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The scarlet H: Herpesvirus hominus -- its clinical manifestations and personal implications

Ann K. Larson

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The scarlet H: Herpesvirus hominus – its clinical manifestations and personal implications

Abstract

Sexually Transmitted Diseases (STDs) tend to affect sufferers psychologically as well as physically. Most of these diseases, however, can be cured and forgotten. Genital herpes, the leading Sexually Transmitted Disease in the United States, seems to cause more psychological damage than do any of the other STDs. (Chase, 1983) Herpetics must cope with the knowledge that their Sexually Transmitted Disease is incurable. The fact that there is a paucity of information on counseling the herpetic contributes to the need for the study. Any professional dealing with an individual who has recently learned he or she has genital herpes needs to be aware of its psychological impact. Herpetics get what Dr. Oscar Gillespie, a research psychologist at Fordham University in New York City, calls the "herpes syndrome." (Schultz-Brooks, 1983) They progress through stages comparable to the stages of grief the terminally ill experience.

THE SCARLET H: HERPESVIRUS HOMINUS--ITS CLINICAL
MANIFESTATIONS AND PERSONAL IMPLICATIONS

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
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In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Ann K. Larson
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7/10/84
Date Approved

Robert T. Lembke
Director of Research Paper

7-12-84
Date Approved

Robert Krajewski
Second Reader of Research Paper

7/10/84
Date Received

Robert T. Lembke
Graduate Faculty Adviser

7-12-84
Date Received

Robert Krajewski
Head, Department of Educational
Administration and Counseling

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Chapter One

INTRODUCTION

Sexually Transmitted Diseases (STDs) tend to affect sufferers psychologically as well as physically. Most of these diseases, however, can be cured and forgotten. Genital herpes, the leading Sexually Transmitted Disease in the United States, seems to cause more psychological damage than do any of the other STDs. (Chase, 1983) Herpetics must cope with the knowledge that their Sexually Transmitted Disease is incurable.

The fact that there is a paucity of information on counseling the herpetic contributes to the need for the study. Any professional dealing with an individual who has recently learned he or she has genital herpes needs to be aware of its psychological impact. Herpetics get what Dr. Oscar Gillespie, a research psychologist at Fordham University in New York City, calls the "herpes syndrome." (Schultz-Brooks, 1983) They progress through stages comparable to the stages of grief the terminally ill experience.

Unlike terminal illnesses, however, herpes causes a psychological response while not appearing to cause permanent damage to the body as do conditions such as diabetes and hypertension. These are "incurable diseases" that have more serious consequences than does herpes. Helping professionals need not use the term "incurable" or the term "disease" when describing herpes. What they need to do is provide accurate information about the virus as well as be sensitive to the emotional state of the patient.

Such actions tend to help clients cope with the feelings of shame and guilt toward themselves that often accompany the disease. (Schultz-Brooks, 1983) This also helps them cope with their expectations that others will judge and chastise them. It seems that many herpetics alienate themselves from others because it is somehow less painful than it would be should others choose to reject them.

The study concerned itself with how counselors could help herpetics cope with the emotional stress of having herpes. Because so little research was available, the study offered only a beginning and much more research will be required before one can derive specific counseling techniques and objectives for working with herpetics.

Statement of the Problem

The problem that was examined by the study consisted of two questions: how did having herpes affect the interpersonal relationships of herpetics, and to whom did herpetics go in seeking professional help? Through determining answers to these two questions, it was hoped that more effective services could be designed and implemented.

Purpose of the Study

The study was undertaken in order to determine some of the attitudes that were held by herpetics toward themselves, toward others, and toward people in the helping professions. To do this, a survey instrument was constructed and administered to herpetic subjects. The purpose of this survey was to ascertain subjects' attitudes toward specific issues. From such a study, it was hope that counseling services and the training of helping professionals could be tailored to the specific needs of herpetics.

