

Management of the stressful stigma attached to sexually transmitted disease (preliminary report)

Radzenie sobie ze stresującym piętnem choroby przenoszonej drogą płciową (badania wstępne)

Rzepa Teresa¹, Żaba Ryszard², Silny Wojciech²

¹ Warsaw Scholl of Social Sciences and Humanities, Campus in Poznan, Poland

² Department of Dermatology, Poznan University of Medical Sciences, Poznan, Poland

Abstract

Background: Syphilis and other sexually transmitted diseases may cause some psychological problems and anxiety among the infected patients.

Objectives: The aim of the study was to examine the differences in stress level and stress coping strategies of patients infected with syphilis and healthy controls. Also, the authors aimed at establishing types of strategies to cope with the stigma of sexually transmitted diseases.

Material and Methods: The study was a survey of 21 syphilis infected subjects and 21 healthy subjects, paired according to age and gender. The respondents used the SRRS questionnaire with some additional questions and the Mental Adjustment to Disease Mini-MAC Scale in Polish adapted version. The latter was given to the syphilis-infected subjects only.

Results: The syphilis infected subjects experienced more acute stress than the healthy subjects. Most healthy subjects used the active task strategy to cope with stress while the infected subjects (particularly females) chose the escape strategy and the 'waiting out' strategy. The infected males preferred an active style of coping with the stigma; among the females, the anxiety style was dominant.

Conclusions: Syphilis is a source of permanent stress and awareness of the possible social consequences is a strong stimulus, prompting the stigma bearer to keep its existence a secret.

Key words: **syphilis / stigma / disease coping strategy /**

Adres do korespondencji:

Ryszard Żaba
Department of Dermatology, Poznan University of Medical Sciences
ul. Przybyszewskiego 49, Poznan 60-355, Poland
phone: +48 61 86 91 718, fax: +48 61 86 91 572
e-mail: zaba@dermatologia.pl

Otrzymano: 15.06.2011
Zaakceptowano do druku: 16.08.2011

Streszczenie

Wprowadzenie: Kiła i inne choroby przenoszone drogą płciową mogą być przyczyną zaburzeń psychicznych wśród chorych.

Cel: Celem pracy było sprawdzenie różnic w zakresie poziomu stresu oraz strategii radzenia sobie z nim między chorymi na kiłę i osobami zdrowymi oraz ustalenie stylu radzenia sobie z piętrem choroby przenoszonej drogą płciową.

Metoda: W badaniu uczestniczyło 21 chorych na kiłę (14 mężczyzn i 7 kobiet) oraz 21 osób zdrowych, dobranych parami pod względem płci i wieku. Zastosowano Kwestionariusz SRRS z dodatkowymi pytaniami oraz (tylko dla pacjentów) Skalę Przystosowania Psychicznego do Choroby Mini-MAC, w polskiej adaptacji.

Wyniki: Chorzy na kiłę doznali bardziej dotkliwych wydarzeń stresujących niż ludzie zdrowi. Wydarzenia te są powiązane z piętrem kiły. Niemal wszyscy zdrowi radzą sobie ze stresem za pomocą aktywnej strategii zadaniowej, zaś chorzy (zwłaszcza kobiety) stosują strategię ucieczkową i „na przeczekanie”. W przypadku chorych na kiłę mężczyzn przeważa aktywny styl radzenia sobie z piętrem, zaś w przypadku kobiet – styl lękowy.

Wnioski: Piętno kiły jest przyczyną wysokiego poziomu stresu u chorych mężczyzn i kobiet. Świadomość napiętnowania i dotkliwych konsekwencji społecznych jest znaczącym hamulcem przed ujawnieniem prawdy o chorobie i może prowadzić do jej rozprzestrzeniania się.

Słowa kluczowe: kiła / piętno / radzenie sobie z chorobą /

Background

Nowadays an illness and its aftermath are known to be the source of psychological stress [1-7] but it is particularly true of illnesses which carry the stigma, such as sexually transmitted diseases [5, 8]. From the psychosocial perspective, the theory of stigma proposed by Erving Goffman can be regarded as the one which adequately and precisely explains the behavior and feelings of patients who are ‘stigmatized’ by such diseases [5]. According to Goffman’s theory, the stigma is (1) an attribute (e.g. outstanding ugliness, physical disability, obesity, untidiness, negative national traits like arrogance, submissiveness, quarrelsomeness, etc.) which brings discredit upon a given person (or a social group); (2) a particular kind of relation between the stigmatizing attribute and an acknowledged stereotype.

