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## An Unanticipated Source of Hope:

Stigma and Cervical Cancer in Brazil

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*In this article, I argue that although cervical cancer is an often stigmatized condition in Brazil, women with cervical cancer in Recife, Brazil, did not simply endure the stigma, they also perpetuated it. I draw on narrative theory and 18 months of ethnographic research in Recife to argue that rather than resisting the stigma associated with their disease, women in Recife used stigma to construct illness narratives that affirmed that they were still held to the same norms and values as the nonill. In turn, those narratives, and the healing narratives constructed along with them, provided women with hope for a future free from cervical cancer and free from the “imperfections” associated with that disease. Thus, women with cervical cancer used stigmatizing narratives both as links back to the “normal” world they inhabited before they became ill, and as bridges forward to the future they hoped to attain. [Brazil, cervical cancer, stigma]*

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Dona Moça lived with her daughter and grandchildren at the top of a steep hill on the outskirts of Recife, Brazil. She had married at 16 and bore four children with her husband before he left her for a younger woman. He was the only sexual partner she'd ever had. As she put it, she had “never been a woman in the street, with other men.” So when she developed cervical cancer at age 68, she was shocked and confused: only promiscuous “dirty” women developed cervical cancer. Ultimately, Dona Moça concluded that, though she had always been monogamous, she had perhaps been too sexually ardent. “I liked it [sex] so much. Maybe that’s why I got sick. I was very hot.” And she was ashamed. She said that if her neighbors knew about her illness, they would gossip and judge her, thinking, “She’s spoiled. She’s ruined.”

During the time of my research in Brazil, Recife recorded the highest documented incidence of cervical cancer in the world (Whelan et al. 1990). Over the course of 18 months in 1994 and 1995, I lived in a shantytown, or *favela*, in Recife studying the relationship among poverty, sexuality, and cervical cancer in that community. I found that women with cervical cancer were not just considered ill, they were also assumed to be dirty, lazy, and promiscuous. Thus, in addition to somatic symptoms, women with the disease suffered from the stigma associated with their condition.

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However, like Dona Moça, women with cervical cancer did not simply endure stigma, they also perpetuated it. They actively incorporated stigmatizing metaphors into their personal illness narratives, at times virtually embracing the negative social labels, even when evidence clearly pointed to the contrary. When I first analyzed my data, almost 10 years ago, I was intrigued and somewhat bothered by women's perpetuation of the stigmatizing discourses surrounding their disease. I postulated that women fell back on stigmatizing narratives to provide context and meaning to a disease that would otherwise be worse than shameful: it would be meaningless and random (Gregg 2003). Yet I remained puzzled by the extent to which they actively reinforced and perpetuated stigma. Why did they go to such lengths to affirm the stigma surrounding their disease? Why not look to other sources to give their disease a meaningful context?

In this article, I reexamine those questions first by revisiting stigma theory and then by drawing on narrative theory to argue that, rather than resisting the stigma associated with their disease, women with cervical cancer in Recife constructed illness narratives using stigmatizing metaphors to mediate the disruption that illness had on their lives. Furthermore, those narratives, and the healing narratives constructed along with them, provided women with hope for a future free from cervical cancer and free from the "imperfections" associated with that disease. Thus, women with cervical cancer used stigmatizing narratives both as links back to the "normal" world they inhabited before they became ill, and as bridges forward to the future they hoped to attain.

### Cervical Cancer in Northeastern Brazil: Diagnosis and Treatment

Brazil operated a cancer registry in Recife from 1967 until 1980. During the years that it maintained that registry, Northeastern Brazil reported the highest documented incidence of cervical cancer in the world (Whelan et al. 1990). The primary risk factor for cervical cancer is infection with the sexually transmitted Human Papillomavirus (HPV); infection with certain strains of the virus may cause cellular changes that ultimately lead to cancer. Screening for the disease, via the Pap smear, can detect these changes before they become cancerous, and follow-up care can ablate abnormal cells, thus preventing the development of cancer.<sup>1</sup>

Most of the women I met and interviewed in Recife were diagnosed with cervical cancer after developing symptoms of relatively advanced disease (symptoms such as postcoital or postmenopausal bleeding), and most required some type of radiation therapy as part of their treatment for the cancer. Unfortunately, none of those women had private insurance and all therefore depended on public insurance or charity for their health care. Because of limited resources and lack of time, women who depended on the public health system received a one-size-fits-all regimen of radiation therapy that was most appropriate for highly advanced cancers. Consequently, all received external radiation five days a week for five weeks. They were then allowed to rest for 15 to 20 days. After that, they returned for four days of brachytherapy (which places the radiation directly inside the cervical cancer tumor, and that generally causes fewer side effects) and then received two more weeks of external radiation.

As the chief of radiation oncology at the largest cancer hospital in the city explained to me, if a woman had private insurance, the amount and type of radiation administered depended on the stage of her cancer. Women without private insurance had fewer options because the hospital had only six beds for brachytherapy and could therefore only treat up to 12 patients a week. As the only hospital in the state providing this treatment for public health patients, the hospital had an immense waiting list and neither the time nor the resources to tailor treatment to each patient. So, women with earlier stages were being significantly overtreated.