Definition of Terms

For the purpose of the study, the terms that need to be defined are Sexually Transmitted Disease and herpes virus. A Sexually Transmitted Disease is a disease caused by any one of seven organisms including bacteria, spirochetes, chlamydia, viruses, fungus, protozoa, and metazoa. The mechanism for transmission of infection is "contact" between carriers and recipients. Contact comprises kissing and varying types of sexual intercourse or activity. Transmission may occur between contaminated surfaces or objects and recipients. (Chase, 1983)

The herpes virus is one of the largest of all viruses. It contains a central core of DNA in the shape of a coil. A group of proteins in barbell formation pass through the coil's opening. An envelope made up of proteins and fats surrounds the core. This envelope aids the virus in attaching to and entering uninfected cells. There are five human herpes viruses: herpes simplex types I and II, herpes III or varicella-zoster virus, herpes IV or Epstein-Barr virus, and herpes V or cytomegalovirus. (Perlow and Perlow, 1983)

Design of the Study

The study was designed as a survey that was administered to a sample of subjects drawn from people who had herpes. A questionnaire was constructed with the assistance of various professors. This questionnaire was given to subjects and their responses tabulated.

Delimitations

The study, because of its exploratory nature, does not attempt to give in-depth answers to many important issues. The study offers a beginning in the study of the counseling needs of herpetics. It also

offers a general idea of how they perceive their disease and their professional counseling needs. Further research will be required to answer questions of how counselors can best help herpetics, what counseling approaches work best, and the types of counselors who will be most effective with herpetic clients.

The study drew its subjects from a population of herpetics who lived in St. Louis and who were members of a city-wide support group. The limited nature of this population makes it difficult to generalize to other groups.

Finally, the study involved the use of a questionnaire as a source of data. Behavioral observations would offer different data and would be an effective alternative to the approach used in this paper.

Chapter Two

REVIEW OF LITERATURE

A myth that abounds concerning genital herpesvirus has to do with its recent nature. Currently, the Center for Disease Control (CDC) reports that the number of people with genital herpes is between ten million and twenty million, while an additional five hundred thousand cases are added each year. (McKinstry, 1983) Before 1966, the CDC did not even bother to report data on genital herpes as it was rarely encountered. That year, genital herpes was recognized as a venereal disease for the first time. Herpes was soon written about and discussed as a Sexually Transmitted Disease (STD). Genital herpes was not a new STD. In truth, it was an old disease that was only newly epidemic.

Several reasons exist for the dramatic increase in occurrences of herpesvirus (Rapp, 1983): (1) Changing sexual values have made casual sex acceptable. (2) The more sexual partners one has, the higher is one's risk of contracting any Sexually Transmitted Disease. (3) Also, choice of contraceptives has changed. More couples are relying on birth control pills rather than condoms, spermicidal foam, or diaphragms, all of which helped to protect individuals from Sexually Transmitted Diseases. (4) A highly mobile culture put people in contact with more differing cultures, thus, more disease. (5) Medical science has made rapid progress, leaving people with the attitude that any disease they caught could easily be cured.

The myth, then, is that genital herpes is a new sexually transmitted disease. In fact, it has been in the world's medical

literature since 1736. (McKinstry, 1983) Throughout the Eighteenth and Nineteenth Centuries, physicians in North America and Europe continued to describe genital herpes using such names as "neuralgic herpes of the genital organs," "les herpes genitaux," and "herpes progeneralis." (Hamilton, 1980) It was known then that herpesvirus was a recurring affliction and doctors listed "lechery," "alcohol," and "nerves" as causes of recurrences. Dr. Henry G. Piffard of the University of the City of New York reported his support of the recurring nature of the virus in 1873. (Hamilton, 1980) He was not sure that it recurred in females, however. A French physician, Alfred Fournier, suggested that herpetics could benefit from avoiding "overtiredness and sexual excess." (Perlow & Perlow, 1983) He promoted "moderate coitus with fidelity" as herpes was not often reported among married couples. Also, most physicians believed genital herpes to be exclusively a male disease. This belief was not supported by Paul Gerson of Germany who worked for a number of years in an area that was predominantly populated by prostitutes. At the end of his work there, he reported about two hundred cases of genital herpes in females. (Hamilton, 1980) During the late eighteenth hundred, reports of genital herpes continued, yet they disappeared from the medical literature during the first half of the twentieth century.