In cases when the stigma and the awareness of being stigmatized (and the frequency of experiencing aversion, rejection and social exclusion) are connected with clearly visible characteristics, discrediting of the stigmatized person depends largely on the knowledge and culture of the observers. Moreover, the strength and quality of discrediting behavior depend also on the acknowledgement and exposition of the stigma by its bearer and the bearer’s attitude to the stigma. In case of sexually transmitted diseases, however, factors which usually diminish the negative power of the stigma do not operate at all.

Sexually transmitted infections (STIs) are a major global reason for acute illnesses, infertility, long-term disability and even death, causing severe medical and psychological consequences for millions of men, women and infants. The WHO estimated that over 340 million new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis occur annually throughout the world in men and women aged 15-49 [9-13]. The ratio of sexually transmitted diseases, including syphilis, has grown conspicuously in recent years. It is believed to be the aftermath of people’s migration and risky sexual behavior – these diseases are most frequently contracted (about 95% of all cases) during sexual intercourse. Syphilis (*syphilis*, *lues*) is an infectious, chronic disease caused by spirochete *Treponema pallidum* or *Spirochaeta pallidum*.

The course of the disease is characterized by varying intensity of various and symptom-rich clinical changes, interspersed with asymptomatic periods.

The disease was first mentioned at the beginning of the 16th century and brought to Europe by sailors coming back from far away countries. Epidemiological data point to the decrease of cases in the last decades of the 20th century. However, 936 cases of all forms of syphilis were reported in Poland in 2006 – 127 more than a year before. The ratio of early latent syphilis has also increased. Infants with congenital syphilis have still being born. 83 women were diagnosed with syphilis during pregnancy or labor in 2006 comparing to 70 women in 2005. Syphilis in a pregnant woman may result in a miscarriage; in an infant it may lead to numerous lesions of internal organs, including the nervous system. In Western Europe, the prevalence of syphilis has declined substantially since its peak after the Second World War, with incidence rates below 5 per 100 000 in most countries [9-13].

In most stigmatizing diseases, particularly those which are sexually transmitted (or known as ‘venereal’ as they have been called for centuries – the name being far from ‘correct’ though adequately pointing to the source), one needs to face an extremely complicated psychosocial situation. To an outsider, the stigma of the disease is either not visible at all or hardly recognizable. It is the bearers of the stigma who know about the disease and they have the discretion to decide whether to hide or reveal its existence. Undoubtedly, this is a very difficult and stressful decision. Being brought up in particular social and cultural environment, the stigma bearer is fully aware of the possibility of being not only ‘marked’ with a derogatory label (like ‘infected’, ‘lecher’, ‘clapped-up’, ‘sypho’) but also of being openly rejected and socially excluded. Anticipating the occurrence of various forms of social ostracism, the stigma bearer is strongly inhibited from revealing the existence of the disease. In addition, this knowledge is reinforced with double shame combined with guilt: firstly, because of having the discrediting attribute, and secondly, because of the stigmatizing content of the stereotype

of a venereal disease. As the stereotype holds, venereal diseases are the evidence of having committed one of the cardinal seven sins – covetousness – which is equivalent to leading a lustful life. At the same time, the stereotype explains the contraction of a venereal disease as God's punishment imposed upon lechers and 'fornicators'. On the other hand, however, this reason-based and well established belief is the basis of the strong and widespread fear of sexually transmitted diseases, particularly of syphilis and AIDS.

Objectives

Therefore, the stigma bearers are under a continual stressful strain, thus experiencing an inner conflict which Goffman describes as the conflict between acting openly and acting adequately, as they wait to be condemned and gather their strength to fight back [5]. Faced with social situations the stigma bearers must make stressful choices and decide (each time taking into consideration the self, other people and the kind of situation – particularly intimate situations) which role to assume: whether to be a normal (stigma-free) and 'adequate' person or an 'open' person stigmatized with a venereal disease. As it may be expected, the majority of choices in the latter case would bring failure because the chances of being understood and approved by another person are very limited, indeed.

It seemed interesting, therefore, to examine differences in stress level and coping strategies of syphilis infected and healthy people. The authors assumed that diseased people would experience much more severe stress related to life situations connected with the stigma of syphilis and choose passive strategies of stress management more frequently than healthy people. Additionally, the authors assumed that, due to the power of the stigma, people infected with syphilis would prefer the anxiety style of coping with their disease.