That overtreatment was important given the severe side effects often caused by radiation. Effects include rectal bleeding, nausea, intestinal strictures and obstruction, bladder inflammation, diarrhea, and burning with urination. Later, the main chronic side effect is sexual morbidity because of vaginal stenosis and lack of lubrication, making sexual activity often quite painful. Other chronic problems that may result are bowel obstruction, hemorrhagic cystitis (inflammation of the bladder leading to bleeding), and increased urination because the bladder shrinks (Frumovitz et al. 2005:7428–7436; Jensen et al. 2003:937–949).<sup>2</sup>

### Northeastern Brazil: Sensuality and Sexual Control

Recife is a city of approximately a million and a half people located in the northeastern corner of Brazil in the state of Pernambuco. The north and northeastern regions of Brazil are the poorest in the country, and they suffer from much higher rates of poverty, malnutrition, illiteracy, and disease than do the more southerly regions of the country. They also tend to be more socially and sexually conservative than southern Brazil, and women in north and northeast continue to be defined largely in terms of their sexual behavior.

On the one hand, women in Brazil, and particularly in the northeast, have been portrayed both by Brazilians and by those outside of Brazil as more sexual than other women, more vibrantly sensual (Freyre 1986; Guimarães 1996; Parker 1991; Scheper-Hughes 1992). In the northeast of the country, specifically, Scheper-Hughes has noted that “Sexual vitality is . . . a variant of the ‘autoethnography’ of *Nordestinos*, who do project to themselves, to each other, and to outsiders as an erotic and immensely sensual, as well as sexual, people” (Scheper-Hughes 1992:164). As I was informed by a study participant, “Women in the Northeast are hot, so hot that if you light a match near them, they ignite.”

On the other hand, while Brazilian women may be expected to be “naturally” sexually ardent, ideals of sexual propriety suggest that women’s sexuality must also be vigorously controlled. Values consistent with what has often been called an “honor and shame” complex, and brought to Brazil by Portuguese colonists and the Catholic church, have had a significant impact on Brazilian attitudes toward female sexuality (Bruschini 1990; Russell-Wood 1978; Vainfas 1989). Within this value system, women are generally expected to remain virgins until marriage and to be sexually faithful thereafter. Men are expected to control the sexuality of women in their families and to have complete sexual liberty themselves. While values associated with honor and shame have, historically, been more rigorously applied to white, elite women than to poorer, darker women (Freyre 1986; Vainfas 1989; Nazzari 1997), scholars have documented the application of values associated

with honor and shame across time and social strata in Brazil (Caufield and Esteves 1993; Graham 1988; Sarti 1995).

In present-day Brazil, these values may be particularly prevalent in the more rural and conservative northeast (Caravelas 1994; Rebhun 2004). Women in my study stressed the importance of “imprisoning” their daughters and thereby maintaining their “value” until marriage. As a neighbor in the favela explained to me, “well, there are other things, like their lives, that are valuable, too, but virginity has value.” Likewise, married women would point to their own sexual propriety by stressing their inclination to stay “hidden” inside their marital homes.

### Stigma, Social Networks, and the Absence of Resistance

Those gendered values were drawn on to create the stigma around cervical cancer. In his now classic work on the subject, Goffman defines stigma as a discrediting attribute, an undesired differentness from social expectations. Furthermore, when confronted with a stigmatized individual, he argues, “we construct a stigma-theory, an ideology to explain and account for the danger he represents” (Goffman 1963). That stigma theory draws on cultural norms and values and allows those without stigma to “impute a wide range of imperfections on the basis of the original one” (Goffman 1963). Stigma becomes metaphor, a way of thinking about X (e.g., disease or disfigurement) in terms of Y (e.g., dirt, decay, immorality).

Recent theorists in sociology and anthropology have built on and refined Goffman’s definition of stigma. They have pointed out that while Goffman’s work stressed the entirely social nature of stigmatization, much of the research on stigma that has followed Goffman’s work has considered stigma less as a social product than as an unchanging attribute attached to individuals. Veena Das, for instance, has argued that stigma is not attached to individual bodies, but rather is primarily located within impaired individuals’ networks of social relationships. Those networks confront or constrain the effects of stigma on others in the network, often by excluding or confining impaired individuals (Das 2001; Das and Addlakha 2001). Indeed, Das argues, “the entire discourse of anxiety that surrounds the stigma of deformed bodies thus is about reduction of sociality, exclusion from moral community as well as subjective feelings of guilt and shame” (Das 2001:4).