The term "herpes," coming from the ancient Greeks, means "to creep." (Hamilton, 1980) Perhaps this is an attempt to explain the mysterious manner in which the lesions spread and multiply on the mucous membranes. Herpesvirus can attack multiple body sites including the lips, genitalia, skin, eyes, and infrequently the central nervous

system and visceral organs. There are over 70 different herpes viruses while only five of them affect humans. (McKinstry, 1983) Herpes I and Herpes II are well known as herpes above and below the waist. It is incorrect to assume, though, that herpes I cannot be spread from the lips to the genitalia. Herpes III is known as the varicella-zoster virus (VZV), varicella pertaining to chicken pox and zoster to shingles. The Epstein-Barr virus (EBV), names for its discoverers, Epstein and Barr, is one of the most prevalent human viruses, Herpes IV. Most humans show evidence of having this virus at some point in their lives, usually during childhood. Mononucleosis develops in about 50% of individuals who suffer from EBV in early childhood. Herpes V, or cytomegalovirus (CMV) is also carried asymptotically by much of the population. It can be severe among patients with suppressed immune systems.

The Nature of the Herpesvirus

Viruses are much smaller than bacteria and the two differ in structure and life cycle. Bacteria are able to divide on their own while viruses must live within cells. These viruses use the chemicals and biological systems belonging to the cell, or host, to aid them in replication. Viruses, in general, are comprised of proteins. Inside the virus protein coat is a single molecule of either RNA or DNA, unlike human or bacterial cells which contain both.

Herpesviruses cannot be cultivated in the usual mixtures of sugared gelatins as can bacteria. This makes their study and treatment more difficult. Since they exist within living cells, they require a living tissue culture. Herpesviruses are among the largest of all

viruses though they are tiny compared to bacteria or protozoa. Herpesviruses are sensitive to heat and cannot survive long outside the human body. They are non-living organisms or "Obligate, intracellular parasites." (McKinstry, 1983) They can be differentiated from other viruses in that they contain DNA in a coiled fashion. Groups of proteins pass through this coil's opening as the herpesvirus reproduces. Also, unlike other viruses, their core is surrounded by an envelope composed of glycoproteins and fats. This envelope makes infecting normal cells possible.

The herpesviruses differ in DNA structures. The molecules for each vary in size and orientation with CMV possessing the largest DNA molecule and VZV the smallest. (Rapp, 1983) Those of HSV-I and HSV-II are about the same size. Most of the viruses do not show genetic relatedness with the exception of HSV-I and HSV-II which share approximately 50% of their common nucleic acid base sequences. (McKinstry, 1983) HSV-I and HSV-II occur in human as well as non-human species and in several cell types. CMV, VZV, and EBV occur solely in human cells.

Herpes and Normal Cells

The body's defense system (Tartora & Anagnostakos, 1978) consists of white blood cells or macrophages, B-lymphocytes, plasma cells, and T-lymphocytes. They all originate from bone marrow with macrophages maturing in bone marrow as well. These attack foreign organisms in the blood stream. B-lymphocytes mature in the lymph system and either remain in lymph nodes or move between lymph and blood systems. When they encounter foreign organisms, they split. Some of the

B-lymphocytes travel back to nodes with the "message" that a "foreigner" is present. Others turn into plasma cells at the infection site. These secrete antibodies attempting to fight the foreign organisms. They also coat the invading cells with a substance that attracts macrophages.

T-lymphocytes originate in the thymus gland and are triggered by B-lymphocytes. When a T-lymphocyte fights invaders, it converts into a cell called a lymphoblast releasing chemicals called lymphokines. One of the chemicals literally excites macrophages, increasing their "appetite" for invaders. Another keeps the macrophages centered at the infection site. A third activates T-lymphocyte cells that may not yet be participating in the fight against the foreign organism.

Blood proteins, C through C, work with B-lymphocytes in that the lymphocytes help them to "fit" onto the infected cells. C through C bind together, explode, and destroy the cells in seconds. Finally, a chemical compound known as interferon (antiviral substance) is produced by the infected cells. Interferon strengthens uninfected cells so they are more resistant to infection.

Normal human cells have two reactions to herpes simplex infections. One is of a productive nature; the cell's machinery is used for reproducing the virus. The normal cell eventually dies as it is kept from carrying on with its usual functions of protein synthesis. The second reaction is that the "uninvited" virus remains within the human cell with both virus and cell surviving.