Material and methods

In order to prove the hypothesis that people infected with syphilis experience different stress levels and prefer different coping strategies than healthy people, from July 2007 to October 2008 the authors examined 21 patients (14 men and 7 women) treated at the Dermatological and Venereological Ward of the Clinic of Dermatology in Karol Marcinkowski Medical University in Poznań, Poland. The average age of the males was 32.5, of the females – 32.0; two women were heavily pregnant. The healthy subjects were recruited among the extramural students enrolled at that time to the sociology program at the University of Szczecin. It was not challenging to pair them into 21 couples (14 male and 7 female ones), matched by age.

Considering the delicate matter of the study, the interviews were entirely anonymous and were conducted individually by an experienced psychologist. The patients, who had been identified by an experienced dermatologist specializing in sexually transmitted diseases, were told that the experimenters would study the relation between hospital treatment as a stressful situation and stress-coping strategies and skills of patients. Interestingly enough, the authors made an observation which once again proves the power of the stigma in inhibiting the revelation of its existence. An individual interview lasted for about two hours and despite the fact that in each case the psychologist established a good relation with the patient and created an atmosphere full of understanding

and interest, and despite the openness and additional chats about personal problems of the patients, only 3 persons from the whole group actually openly used the name of their disease and pronounced the word 'syphilis' (one did it by mistake).

The SRRS Questionnaire was used to establish the level of stress the subjects had experienced in the last two years [14]. Additionally, the subjects were asked to (1) identify and assign the value (in numbers 1-5) to five most stressful events of their life; (2) answer a basic descriptive question about how they coped with stress and indicate the preferred strategy (active/task, passive/escape-retreat, passive/waiting out); (3) specify the level of coping with stress on a 1-5 scale. This tool was used to examine both groups. These relations were verified of the χ^2 test. In addition, the syphilis infected subjects filled in the Mental Adjustment to Disease *Mini-MAC* Scale in the Polish adapted version [15-16]. Needless to say, all words referring to carcinoma were omitted.

Results

All results obtained in the study were shown in Figures 1-4.

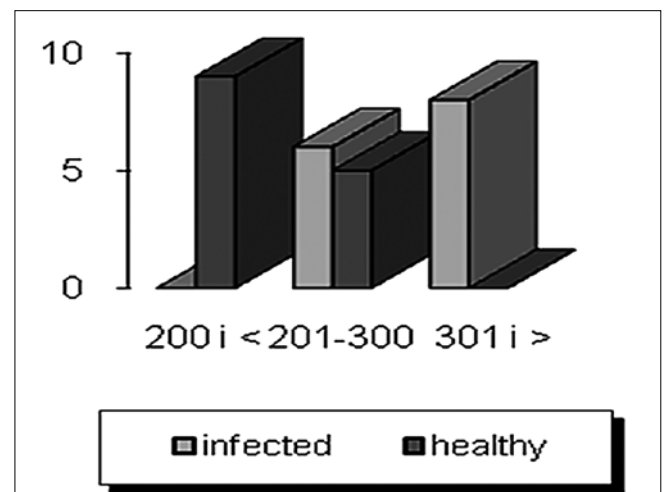


Figure 1. Stress level in the last two years for syphilis infected and healthy male subjects.

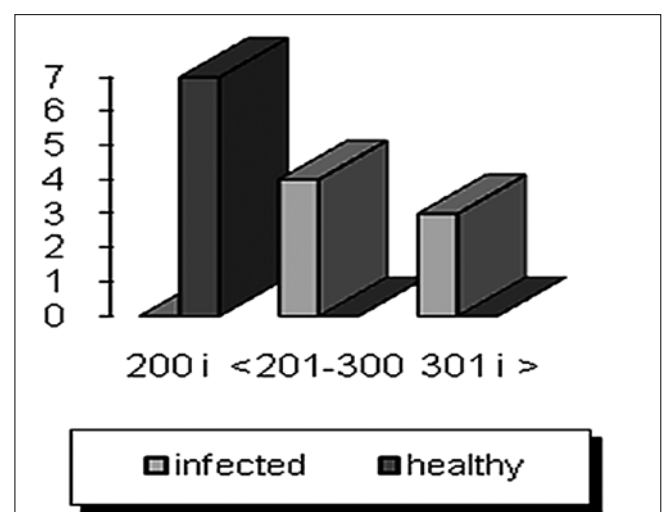


Figure 2. Stress level in the last two years for syphilis infected and healthy female subjects.