A focus on the individual nature of stigma has also contributed to a general lack of attention paid to issues of power and inequality as they relate to stigma. More recent theorists have stressed the central role of power in creating and perpetuating stigma (Link and Phelan 2001; Rebhun 2004; Parker and Aggleton 2003). They note that only those with power are able to enforce discriminatory consequences on those whom they have stereotyped. Thus “for stigmatization to occur, power must be exercised” (Link and Phelan 2001:363). The stigmatized, in turn, naturally resist discrimination and their attendant powerlessness to the best of their ability given often limited resources (Link and Phelan 2001). And, in fact, efforts to resist stigma and stigmatizing discourses have been documented among populations as diverse as the physically and mentally disabled, dwarfs, persons with HIV, and victims of cholera, as well as among their kin networks (Ablon 1984, 2002; Das and Addlakha 2001; Nations and Monte 1997; Whittaker 1992).

However, none of the women with cancer in my study resisted, or even questioned, the stigma surrounding their disease. Instead, they maintained it, even creating stories of personal sexual misconduct when none existed, rather than challenge it.

### Illness, Narrative, and Challenges to Identity

Narrative approaches in medical anthropology may be useful for understanding this seemingly paradoxical behavior. These approaches suggest that while stigma may be a social construct, it may also be used by impaired individuals as an organizing metaphor in the construction of illness narratives. Thus, individuals may, in fact, choose not to resist stigma in favor of using it to resist a perhaps more disturbing sense of biographical disruption.

Narrative scholars have described illness or bodily disruption such as aging or infertility as breaks with the known self, moments when an individual's identity is altered and must be remade (Becker 1997; Mattingly 1988). Writing specifically about cancer, Linda Hunt has argued that chronic illness "may present the afflicted with permanent challenges to their identity: it does not permit one to go on living in an undisputed, familiar world" (Hunt 2000:88). Disease in general, and cancer specifically, serves as a "biographical disruption" that changes not only how an individual feels somatically, but also how she understands who she is and her role in the world" (Bury 1982).

Becker has written extensively and persuasively about the individual use of narrative and the metaphors embedded in narrative to make sense of that disruption. Building on Katherine Ewing's suggestion that individuals use metaphorical processes to integrate conflicting self-representations (Ewing 1990), she argues that individuals understand and cope with experiences of illness or other bodily disruption through the use of metaphor. Those metaphors, she suggests, draw on important cultural values but interpret them in new ways that make sense within the individual's new bodily context (Becker 1997). When successful, this allows individuals whose lives have been disrupted to experience again a sense of continuity and life order.

Similarly, Mattingly has referred to two antithetical qualities of the self: "those aspects which ensure sameness over time (including habits, roles, even 'fidelities' and promises) . . . [and] those which ensure discontinuity (shifts in context, the accidents of fortune, human development)" (Mattingly 1988:119). The narrative process, she argues, helps individuals navigate between these forces, creating and recreating selves that contain elements of sameness and of change.

Those newly constructed selves may, in turn, have altered social obligations and different expectations of others and of the future (Becker 1997; Capps and Ochs 1995; Lovell 1997; Polkinghorne 1988). Narrative construction is an ongoing, active process, influenced by action, and influencing action (Bruner 1986; Capps and Ochs 1995; Garro and Mattingly 2000). Narratives are "ways of making sense of ongoing situations and guides for future action" (Garro and Mattingly 2000:17). Thus, narrative not only makes experience sensible, but it also helps shape thought and action in the present and the future. Indeed, Mattingly writes that one of the primary purposes of therapeutic narratives is their ability to "locate desire"

(Mattingly 1988:108). The ill, in conjunction with clinicians, family, and therapists, construct stories about their illness that “foster hope by pointing toward some new telos when the old directions are no longer intelligible” (Mattingly 1988:109).

In addition to fostering hope, individuals may use serious illness as an opportunity to negotiate entirely new social selves. Demonstrating how cancer survivors in Mexico use the impact of their illness and treatment to negotiate new social roles and obligations, Linda Hunt has shown that “the telling of illness narratives may be taken up as an opportunity to reorder contentious elements of the social field, creating new meanings and relationships” (Hunt 2000:90). Thus, the ill may use stories of illness, even stigmatizing stories, to reconstruct or reconfigure problematic social identities.

## Design and Methods

In the mid-1990s I spent 18 noncontiguous months studying the relationship between poverty, sexuality, and the cultural construction of cervical cancer in Northeastern Brazil. The study was approved the Emory University Department of Anthropology human subjects committee and the Institutional Review Board for Emory University graduate studies.

The first six months of the study were split into two three-month periods (June 1993–August 1993 and June 1994–August 1994) while I was between semesters of medical school. The last 12 months were continuous and lasted from January 1995–January 1996. This schedule was chosen for a few reasons. First, having made connections in Recife during a site visit in 1992, I did not want to risk losing those contacts during my first two years of medical school. Second, by stretching my fieldwork over a three-year period, I was able to follow several women with cancer from diagnosis in 1993, through therapy and for several months afterward, as they struggled to make sense of the disease and its effects on their lives.

During my fieldwork, I lived in a single favela in Recife. My methods in the favela included participant-observation and semistructured interviews with 30 women, who were chosen simply by virtue of living in every fifth house on a walk through the community. Interviews gathered basic demographic information and explored issues surrounding health, illness, and sexuality. They also included specific questions regarding women’s cervical cancer screening practices. I interviewed each woman at least twice and often several times over the course of the field work as further questions arose. Interviewees’ ages ranged from 16 to 70, with a mean age of 38.