Transmission of the herpesvirus requires direct contact of infected surfaces or mucous membranes with susceptible (noninfected)

surfaces or mucous membranes. Common modes of transmission comprise:

1. sexual intercourse
2. oral sex
3. lesion to hand--hand to mucous membrane
4. lesion to hand--hand to another individual
5. experimental virus to researcher
6. patient to health provider
7. health provider to another patient

Once it has gained access to the host, the herpesvirus attaches itself to the cell's perimeter. Next, in a process called fusion, the envelope of the virus integrates with the cell's outer membrane. The virus then sheds its envelope and becomes part of the cell. Once inside the cell, the virus is transported rapidly to the cell's nucleus which is the center that directs all cellular activity. The virus takes over, replacing the genetic codes that regulate normal cell functioning with its own code of functioning. For the next twenty hours, the cell will produce over twenty thousand replicas of the herpes simplex virus. Soon after, it is nothing more than a hollow shell. Following a substantial amount of cellular death and tissue destruction, the lesions that are common symptoms of active herpes simplex virus develop. These often spread, forming clusters of sores. Without the workings of the body's defense system, the sores would become deep ulcers within days and, within weeks, the victim's life could be threatened. This is kept from happening as chemical changes from cellular walls signal the macrophages and B-lymphocytes. The macrophages project appendages that surround the infected cells and literally digest them with the help of acids and enzymes.

Again, interferon is produced by the dying cells to strengthen the remaining healthy cells. B-lymphocytes travel to the infection site and transform into plasma cells and these produce the antibodies that coat infected cells. The binding of C through C occurs and within minutes invaded cells begin to disintegrate. Eventually, infected cells are being destroyed faster than the virus is able to attack new cells and tissue regeneration beings.

Genital Herpes

Clinical studies of isolated virus types (Kellum & Loucks, 1982) found HSV-II to be the causative antigenic type in 85% of genital and perineal lesions. Herpes II is commonly known as herpes below the waist, but in fact, it is responsible for lesions on the arms, hands, thighs, genitals, and anal areas. HSV-I is isolated around the mouth, eyes, upper body, and brain. HSV-II can be transmitted to the oral mucosa and approximately 20% of genital herpes infections are caused by antigenic type I. (Kellum & Loucks, 1982)

The incubation period is two to twenty days with symptoms developing four to seven days after exposure. Herpetics report flu-like symptoms before initial outbreaks. These include fever, chills, headache, or general malaise. Next, the herpetic experiences the prodrome, or heralding of the coming outbreak. During the prodrome, the skin or mucous membrane where the virus entered will itch and tingle causing a pins-and-needles sensation. The herpes viruses are beginning to attack healthy cells as these symptoms are manifesting themselves. The surface or mucous membrane then becomes swollen and inflamed as more and more healthy cells are destroyed. Sores, or

papules, develop and may take a blister-like appearance, filling with fluids produced by the body's defense system. The blisters, or vesicles, frequently break open forming infectious ulcers. Healing begins when the ulcers crust or scab, and it is at this time that the body's defense system has destroyed many of the infected cells. New skin develops at the outer edges of sores moving inward. Scar formation is uncommon.

Genital herpesvirus manifests itself in males anywhere on the penis including the head and foreskin. Urethral involvement is uncommon though possible and may cause discharge and painful urination. The herpesvirus has also been cultured from the prostate gland. (Bettoli, 1982) Uncircumcised males with penile lesions usually suffer maceration of tissue and lengthy infections due to the moist nature of the skin. Overall moist-skin lesions heal more slowly than dry-skin lesions. The herpesvirus in males also may infect the thighs or anus, depending on where sexual contact occurred.

In females, the lesions may form anywhere on the labia minora or labia majora, thighs, perianally, and within or about the urethra. Some may have a single lesion while others may experience a cluster of lesions from the urethra to the anus. Females have special concerns in that urine passing over lesions on the urethra causes burning pain. Many resort to urinating while sitting in a tub of hot water. Another problem for females is that 20% of their infections are asymptomatic or "silent," occurring in the cervix or the vagina. Such infections have no visible lesions, yet are contagious. This phenomenon, called "silent shedding" often is the cause of sexual partners acquiring the disease without even knowing they were exposed to it.