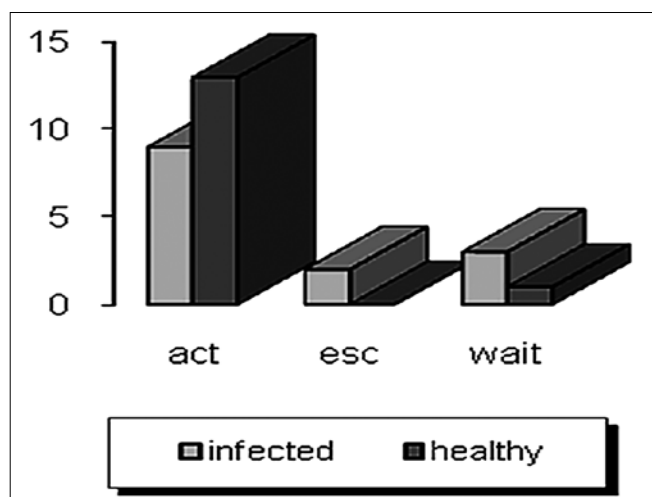


Figure 3. Coping with stress for infected and healthy male subjects.

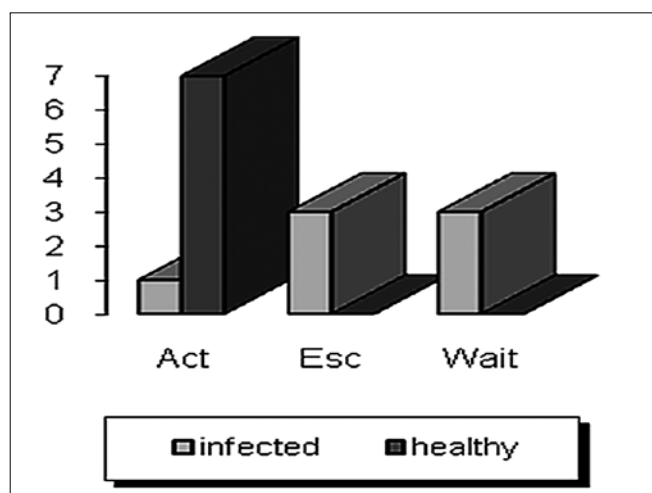


Figure 4. Coping with stress for infected and healthy female subjects.

The differences are statistically significant ($p < 0.01$). The five most stressful life situations most frequently indicated by the syphilis infected male subjects were as follows: 6 – own serious disease; 3 – separation or breaking up with the partner; 19 – change of job; 4 – death of a close family member; 14 – sexual problems.

The differences are statistically significant ($p < 0.025$). The five most stressful life situations most frequently mentioned by the syphilis infected female subjects were as follows: 6 – own serious disease; 3 – separation or breaking up with the partner; 19 – change of a job; 4 – death of a close family member; 11 – serious illness of a family member; 20 – quarrels with husband or partner. (Table I).

For the preferred stress coping strategies (Figures 3 and 4) the differences are statistically significant for all infected and healthy subjects, irrespectively of gender ($p < 0.05$). It is worth noting that the infected male subjects self-rated their stress coping skills as 3.15 on average (on a 1-5 scale) and the healthy subjects rated them as 4.32.

Similarly, infected female subjects self-rated their skills much lower (the average was 2.83) than the healthy subjects (3.81).

Data on the styles of coping with the stigma of the venereal disease of examined males and females are shown in Table 2. The styles derive from the Mental Adjustment to Disease *Mini-MAC* Scale in the Polish adapted version [15-16].