I also conducted serial interviews with 30 women with cancer, all of whom lived within an hour’s bus ride of downtown Recife. These women were selected from the patient lists of women at the state cancer center who had cervical cancer and at a private nonprofit cancer hospital. These are the only two cancer hospitals in the state for persons without private health insurance. To identify the women whom I would interview, I spent two days a week at each of the hospitals. I also spent one day a week with oncologists at the radiation therapy center. When the physician with whom I was working saw a patient with cervical cancer who fell within the geographical limits of my sample, I would ask that woman if I could interview her after her appointment. All but one assented. I continued this process until I had

identified 30 women. Interviewees' ages ranged from 16 to 70, with a mean age of 50.

Initial interviews were conducted at the clinical sites, while later interviews, exploring women's experience of the disease and its treatment, were conducted at the women's homes. Initial interviews were typically almost identical to interviews with women in the community, except that women with cancer were also asked about their understandings of their disease and how they were coping with it. Finally, I interviewed each of the six physicians with whom I worked at least once. Interview topics included questions regarding how best to therapeutically engage women with cervical cancer, the purpose and types of cancer treatments available, and barriers to health and health care for women with cervical cancer.

Quotations in the text are from notes made at the time of the conversations and not from tape recordings. If I felt that I hadn't captured the person's speech precisely, I paraphrased their words and do not represent them as quotations in the text. All of the interviews were transcribed and analyzed by me in an iterative manner using an ethnographic, inductive approach, meaning that (1) analysis was informed by themes identified in the literature and by my personal reading of the data, and (2) data were analyzed repeatedly as I identified new themes or ideas (Higgins et al. 2008). The case studies and examples below were selected because they are representative of the richest and best examples of widely held patterns in interviews and in casual conversations. None of the women I spoke with discussed cervical cancer in terms free from stigmatizing metaphors.

This is the work of a single ethnographer in a single site and follows in the tradition of interpretivist social science research. Therefore, it is limited in that it reflects my observational and analytical biases, unchecked by the observations or analysis of other researchers. However, it is strengthened by the in-depth contextual knowledge gained after 18 months of fieldwork with the same women, in often emotionally charged interactions. Furthermore, in the interpretivist traditions, I remained attuned to my positionality and assumptions (Higgins 2008). For instance, before beginning interviews with women with cancer, I would always explain to women that I was not a doctor, not part of the oncology service, and could not provide medical advice. I would explain that I wanted to better understand their experiences of being at the hospital and being ill. Even so, I was aware that women clearly associated me with their medical care and their disease. Because of my accent and appearance, I was also clearly "other" and thus not associated with the local culture. Thus, I believe they were more willing to speak to me about their condition (which they sometimes referred to as cancer and other times, more euphemistically, as "inflammation") than they were to speak to others in the local community.

## Results

In presenting the following results, I will first discuss the stigma surrounding cervical cancer, and its negative consequences for women with the disease in Recife. I will then examine women's use of stigma to construct meaning around their disease and to maintain personal and social identity. Finally, I will examine the use of stigma as a metaphor around which narratives of hope and healing were maintained.

*Cervical Cancer and Stigma in Recife*

Cervical cancer in Recife was metaphorically loaded and heavily stigmatized. On the one hand, as a cancer, cervical cancer, like many cancers cross-culturally and historically, was associated with death and with images of the body invaded and inexorably destroyed from within (Chavez et al. 1995; Hunt 1998; Nelson et al. 2002; Panourgia 1995; Sontag 1990). In Recife, women would not risk having their neighbors find out they had cancer, afraid, as Dona Moça put it, that they would say, “She’s spoiled. She’s ruined.” And doctors in Recife would not use the word “cancer,” choosing instead to use euphemisms like “inflammation” or “wound.” As one physician noted, “We say that a lesion is precancerous, or wanting to become cancer, or a bad wound. This is less heavy. . . . Here the word cancer is mystified as synonymous with death.”

As predicted by Das (2001), individuals with cervical cancer were also frequently excluded from their social and moral communities. Early in my research I was explaining to two friends in the favela that I was interested in studying cancer among women in Recife. Both assured me that if they had cancer they would not tell anyone else for fear that neighbors and friends would abandon them. As the husband of one of the women with cancer later put it, people fear cancer because it “eats you up inside and you become rotten inside.” Several people also considered cancer to be communicable, and one woman’s family, when they discovered her diagnosis, asked me if they needed to separate her dishes and laundry from that of the rest of the household. No one in the sample of women with cancer said that she would talk openly about her disease with friends or neighbors.