Latency

Over half a century ago, Goodpasture, the first to demonstrate that the herpes virus traveled along neural routes, suggested that the virus may possess the potential to remain in a persistent state within nervous system tissue. (Baringer, 1974) In 1970, Plummer and associates obtained experimental corroboration of this hypothesis. Rabbits were inoculated with herpesvirus intramuscularly and six to eleven months later, the virus was recovered from ganglion and cord cells. Similar studies with mice provided the first evidence that the latent virus was present in spiral ganglion cells after peripheral inoculation. Further, it was found that the speed of travel of herpesviruses in nerve trunks equaled approximately the speed of retrograde transport of proteins within nerves. Also, latent herpesvirus was detected in cervical and thoracic dorsal root ganglia.

Reactivating events taking place within the ganglia and requirements for recurrence of infection at the periphery remain unknown. (McKinstry, 1983) Various factors seem to cause recurrences, however, such as exposure to sunlight, fever, stress, suppression of the immunological system, friction from tight clothing, or sexual intercourse and menstruation. Whether there is a common denominator remains a mystery.

The Psychology of Herpes

One physician compares genital herpes to the common cold. (Knaup, 1984) The commonalities are that both are viruses, both are contagious, both cause minimal discomfort, both run their course in about one week, and both recur throughout an individual's life.

Herpes, like the common cold, does not become worse in time nor does it seem to cause permanent physical damage to the body. Yet, genital herpes has raised a type of hysteria that the common cold or any other form of the herpesvirus never did. (Knaup, 1984) Herpetics report that the psychological pain of having genital herpes is ultimately worse than the physical pain. Often, guilt or self-reproach lies at the base of this psychological pain. Much of the guilt that herpetics experience is due to the fact that genital herpes is sexually transmitted (Perlow & Perlow, 1983)--it is a permanent symbol of their actions.

The social stigma attached to sexually transmitted diseases was born of the attitude with which sexual values were imprinted within our culture. Undoubtedly, the Bible was the most influential source on sexual values. (Schiller, 1973) Our culture accepted interpretations of Biblical teachings concerning sexuality that weighed heavily on the negative side. The underlying and erroneous belief was that preaching about sex and immorality would keep people from being sexually promiscuous. (Schiller, 1973) A better approach might have been enhancing the human element of sexuality or treating it as a sacred part of life. (Schiller, 1973)

The attitude that sexuality is deeply embedded in the human personality permeates the Bible. There are numerous passages in the Old Testament that sensitively explore the male-female sexual relationship including the physical desire existing between wife and husband. Sex is considered to be a gift of God. The idea that "sex is sin" evolved during the second century A.D. (Schiller, 1973) It was

believed that Paul was quoted as saying it was wrong for a man to touch a woman and the original sin was thought to be sexual intercourse. Self-denial and virginity were considered to be pathways to salvation.

John Calvin's "Augustinian" interpretation of sexuality was brought to America by the Puritans. The Puritans believed that sex was necessary only for procreation and even within the sanction of marriage it was considered immoral. The roots of the double standard were planted as young men acted upon their natural desires with "bad" women and later married virgins or "good women." These codes were eventually patterned into Colonial laws and were reinforced by the Greek philosophy that friendship between same sex partners was more important than marital love. Then, in 1873, Anthony Comstock, secretary of the New York Society for the Suppression of Vice, declared that sex or anything associated with sex was obscene and poisonous to the mind and body. (Schiller, 1973)

The Puritan ethics on sexuality remained at the base of our cultures sexual values. Still, they did not bring about the dissipation of promiscuity. In fact, sexual freedom increased dramatically as new cultural and religious attitudes were brought to the U.S. during immigration in the nineteenth century. The nineteen twenties and thirties saw wide distribution of sex topics through periodicals and paperbacks. More liberal attitudes about sexuality did not enter the scene until 1948 when Dr. Alfred Kinsey published Sexual Behavior in the Human Male. Following were reports by Dr. William Masters and Virginia Johnson of Washington University in St. Louis, Missouri: Human Sexual Response in 1966 and Human Sexual Inadequacy in 1970. (Colton, 1971)

Of the twenty million Americans that have genital herpes, the majority are between the ages of 18 and 35. (Elahi, 1982) When young adults of this generation were infants, current knowledge about sexuality did not exist. It was believed, for instance, that masturbation among small children might one day prove harmful. Infants six months of age have been observed rubbing their genitals pleurably. It is not uncommon for small children to develop natural curiosity about their bodies, including their genitals, as well as the bodies of other children. (Colton, 1971) But, thirty years ago, children were often punished for exploring their bodies or for masturbating.