Table I. Events found stressful by infected and healthy subjects (compared).

| Categories | Infected subjects | Healthy subjects |
|--|-------------------|------------------|
| Own serious disease | 85.7 | 4.8 |
| Separation or breaking up with partner | 76.2 | 9.5 |
| Serious illness of a family member | 61.9 | 14.3 |
| Sexual problems | 52.4 | 4.8 |
| Job change | 38.1 | 14.3 |
| Quarrels with husband or partner | 33.3 | 9.5 |
| Death of a close family member | 28.6 | 19.0 |
| Paying off a large debt | 14.3 | 47.6 |
| Business readjustment | 9.5 | 42.8 |
| Accident | 4.8 | 28.6 |
| Moving house | - | 23.8 |

source: the authors' own study

Table II. Styles of coping with the disease – syphilis infected male and female subjects compared.

| Style | Males (per cent average rate) | Females (per cent average rate) | (Per cent) average for style |
|--------------|-------------------------------|---------------------------------|------------------------------|
| 1. Active | 73.1 | 51.1 | 62.1 |
| 2. Anxiety | 43.3 | 62.9 | 53.1 |
| 3. Cognitive | 52.5 | 43.9 | 48.2 |
| 4. Helpless | 27.9 | 38.1 | 33.0 |

source: the authors' own study

Discussion

The present comparative study shows not only that the syphilis infected subjects experienced significantly more stressful events than the healthy subjects but that these events had and have been clearly related to the kind of the disease (the stigma). Both infected male and female subjects perceived their own serious disease as the most stressful life event in the last two years and rated it as number one. It is also important diagnostically that the infected males as well as the infected females rated separation or breaking up with the partner as number two. The authors presume that this event was the consequence of the patients being diagnosed with syphilis.

This presumption is confirmed by comments of the three aforementioned subjects who revealed the name of the disease: the woman confessed she had broken up with her partner as soon as she had been diagnosed; the two men said they had been

hastily abandoned by their partners the moment they decided to assume the 'open' role [5]. Moreover, the infected male subjects often rated the change to a different job as an extremely stressful event. It is quite likely that they made such a decision for fear that the true reason of their hospital treatment (for some it was the second treatment) would be revealed. The fact that male subjects self-rated sexual problems as an extremely stressful event is symptomatic and does not call for a comment. Besides, it is worth noticing that the syphilis infected female subjects identified two events, which may be directly related to their present situation: quarrels with husband or partner, and a serious illness of a family member. Most probably the fact they identified these events and rated them so high depended on their acquired knowledge about the partner's syphilis and their reaction (quarrels) to such a negative message.

Nevertheless, it should be noticed that for the healthy subjects the stressful events were usually connected with entirely different matters, such as paying off a large debt (21), business readjustment (16), accident (5), moving house (31), or death of a close family member (4).

Another significant difference between the infected and the healthy subjects is the difference in the preferred stress coping strategy. Except for one male, all healthy subjects opted for the active, task strategy and saw the stressful situation as a problem to be satisfactorily solved. The male infected subjects also preferred this strategy (9 indications). However, they also opted for the passive strategy set for waiting out and hoping that the problem would be solved without their stir (3 indications) and also for the escape strategy meaning retreat and denial of the problem (2 indications). The results of this comparison are most unfavorable in the infected female subjects: only one of them indicated the active stress coping strategy. Other subjects indicated either the escape strategy or the 'waiting out' strategy (3 indications each). Unsurprisingly, differences in self-rating the stress coping skills between the healthy and the infected subjects, both males and females, oscillated around one point (on a 1-5 scale). It is worth noting that women, irrespective of their health state, rated their stress coping skills much lower than men.

The subjects seemed to somehow agree with the previously described indications, concerning preferred styles of coping with the stigma of venereal disease (mental adjustment to disease) [14-20]. Contrary to the predictions of the authors, the subjects generally preferred the active style, opting for putting up a fight and perceiving the disease as a personal challenge, thus mustering strength and struggling against the disease. However, this style was preferred by male patients only; female patients rated it as number two. As it had been predicted, female subjects preferred the anxiety style (male patients rated it as number three) pointing to distress caused by the disease and the knowledge about its stigmatizing nature. In such a case, the disease is interpreted as a seriously threatening event which stimulates the inner tension and remains beyond a personal control.

Similar differences in self-rating the style of coping with the stigma of syphilis were found for the cognitive style (male patients rated it as number two, female subjects as number three).

The cognitive style (positive reevaluation) means the reorganization of the perception of one's own disease in such a way as to preserve the opinion on the quality of one's life help up to this time and to be able to still treasure its quality. Most

frequently this involves the use of the available and reliable defense mechanisms. The style which involves helplessness, giving up fighting and feeling lost, subsequently leading to submission to the disease, was rated as the last one by all subjects, irrespectively of their gender. It is worth mentioning that the style was more frequently indicated by the female patients though.

