

Neal, T.M.S., Lichtenstein, B., & Brodsky, S.L. (2010). Clinical implications of stigma in HIV/AIDS and other sexually transmitted infections. *International Journal of STDs & AIDS*, 21, 158-160.  
doi/10.1258/ijsa.2008.008445

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FULL TITLE: Clinical implications of stigma in HIV/AIDS and other sexually transmitted infections

SHORT TITLE: Stigma in HIV/AIDS and other STIs

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Footnote : The authors are indebted to Michael Conaway, Director of the Capstone Poll, and to the Institute for Social Science Research at the University of Alabama, USA, for their invaluable assistance in collecting these data.

### Abstract

This study sought to identify stigma differences between HIV/AIDS and other sexually transmitted infections (STIs). Interviewees from Alabama, USA ( $n=537$ ) rated two types of stigma (damage to social reputation and “moral weakness”) for seven infections ranging from “nuisance” conditions (e.g., pubic lice) to life-threatening disease (e.g., HIV/AIDS). When asked which of the seven STIs would be most damaging to reputation, 74.8% of respondents chose HIV/AIDS. However, when asked to choose which STI represented moral weakness in infected persons, HIV/AIDS was rated as significantly *lower* than the other STIs, which suggests that HIV/AIDS is perceived differently than non-HIV STIs. This study addresses the possibility that advances in public awareness of HIV/AIDS have not necessarily been extrapolated into awareness of other STIs. Clinicians should be aware of these high levels of stigma as potential barriers to treatment for all STIs. Public health officials should consider the impact of undifferentiated stigma on STI prevention messages.

## Introduction

Sexually transmitted infections (STIs) have been stigmatized since syphilis was associated with sin and moral laxity in 14<sup>th</sup> century Europe.<sup>1</sup> Until modern times, STIs were known collectively as venereal diseases with undifferentiated stigma because many infections were unrecognized or poorly defined.<sup>2</sup> In the AIDS era, HIV stigma is widely considered to be distinct from and more severe than other STIs.<sup>3</sup> However, the stigma of non-HIV STIs still exists and is blamed for a host of problems, including delayed treatment and increased morbidity from common infections.<sup>4</sup> Differences between non-HIV and HIV stigma have yet to be examined fully, although work by Fortenberry et al. (2002; 2004) and others have begun to address this issue in clinical settings.<sup>5,6</sup> In their study of community-based stigma, Lichtenstein, Neal, and Brodsky (2008) identified higher levels of HIV stigma compared to other STIs, but found that these “lesser” infections attracted substantial stigma as well.<sup>7</sup> In that study, non-HIV STIs were all considered to be a sign of sexual immorality regardless of the perceived seriousness of the disease. This result is perhaps unexpected given that most STIs are curable or highly treatable and are among the most frequently reported diseases in the United States.<sup>4</sup>

The present study examined differences in relation to stigma for HIV/AIDS and non-HIV STIs among a community sample in a southern U.S. state, the region with the highest HIV/STI rate in the U.S.<sup>8</sup> We used two stigma constructs from Goffman’s (1963) theory on stigma: damage to social reputation (a social attribution, often based on group stigma) and attributions of moral weakness for afflicted individuals (an individual attribution for blame, broadly defined in terms of a deficient personal trait).<sup>9</sup> These theoretical constructs have been applied to numerous studies on disability, and on mental and physical illness including for STIs.<sup>10,11,12</sup> Clinical studies typically differentiate between group and individual stigma in describing barriers to

partner notification and treatment for STIs.<sup>5,6</sup> In Lichtenstein, Hook, & Sharma's (2005) community survey, respondents were unlikely to notify their sexual partners if they feared being labeled as immoral or sexually deviant.<sup>13</sup> They were also likely to delay or avoid treatment for fear of being classified as members of a stigmatized group (e.g., STI clinic attendees). For the present study, the two constructs were operationalized in items about damaged reputation and moral weakness of character for seven infections ranging from least serious (pubic lice) to most serious (HIV/AIDS). We hypothesized that stigma differences would occur for the selected STIs based on perceived seriousness in social or clinical realms.