Another common myth was that if one did not talk about sexuality or the sexual organs with one's children, these children would not develop promiscuous lifestyles. What many did develop was a reluctance to examine their own genitals without shame or embarrassment. They also developed insatiable appetites for casual sex though guilt or self-reproach remained as remnants of all they had learned about sexuality during childhood. (Colton, 1971)

Herpetics frequently suffer from guilt, believing that they contracted the virus by doing something wrong. Because many of them had received the message as children that their genitals were shameful and that sex was immoral, they felt they deserved to contract herpes. It was not unusual for a herpetic to adopt a celibate lifestyle, whether it be to avoid infecting others or as a self-punishment for contracting the virus. (Hamilton, 1980) Males with genital herpes sometimes become impotent due to a fear of infecting their partners.

Underlying any of these behaviors is the idea that sex is sinful and an illness of the sexual organs is much more than a physical ailment.

Stress and Herpes

Selye's (1956) general adaptation syndrome outlines three stages of stress response: (1) the alarm reaction when the body is mobilized to confront a stressor, (2) resistance when the body is dealing effectively with the stressor, and (3) exhaustion when stress is unresolved. Selye, however, was not the first person to discuss this general stress response. Walter Cannon (1939) began studies on physiological responses to environmental stimuli. From his work, Selye became interested in physiological responses to noxious stimuli (stressors) and the uniform manner in which numerous stimuli resulted in a common response.

Over the years since Selye's seminal work, this stress response has been studied and the theory surrounding it has been made more comprehensive. In general, however, the study of stress has remained the study of the "fight or flight" response that Cannon initially identified.

At a physiological level, environmental stressors are responded to in much the same way as are cognitive or emotional stressors. It seems that the brain does not differentiate between the external environment and the internal environment. (Veno & Davidson, 1978) The reticular activating system of the brain, comprised of many of the endocrine glands within the brain (the limbic system, and the temporal lobes) scans the environment for signs of stressors. This reticular activating system does not have the capacity to differentiate between

stimuli that are generated internally or externally, so everything is perceived as though it were equally "real."

The reticular activating system generates hormonal responses in the endocrine gland, the hypothalamus. The hypothalamus responds by stimulating the pituitary gland and by activating the autonomic nervous system. The pituitary gland stimulates the adrenal gland to produce corticosteroids and catecholamines. The autonomic nervous system raises blood pressure, decreases blood flow to the extremities, and stimulates the thymus gland.

At the same time, the heart rate becomes more rapid, breathing becomes more rapid and shallow, and muscles become more tense. At this point, the body is ready to fight or flee and can respond instantaneously to any sign of threat. If no threat is presented, or once the stressor is removed, the body requires a short time to return to a normal state.

Over time, if people are exposed to prolonged stress, the stress response tends to wear the body out. Of primary importance to herpetics is the tendency for the thymus and the entire immunological system to wear down after exposure to prolonged stress. (Solomon, Amkraut, & Kaper, 1974) The stress of having an outbreak of herpes often contributes to a weakening of the immunological system, that system that is primarily responsible for alleviating the symptoms of herpes. (Bresler, 1983) The interpersonal and emotional stresses of being a herpetic contribute to new outbreaks of herpes. In this way, the body eventually is worn down and bouts of herpes may become more severe and prolonged.

One physician reports that the majority of herpetics he has dealt with admit to being under an unusual amount of stress at the time they first contracted the virus. (Bresler, 1983) The possibility exists that they had decreased immune competence or decreased host resistance when they were exposed to the virus. Also, almost all of these individuals knew before they contracted herpes that stress could precipitate an outbreak. And, just having the virus is enormously stressful in itself. Herpetics feel a loss of control or predictability in their lives because of the very unpredictable nature of the herpesvirus. (Perlow & Perlow, 1983) They adopt a sense of helplessness, allowing the virus to take control of their bodies and minds and the vicious cycle of stress and herpes outbreaks is set in motion.

