not met, accounts as described by Lyman and Scott are employed in order to gain some type of sympathy from the viewing audience which might result in a lessening of the severity of the social response. With regard to the negotiation of the labeling effect of venereal disease by the respondents, account giving was not found to be a generic response to the stigmatizing situation. Individuals did not employ accounts. Individuals simply did not expect to be relieved of their responsibility for not meeting socially defined expectations nor did they attempt to prove that given the situation at the time, these social assumptions should be suspended. Rather, they seemed to understand that a certain amount of damage to the presented social self was their due. Disclaimers, not accounts, were employed consistently in the negotiation of labeling effects.

While disclaimers are usually viewed as a means of gaining audience acceptance prior to the committment of a social act which would normally generate a negative response from the viewing audience, disclaimers were also employed by the respondents in a unique manner inasmuch as they were utilized after the fact of a social act in an attempt to relieve the severity of the social consequences. Individuals so stigmatized with venereal disease seemed to accept that their social identity would be spoiled, and the argument was not that the spoilage was unjustified. The spoilage was accepted by the individuals, even to the extent that they conceptualized themselves as spoiled prior to the offering of the stigmatizing attribute to a viewing audience. Disclaimers were utilized in an attempt to salvage part of a social identity. Their request was

not for the continuation of a whole, undamaged social identity, but rather for the retention of a part of the social identity which was considered acceptable. This is evidence in the completeness of confession by the respondents to partners in a lasting relationship. They appeared to be admitting that indeed they deserved to be discredited because they were infected with venereal disease, however, total discredit was not justified because at least they were honest in admitting the discrediting attribute. The claim, then, is for partial salvation of the social identity due to the acceptable attribute of honesty. It would appear then, that when one considers the types of moral careers one engages in while attempting to deal with the stigmatizing effect of venereal disease, disclaimers are utilized when one engages in the moral career of normalization.

The ability to utilize disclaimers appears to be associated with the length of time one has had in experiencing the effect of the stigma. This may be a direct result of trial and error on the part of the individual as he progresses from one interaction to another. He may become quite pragmatic as he gains more experience in dealing with his attribute during interaction. He may find that one disclaimer is more effective than another in the salvation of a part of his social identity and will thus utilize the more effective disclaimer. This can be seen in the types of disclaimers offered by the respondents to the researcher as a function of the length of time involved since the infection. As a disclaimer is employed and found effective during interaction for relieving the severity of the damage to the social identity, the individual may become more confident of his ability to salvage part of his social identity, thus causing him to identify more and more with the

moral career of normalization and less with the moral career of passing. This concept of practice with disclaimers may be used in an explanation of why only respondents with a past history of an infection three months old or longer willingly participated in the research. Perhaps a newly diagnosed individual had not had the opportunity to experiment with the use of disclaimers in interaction and was unaware of the ability to negotiate social reaction through utilization of disclaimers.

In conclusion, venereal disease may be seen as an attribute which is deeply discrediting. Possession of this attribute generates changes in interaction experienced by the recipient of the infection. Venereal disease may be described by an accounting of the changes in relationships which occur as a consequence of being infected. Negotiation of the labeling effect generated by venereal disease may be viewed in terms of disclaimers employed by the infected individuals. The decision to engage in a moral career of either passing or normalization may be seen as a function of the individual's ability to employ disclaimers effectively.

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