## **Method**

### ***Participants***

The respondents ( $n=537$ ) were predominantly white (78%) and female (63%) with a mean age of 52.6 years. Forty-six percent of respondents were unemployed; the retired 30% of respondents were counted as unemployed. Fifty-eight percent of respondents were married, 85% had at least a high school education, and 69% lived in an urban area. Ninety-six percent of respondents reported a religious affiliation (79% self-identified as Protestant). Elderly persons, women, and whites were over-represented compared to the general population. This artifact is common in RDD surveys.<sup>14</sup>

### ***Procedure***

A random-digit-dialed (RDD) telephone survey asked adults in Alabama, USA, about stigma attributions for HIV and other STIs. The research was approved by the University of Alabama Institutional Review Board. The survey was embedded in a larger yearly omnibus survey of attitudes held among citizens who were representative of the state. The questions were asked by staff at the Institute of Social Science Research at the University of Alabama who were

blind to the purposes of the study. After successful contact was made, respondents were informed that they would be asked three questions about sexually transmitted diseases. Thirty-five respondents (6%) spontaneously objected to the topic and did not complete the survey. The respondents who agreed to participate were then asked to rank the stigma of seven types of infection: pubic lice, gonorrhea, syphilis, chlamydia, genital warts, genital herpes, and HIV/AIDS. Our response rate was 93.9% of surveys completed, which yielded 537 respondents for the final sample.

The survey items were developed from the two stigma constructs: “damage to social reputation” and “weak moral character.” The survey questions were posed as follows.

1. Respondents were asked to identify which STI would be most damaging to someone’s social reputation by choosing one of eight items. Options were genital herpes, gonorrhea/clap, HIV/AIDS, genital warts, syphilis, pubic lice/crabs, chlamydia, don’t know/ other.
2. The respondents were then asked which STI was the second most likely to damage social reputation by choosing one of the remaining seven options listed in question 1.
3. The third item took the form of a set of questions that asked respondents to rate each STI on a scale of 1 to 5 for the weak moral character construct, with 1 being “do not agree” and 5 being “strongly agree” for each STI.

### **Results**

For the first question, 74.8% of respondents reported that HIV/AIDS would be the *most* damaging to somebody’s reputation. This response was significantly higher than for any other choice, with genital herpes (3%) ranked a distant second. For the second question, 26.4% of

respondents identified genital herpes as the next most stigmatizing infection. Again, this response was significantly higher than for any other choice, with syphilis (17.3%) ranked after genital herpes. For both the first and second choice options, the responses for chlamydia, genital warts, and pubic lice ranked well below the responses for HIV/AIDS (Table 1).

- INSERT TABLE 1 ABOUT HERE -

Results for the weak moral character sequence of stigma questions were analyzed through paired-samples t-tests. Agreement with the 5-point Likert-type scale is presented with means and standard deviations for each STI (Table 2). The options ranged from 1 (“strongly disagree that [STI] is a sign of a weak character”) to 5 (“strongly agree”).

As opposed to the results for items 1 and 2, responses to item 3 indicated that HIV/AIDS had the *lowest* mean score for any infection. Thus, acquiring HIV/AIDS was perceived to be less blameworthy in terms of individual moral character traits than other STIs. The mean for HIV/AIDS was significantly lower than the means for gonorrhea ( $t[536] = 2.038, p = .042$ ), syphilis ( $t[536] = 2.549, p = .011$ ), pubic lice ( $t[536] = 3.485, p = .001$ ), and chlamydia ( $t[536] = 7.245, p < .001$ ). In turn, the mean score for chlamydia was significantly higher than the means for pubic lice ( $t[536] = 4.571, p < .001$ ), syphilis ( $t[536] = 6.104, p < .001$ ), gonorrhea ( $t[536] = 6.387, p < .001$ ), genital herpes ( $t[536] = 6.71, p < .001$ ), genital warts ( $t[536] = 7.103, p < .001$ ), and HIV/AIDS. Nevertheless, the mean scores in this section ranged from a high of 3.72 for chlamydia to a low of 3.72 for HIV/AIDS, indicating moderately high stigma for all STIs in terms of blame for being infected (Table 2).