Conclusions

To conclude, the findings of the present study show that the stigma of syphilis is a source of permanent stress and the anticipation of the social consequences after revealing its existence is a strong stimulus prompting the stigma bearer to keep a secret. The patient is trapped in a vicious circle: being hindered from assuming the 'open' role in the relation to (among others) the sexual partner, the patient may end up disseminating this serious disease. Moreover, the stigma of syphilis is a much more distressing experience for women who neither cope so well with the stress induced by the disease nor adjust to the awareness of being a stigma bearer. The stigma can be said to radically change their self-perception and their own abilities to fight with the disease. Faced with the stigma, they appear stressed, frightened, full of strain and anxiety, lost and passive.

References

- Kenny D, Carlson J, McGuigan F, Sheppard J. Stress and health: research and clinical applications. Amsterdam: Harwood Academic Publishers Press, 2000.
- Kubacka-Jasiecka D, Ostrowski T. Psychological dimension of health, crisis and illness. Krakow: Jagiellonian University Press, 2005.
- Schwarzer R. Psychologie des Gesundheitsverhaltens. Göttingen: Hogrefe, 2004.
- Folkman S, Moskowitz J. Positive affect and the other side of coping. *Am Psychol*. 2000, 55, 647-654.
- Goffman E. Stigma. Gdańsk: Gdańskie Wydawnictwo Psychologiczne, 2005.
- Heszen-Niejodek I. Theory of psychological stress and its management. In: J. Strelau, ed. Psychology. Academic coursebook. Vol. 3. Gdańsk: Gdańskie Wydawnictwo Psychologiczne, 2001, 465-492.
- Heszen-Niejodek I, Sęk H. Health psychology. Warszawa: Warsaw: Polish Scientific Publishers PWN, 2007.
- Rzepa T, Żaba R. Psychological consequences of the stigma attached to sexually transmitted disease. In: Psychological and medical aspects of skin diseases. Eds. Rzepa T, Szepletowski J, Żaba R. Wrocław: Cornetis, 2011, 105-110.
- Mroczkowski T. Sexually transmitted diseases. Lublin: Wydawnictwo Czelej, 2006.
- Jakubowicz O, Żaba R, Czarnicka-Operacz M. Serological tests for syphilis performed in the Sexually Transmitted Diseases Diagnostic Laboratory in Poznań between 2000-2004. *Post Dermatol Alergol*. 2011, 28, 30-35.
- Jakubowicz O, Żaba R, Czarnicka-Operacz M. Serological tests for syphilis performed in Sexually Transmitted Diseases Diagnostic Laboratory in Poznań between 2005-2009. *Post Dermatol Alergol*. 2010, 27, 275-281.
- Jakubowicz O, Żaba R, Czarnicka-Operacz M. Leczenie zakażeń wywołanych przez Herpes simplex virus typu 1 i 2 oraz Varicella-zoster virus. *Post Dermatol Alergol*. 2010, 27, 303-307.
- Talarowska M, Florkowski A, Galecki P, [i wsp.]. Współwystępowanie zaburzeń depresyjnych, lękowych oraz zaburzeń funkcji poznawczych wśród pacjentów cierpiących na przewlekłą obturacyjną chorobę płuc. *Post Dermatol Alergol*. 2009, 26, 201-205.
- Holmes T, Rahe R. The Social Readjustment Rating Scale. *J Psychosom Res*. 1967, 11, 213-218.
- Juczyński Z. Measurement tools in promotion and psychology of health. Warszawa: Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, 2001.
- Kozińska B. Type of attachment and the multidimensional self-evaluation of women suffering from breast cancer. Gdańsk: unpublished doctoral dissertation, 2007.
- Rue V, Coleman P, Rue J, Reardon D. Induced abortion and traumatic stress: a preliminary comparison of American and Russian women. *Med Sci Monit*. 2004, 10, 5-16.
- Schwarzer R. Stress, resources, and proactive coping. *App Psychol International Rev*. 2001, 50, 400-407.
- Sedgeman J, Sarwari A. The effect of a Health Realization/Innate Health psychoeducational seminar on stress and anxiety in HIV-positive patients. *Med Sci Monit*. 2006, 12, 397-399.
- Watson M, Law M, dos Santos M, [et al.]. The Mini-MAC: further development of the mental adjustment to cancer scale. *J Psychosoc Oncol*. 1994, 12, 33-46.