Furthermore, women with cervical cancer were dealt a double metaphorical blow. As I have discussed elsewhere, the women I interviewed often considered cervical cancer to be the end result of untreated, accumulated STDs (Gregg 2000, 2003). Similar to many other regions of the world, STDs are highly stigmatized in Brazil (Guimarães 1996; Malta et al. 2007) and are particularly stigmatizing for women, for whom cultural ideals of premarital virginity, marital monogamy, and respectability clash with the reality of a sexually transmitted infection (Giffin and Lowndes 1999; Knauth 1999; Malta et al. 2007; Rebhun 2004). As noted by Giffin and Lowndes, in their study of sexually transmitted disease prevention among Brazilian women, while STDs among men may be considered a “natural” consequence of normal male sexual behavior, “women learn that they will be blamed, devalued, and perhaps even punished if they even suspect they have an STD” (Giffin and Lowndes 1999:291).

In discussions about cervical cancer in Recife, individuals reinforced gendered expectations of sexual health, and women with cervical cancer were not just considered “rotten,” they were also presumed to be promiscuous. So, in response to the question, “Why do women get cervical cancer?” interviewees referred to women’s supposed improper sexual activities and poor hygiene, and, rarely, if ever, referenced lack of health care, inability to leave work to get care, or male sexual behavior. Instead, I was told: “You get it if you go out looking for a man”; “[women] have sex every day in the street and then don’t go to the gynecologist”; and “They have sex with men who are dirty.”

Women with cervical cancer echoed those sentiments. Thus, Maria Jose—who eventually died from complications of her cancer at age 44—blamed her cancer on her own sexual misconduct. Maria Jose had legally married her first husband, who later died in an accident. She then lived with another man for four years, until his job forced him to move. At the time of her diagnosis, she was involved with a third man, but not living with him. That she had more than one sexual partner in her lifetime seemed to her to be the most likely reason she developed cervical cancer. She had the disease, she said, “because I had more than one man.” Even Dona Moça, who had only ever had sex with her husband, and who could not therefore associate her cancer with extramarital sex (or sex “in the street”), did not question the validity of the stigma surrounding her disease. Instead, she assumed that simply having sexual desire made her less virtuous and must ultimately have caused her cancer.

### *Stigma and Illness Narratives*

Of course, it is not surprising that Dona Moça, Maria Jose, and other women with cervical cancer in Recife would be aware of, and even reflect, the stigma surrounding their disease. Faced with a diagnosis of cervical cancer, women in the favela drew on cultural resources to give meaning to their suffering by understanding it in terms of particularly potent cultural norms (Brandt 1997; Becker 1997; Hunt 1998; Sontag 1990). However, women with cervical cancer also used stigmatizing metaphors to make sense not only of disease but also as a trope around which to organize the illness narratives they used to make sense of their newly diseased selves and lives. Women with cancer in Recife drew on stigmatizing metaphors to construct narratives that would help them understand the relationship between their new, ill, and, therefore, different selves and the world they have always known.

Notably, however, in Recife, women with cancer did not attempt to resist or reorder the social field. Nor did the narratives they constructed and the metaphors they drew on help them learn to be different or to adhere to a new idea of normal. Rather, they were determined to avoid reconfiguration of their social identities or remaking of their selves. They identified the behaviors that they felt were furthest from normal and highlighted their deviance from those norms. For Dona Moça, the “abnormal” behavior was too much sexual desire. For Maria Jose, the behavior was having multiple lifetime partners. For another woman in my sample, Marli, the behavior was homosexual desire. Marli was a heroin addict and prostitute, but she didn’t believe she developed cancer because she had multiple sexual partners. She believed she had cancer because “I’m not going to lie. I was with a girl.” She highlighted and emphasized what for her (and what culturally) was her most sexually inappropriate behavior and reinforced the idea that she was still held to those cultural norms.

Thus, women in Recife used stigmatizing narratives to hold themselves to the explicit cultural and moral standards, “the habits, roles, even fidelities” of the non-ill, the undisrupted. By doing so, they maintained continuity with their “same self.” Marli, Maria Jose, and Dona Moça, rather than resisting stigma, fortified stigmatizing metaphors and blamed themselves, quite unjustly, for their own misfortune. In

doing so, they maintained a connection to their selves and mediated the disruption that illness had on their lives.

### *Stigma and Healing Narratives*

Stigmatizing narratives also provided women with cervical cancer in Recife with a metaphor for thinking about health and, perhaps, redemption. Health or cure was described, both by women with cancer and by their physicians, in terms of a return to sexual purity. So, just as Dona Moça blamed her cancer on excessive sexual desire, she was also hopeful. She noted that after she had completed a painful course of radiation therapy, “one of the doctors told me that ‘you are going to get better because you don’t have a husband’” and, therefore, no longer had sex.

Mara Jose, referenced above, understood her disease in terms of having too many sexual partners, and, like Dona Moça, Maria Jose endured several painful radiation sessions. Although ultimately her treatments did not save her life, immediately after the first round of radiation she was quite hopeful, telling me that, because she could no longer have sex due her vaginal stricture and pelvic pain, “I’m like a virgin again. It is like I’m 15.”

For women with cervical cancer in Recife, those stories were constructed from stigmatizing metaphors. Thus, for many of the women with cancer I knew, the story of sexual impurity and cervical cancer wasn’t simply stigmatizing and shaming. It was, unexpectedly, also a story that provided hope for redemption, a place to locate their desire to go back in time to health and sexual purity. Women reported, and I observed, that physicians frequently explained to their patients that the vaginal narrowing and dryness caused by radiation therapy would render sex painful and, perhaps, impossible. Thus, doctors suggested, the women were not just healed, they were “virgins” again.