- INSERT TABLE TWO ABOUT HERE -

## Discussion

These results help to differentiate between STI and HIV stigma as perceived by a representative sample of residents in a southern US state. HIV/AIDS was rated significantly more likely to damage someone's social reputation than the other infections. However, HIV/AIDS attracted the least stigma for the weak moral character items compared to other STIs. This paradox illustrates how HIV/AIDS is understood differently from other STIs, and might be explained by social desirability bias.<sup>15</sup> In this bias, respondents correct for attitudes they know to be unpopular, or their responses reflect media influences that frame HIV-positive people as sympathetic victims<sup>16</sup> (e.g., in the case of "AIDS victims" in sub-Saharan Africa). The dichotomy identified here suggests that non HIV-STIs may be viewed as merely "nasty." By contrast, HIV stigma has eased over time, with fear-based punitiveness towards HIV-positive people declining substantially in recent years.<sup>17</sup>

The finding that attributions of blame in the "weak moral character" section were moderately high for all STIs is meaningful because personally experienced stigma is a barrier to care-seeking.<sup>6</sup> This convergence suggests that stigma is relatively consistent for all STIs included in this study regardless of the seriousness of the infection.<sup>7</sup> Nevertheless, caution should be taken in interpreting the results. In the case of STI stigma, respondents may lack sufficient knowledge about the "lesser" infections to know how to rank each condition in terms of relative stigma. As noted in Table 1, 10.7% and 19.2% of respondents to items 1 and 2 answered "don't know" or "refused" for the stigma rankings. These non-responses indicate that some respondents may have been unable to distinguish between different STIs or found the ranking process to be unpleasant, itself a possible reflection of stigma attributions. If the sample refused to answer because of inability to distinguish between STIs, then this deficit raises the issue of the role of stigma in lack



of knowledge about infections that range from the merely irritating (pubic lice) to life-threatening (syphilis and HIV/AIDS).

The results of this study have implications for prevention and treatment in the southern US. If common STIs are more likely than HIV/AIDS to attract stigma because of attributions of individual blame, then even minor infections might result in delays and non-treatment, which clearly has implications for prevention. The heightened stigma for minor STIs may be implicated in the high burden of STIs in the United States, especially if lack of awareness about different STIs results in widespread avoidance of screening and treatment.<sup>4</sup> Clinicians should be aware of this relatively undifferentiated stigma, at least in Alabama, USA, and of the possibility that patients will refuse to disclose symptoms for fear of stigma, even when the infection is minor or highly curable. Further research should determine whether these findings are applicable to other regions. If so, treatment and prevention efforts should be tailored accordingly.

On a final note, our results suggest that prevention messages, particularly in the southern US, should target all STIs rather than target HIV risk alone. Such messages would take account of the knowledge that non-HIV STIs are substantially more prevalent than HIV/AIDS in the United States and other western nations, and that stigma is a relatively unitary construct as measured in Alabama that impedes the reduction of both HIV/AIDS and non-HIV STIs.

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**TABLE 1**Percentage Responses for STIs as Damaging to Reputation (*n*=537)

First choice	(%) <sup>1</sup>	Second choice	(%) <sup>1</sup>
HIV/AIDS	78.0	Genital Herpes	26.4
Genital Herpes	3.0	Syphilis	17.3
Syphilis	2.8	Gonorrhea	9.8
Gonorrhea	1.2	HIV/AIDS	2.6
Genital Warts	no data	Chlamydia	2.3
Chlamydia	no data	Genital Warts	0.5
Pubic Lice	no data	Pubic Lice	0.2

1. These totals do not add up to 100%. For first choice, 10.7% did not know/respond. For second choice, 19.2% did not know/ respond. Overall, 6% of respondents spontaneously objected to the topic.

TABLE 2

Means and Standard Deviations for STIs as Sign of Weak Character

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Item	Mean	Standard Deviation
Chlamydia	3.72	2.21
Pubic Lice	3.32	1.85
Syphilis	3.22	1.79
Gonorrhea	3.19	1.76
Genital Herpes	3.15	1.76
Genital Warts	3.10	1.88
HIV/AIDS	3.06	1.72

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