As one woman, recounting her discussion with the doctor, said,

After the operation he asked me if I wanted my health. I said yes. He said that I had to do that treatment [radiation] then, and I suffered so much. But I did it and I came back to him and he said that I was doing well. He said I was a virgin [*Moça*] again.

In another conversation, over a year later, the same patient noted,

Well the doctor freed me [to have sex]. The last time we went, my husband said, “When, doctor, can we?” The doctor said, “Listen, you can begin, but you have to go slow. Your wife’s vagina is very narrow now. It is like she is virgin again. You have to be patient and go slow.”

Similarly, another woman explained that her physician had told her that was she both like a virgin and like a man, because “with this application [radiation] I’m different. I don’t have anything any more . . . I have relations but without pleasure. I feel nothing, or pain . . . It closed me inside. I’m the same as a man. The doctor said so.”

Other women were clear that now that they were back to this asexual, or virginal state, they did not wish to risk having sex again.

I was married for 13 years, but now when someone wants to keep me company, I have to be clear. I had a disease that could have become cancer, and I can't do that now. Lots of young women now put the man's penis in their mouths, but I say that is just looking for death. They could get cancer. They are looking for death. . . . Every time I feel something, I jump, and I think it's this disease back again. It does that, it stays quiet and feeds on your blood, right? I feel any little pain and I think it's cancer! But it is not that disease. I'm not thin and I can defecate well. Maybe I'm healthy because I don't have sex any more.

Notably, Marli, the heroin addict and prostitute who believed that her cancer was caused by her sexual preference for women, found no hope in narratives that reference virginity and sexual propriety. Believing herself already blameworthy because of her sexual preferences, she also believed that treatment would "turn me into a man," thus worsening the problem. She therefore refused to complete it and eventually died.

## Discussion

This article adds to the body of research seeking a more nuanced understanding of stigma and its effects. It suggests that, while it is certainly true that stigma is a social product with social consequences, and that the stigmatized and their kin networks generally resist social discrimination and powerlessness, it also true that stigma is experienced as part of an individual's bodily and biographical disruption. Furthermore, how those individuals experience and use stigma may not parallel the experience and use of stigma within the social network.

Thus, on the one hand, this work supports Veena Das's important observation that the power of stigma lies not in its attachment to a particular individual but, rather, in its effects within social networks and in the threat (and reality) of social exclusion that is often the result of stigma management. Certainly, for the women in this study, the stigma attached to cancer and to sexually transmitted disease resulted in social marginalization as family and friends (and the women themselves) speculated about diseased individuals' sexual transgressions and about the contagion from the "rotting" that was presumed to be occurring inside them.

On the other hand, the work also suggests that, paradoxically, on an individual level, women with cervical cancer in Recife used stigmatizing metaphors in illness narratives that emphasized their acceptance of community values and norms and thus their continued membership in that community. Rather than resist stigmatizing narratives and rather than reinterpret cultural values and norms, they reinforced those values and norms through metaphors that maintained their connection to who they were before they were ill. They held tightly to stigmatizing metaphors that questioned their moral character, but that also provided a connection to what was the same, what remained unchanged, what was prior to illness.

In her now classic work exploring stigma, Susan Sontag makes the case against the use of illness as a metaphor, particularly stigmatizing metaphor, arguing that “the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking” (Sontag 1990:3). In later work, turning her eye specifically to the stigmatizing metaphors surrounding AIDS, she goes on to argue that “metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticized, belabored, used up” (Sontag 1990:182). They must be resisted.

None of the women with cancer in my study resisted, or even questioned, the stigma surrounding their disease. Instead, they maintained it, even creating stories of personal sexual misconduct when none existed, rather than challenge it. But while women with cervical cancer didn’t resist stigma, they also didn’t simply accept it as their unfortunate lot in life. Rather, they used it. Stigmatizing metaphors of sexual impurity provided many women with cancer with a way to organize illness narratives and to thereby make sense of the relationship between their new, ill, and therefore different selves and the world they have always known. Stigma allowed them to maintain their identities as members of a particular cultural and moral universe. Even more than that, though, women with cancer (and their physicians) intertwined stigmatizing metaphors with therapeutic metaphors and narratives of virginity and cure that allowed the women to maintain hope.

I would caution, then, that before we rush to “belabor” metaphors, or to assume that stigma will be resisted because it seems clear that it should be resisted, we pause to consider what else, what other uses metaphor, even stigmatizing metaphor, may serve in lives of the ill. And while metaphor, particularly stigmatizing metaphor, clearly increases the suffering surrounding disease, we should tread carefully before we divest the ill of meaning and comfort derived from unanticipated sources.

## Notes

1. Recently, development of a vaccine against HPV has provided yet another powerful tool against development of the disease, though the expense of the vaccine will likely limit its widespread use in Northeastern Brazil for years to come. (Goldie et al. 2007:6257–6270).

2. The ideal solution to this problem would have been the ability to apply high doses of short-term radiation, but at the time of my research the government would not fund a machine with that capability in Pernambuco. As one radiation oncologist explained, the problem lay in regional health care inequalities. The ideal, he said, would be if oncologists in Recife could get a “high dosage” machine, which has the same effects as brachytherapy, but that is effective in about ten minutes instead of four or five days. “The patients would do the same treatment in one hour that now takes days. This line of patients we have would disappear. And with this maybe we could individualize patient care.” He added that with this machine the danger of radiation exposure to the health care worker, which is a part of brachytherapy, disappears.

## References Cited

Ablon, Joan

1984 *Little People in America: The Social Dimensions of Dwarfism*. New York: Praeger.

2002 The Nature of Stigma and Medical Conditions. *Epilepsy and Behavior* 3(6 suppl. 2):2–9.

- Becker, G.  
 1997 *Disrupted Lives: How People Create Meaning in a Chaotic World*. Berkeley: University of California Press.
- Brandt, Allan M.  
 1997 Behavior, Disease, and Health in the Twentieth-Century United States: The Moral Valence of Individual Risk. *In* *Morality and Health*. Pp. 53–78. New York: Routledge.
- Bruner, Jerome Seymour  
 1986 *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.
- Bruschini, M. C. A.  
 1990 *Mulher, Casa, e Família: Cotidiano Nas Camadas Medias Paulistanas*. Sao Paulo: Fundação Carlos Chagas.
- Bury, Michael  
 1982 Chronic Illness as a Biographical Disruption. *Sociology of Health and Illness* 4:167–182.
- Capps, Lisa, and Elinor Ochs  
 1995 *Constructing Panic: The Discourse of Agoraphobia*. Cambridge, MA: Harvard University Press.
- Caravelas, L.  
 1994 *O Que Os Homens Fazem e Pensam Sobre Sexo*. Recife: Editora Universitaria da UFPE.
- Caufield, S., and M. d. A. Esteves  
 1993 50 Years of Virginity in Rio de Janeiro: Sexual Politics and Gender Roles in Juridical and Popular Discourse 1890–1940. *Luso-Brazilian Review* 30(January):47–73.
- Chavez, L. R., F. A. Hubbell, J. M. McMullin, R. G. Martinez, and S. I. Mishra  
 1995 Structure and Meaning in Models of Breast and Cervical Cancer Risk Factors: A Comparison of Perceptions among Latinas, Anglo Women, and Physicians. *Medical Anthropology Quarterly* 9(1):40–74.
- Das, V.  
 2001 Stigma, Contagion, Defect: Issues in the Anthropology of Public Health. Paper presented at Stigma and Global Health: Developing a Research Agenda International Conference. Bethesda, MD, September 5–7, 2001.
- Das, V., and R. Addlakha  
 2001 Disability and Domestic Citizenship: Voice, Gender, and the Making of the Subject. *Public Culture* 13(3):511–531.
- Ewing, K. P.  
 1990 The Illusion of Wholeness: Culture, Self, and the Experience of Inconsistency. *Ethos* 18(3):251–278.
- Freyre, G.  
 1986 *The Mansions and the Shanties: The Making of Modern Brazil*. Berkeley: University of California Press.
- Frumovitz, M., C. C. Sun, L. R. Schover, M. F. Munsell, A. Jhingran, J. T. Wharton, P. Eifel, T. B. Bevers, C. F. Levenback, D. M. Gershenson, and D. C. Bodurka  
 2005 Quality of Life and Sexual Functioning in Cervical Cancer Survivors. *Journal of Clinical Oncology* 23(30):7428–7436.
- Garro, Linda C., and Cheryl Mattingly  
 2000 Narrative as Construct and Construction. *In* *Narrative and the Cultural Construction of Illness and Healing*. Cheryl Mattingly and Linda C. Garro, eds. Pp. 1–49. Berkeley: University of California Press.

- Giffin, K., and C. M. Lowndes  
1999 Gender, Sexuality, and the Prevention of Sexually Transmissible Diseases: A Brazilian Study of Clinical Practice. *Social Science and Medicine* 48(3):283–292.
- Goffman, Erving  
1963 *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster.
- Goldiea, Sue J., Jane J. Kima, Katie Kobusa, Jeremy D. Goldhaber-Fieberta, Joshua Salomon, Meredith K. H. O’Sheaa, F. Xavier Boschc, Silvia de Sanjoséc, and Eduardo L. Franco  
2007 Cost-Effectiveness of HPV 16, 18 Vaccination in Brazil. *Vaccine* 25(33):6257–6270.
- Graham, S. L.  
1988 *House and Street: The Domestic World of Servants and Masters in Nineteenth-Century Rio de Janeiro*. Austin: University of Texas Press.
- Gregg, J.  
2000 Mixed Blessings: Cervical Cancer Screening in Recife, Brazil. *Medical Anthropology* 19(1):41–63.  
2003 *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford: Stanford University Press.
- Guimarães, Kátia  
1996 Nas Raízes do Silêncio: A Representação Cultural Da Sexualidade Feminina e a Prevenção do HIV/AIDS. In *Quebrando o Silêncio: Mulheres e AIDS no Brasil*. Richard Parker and Jane Galvão, eds. Pp. 89–114. Rio de Janeiro: Relume-Dumará.
- Higgins, J., J., S. Hirsch, and J. Trussell  
2008 Pleasure, Prophylaxis and Procreation: A Qualitative Analysis of Intermittent Contraceptive use and Unintended Pregnancy. *Perspectives on Sexual and Reproductive Health* 40(3):130–137.
- Hunt, Linda M.  
1998 Moral Reasoning and the Meaning of Cancer: Causal Explanations of Oncologists and Patients in Southern Mexico. *Medical Anthropology Quarterly* 12(3):298–318.  
2000 Strategic Suffering: Illness Narratives as Social Empowerment among Mexican Cancer Patients. In *Narrative and the Cultural Construction of Illness and Healing*. Cheryl Mattingly and Linda Garro, ed. Pp. 88–107. Berkeley: University of California Press.
- Jensen, P. T., M. Groenvold, M. C. Klee, I. Thranov, M. A. Petersen, and D. Machin  
2003 Longitudinal Study of Sexual Function and Vaginal Changes after Radiotherapy for Cervical Cancer. *International Journal of Radiation Oncology, Biology, Physics* 56(4):937–949.
- Knauth, Daniela Riva  
1999 Subjetividade Feminina e Soropositividade. In *Sexualidades Pelo Averso: Direitos, Identidades, e Poder*. Pp. 121–136. São Paulo: Editora 34.
- Link, B. G., and J. C. Phelan  
2001 Conceptualizing Stigma. *Annual Review of Sociology* 27:363–385.
- Lovell, Anne M.  
1997 “The City Is My Mother”: Narratives of Schizophrenia and Homelessness. *American Anthropologist* 99(2):355–368.
- Malta, M., F. I. Bastos, S. A. Strathdee, S. D. Cunningham, J. H. Pilotto, and D. Kerrigan  
2007 Knowledge, Perceived Stigma, and Care-Seeking Experiences for Sexually Transmitted Infections: A Qualitative Study from the Perspective of Public Clinic Attendees in Rio De Janeiro, Brazil. *BMC Public Health* 7:18.

Mattingly, Cheryl

1988 *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*. Cambridge: Cambridge University Press.

Nations, Marilyn K., and Cristina G. Monte

1997 "I'm Not Dog, No!": Cries of Resistance Against Cholera Control Campaigns in Brazil. *In The Anthropology of Infectious Disease: International Health Perspectives*. Marcia C. Inhorn and Peter J. Brown, eds. Pp. 439–482. Amsterdam: Gordon and Breach.

Nazzari, Muriel

1997 Sex/Gender Arrangements and the Reproduction of Class in the Latin American Past. *In Gender Politics in Latin America: Debates in Theory and Practice*. E. Dore, ed. Pp. 134–148. New York: Monthly Review.

Nelson, K., A. M. Geiger, and C. M. Mangione

2002 Effect of Health Beliefs on Delays in Care for Abnormal Cervical Cytology in a Multi-Ethnic Population. *Journal of General Internal Medicine* 17(9):709–716.

Panourgia, E. Neni K.

1995 *Fragments of Death, Fables of Identity: An Athenian Anthropography*. Madison: University of Wisconsin Press.

Parker, R.

1991 *Bodies, Pleasures, and Passions: Sexual Culture in Contemporary Brazil*. Boston: Beacon.

Parker, R., and P. Aggleton

2003 HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action. *Social Science and Medicine* 57:13–24.

Polkinghorne, Donald E.

1988 *Narrative Knowing and the Human Sciences*. Albany: State University of New York Press.

Rebhun, L. A.

2004 Sexuality, Color, and Stigma among Northeast Brazilian Women. *Medical Anthropology Quarterly* 18(2):183–199.

Russell-Wood, A. J. R.

1978 *Female and Family in the Economy and Society of Colonial Brazil*. Westport, CT: Greenwood.

Sarti, C.

1995 Morality and Transgression among Poor Families. *In The Brazilian Puzzle: Culture on the Borderlands of the Western World*. D. J. Hess and R. A. Da Matta, eds. Pp. 114–133. New York: Columbia University Press.

Scheper-Hughes, N.

1992 *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.

Sontag, Susan

1990 *Illness as Metaphor and AIDS and Its Metaphors*. New York: Anchor.

Vainfas, R.

1989 *Tropico Dos Pecados: Moral, Sexualidade, e Inquisição no Brasil*. Rio de Janeiro: Editora Campus.

Whelan, S. L., D. M. Parkin, and E. Masuyer

1990 *Patterns of Cancer in Five Continents: IARC Scientific Publication no. 102*. Lyon, France: International Agency for Research on Cancer.

Whittaker, A. M.

1992 Living with HIV: Resistance by Positive People. *Medical Anthropology Quarterly* 6:385–390.