Herpes and Counseling

Any professional dealing with an individual who has recently learned he or she has genital herpes needs to be aware of its psychological impact. Herpetics progress through stages comparable to the stages of grief the terminally ill experiences. (Schultz-Brooks, 1983) Initially, the individual diagnosed as having genital herpes will experience shock. This may be attributed to the fact that herpes is often described as an incurable disease, which is technically correct even though it precedes some false assumptions. Unlike cancer, herpes does not worsen nor does it appear to cause permanent damage to the body. Conditions such as diabetes and hypertension are "incurable diseases" that have more serious consequences than does herpes. Helping professionals need not use the term "incurable" or the term

"disease" when describing herpes. What they need to do is provide accurate information about the virus as well as be sensitive to the emotional state of the patient.

A patient may display denial as well as shock after the initial diagnosis. People who demonstrate denial tend to act as though they were non-symptomatic and as though there were no possibility that they actually had herpes. If confronted with the reality of their condition at this point, they may actively resist acknowledging any medical facts. It, therefore, would not be therapeutic or practical to confront them with the facts of having herpes until they are ready to "hear" them. To confront them with the reality too early in this process may result in their going "doctor hopping" in hopes of finding a physician that agrees with their personal "diagnosis."

The next stage is that of anger. During this stage, patients no longer are able to deny the truth of their condition and face the fact that they have herpes. In response to this, they become angry at numerous people. Often the anger is directed at partners from whom herpes was contracted and the physicians who diagnosed herpes. Some patients may be angry at people who do not have herpes and desire revenge by attempting to spread the virus to as many unsuspecting partners as possible. And, during this stage many herpetics blame the physician for diagnosing genital herpes because they are afraid to blame their partner. This also leads to "doctor hopping" and much unnecessary expense.

The stages of shock, denial and anger commonly occur within a short period of time. (Schultz-Brooks, 1983) The herpetic often

displays all three during the first few hours or days after the initial diagnosis. Such trauma leaves the herpetic in a state of exhaustion, perhaps self-imposed isolation, loneliness and deepening depression. (Schultz-Brooks, 1983) It is at this point that many herpetics decide that they will discontinue intimate involvement with primary partners or that they will become celibate. (Chase, 1983) Such actions may also be forms of self-reproach as punishment for the sin of contracting genital herpes. Not only do herpetics feel shame and guilt toward themselves, but they expect others to judge and chastise them as well. It seems that many herpetics alienate themselves from others because it is somehow less painful than it would be should others choose to reject them.

For some herpetics, having the virus rescues them from risk-taking within relationships. Others alienate themselves because they cannot face the possibility of infecting a future partner. Finally, herpetics frequently adopt a negative body image. (Perlow & Perlow, 1983) Much of their depression and self-imposed isolation stems from a feeling that they are damaged, unclean and scarred. (Leo, 1982)

Not all herpetics experience the above stages. There are those who seem to accept the initial diagnosis when it is given. Most, however, seem unable to accept the fact that they have genital herpes until they have progressed through feelings of shock, denial, anger and depression. This process commonly covers the span of one or two years. Acceptance usually follows some meaningful interpersonal encounter.

The Herpes Resource Center in Palo Alto, California is made up of approximately 30,000 members and 45 chapter Help groups. (Leo, 1982) Help groups are beneficial in that it is consoling for individuals who have genital herpes to meet with others who also suffer from the virus. The support group atmosphere provides a safe environment in which herpetics can disclose feelings that they might not when in their daily environments. Also, because of the nature of support groups, participants who have worked through the stages and arrived at acceptance experience further inner growth as they have an opportunity to help newer members of the group. Still, the task of Help groups remains a difficult one. Members who have reached an optimal level of functioning attempt to lead others back to living normally. They hope to teach others to regain a sense of control in their lives by removing thoughts of herpes from the center of their existence.

Individuals who contract genital herpes often find themselves within a crumbling relationship. (Leo, 1982) This mysterious virus has the potential to plant seeds of mistrust. Individuals who infect their partners are accused of being unfaithful, when in fact, it is possible for the virus to erupt after years of lying dormant. (Hamilton, 1980) Herpes is sometimes "used" as a reason for ending an unsatisfactory relationship. (Leo, 1982) It spurs anger that might otherwise have been repressed and strips individuals of masks and roles, giving them courage to face confrontation. People who end primary relationships for the sole reason that genital herpes has entered the scene may be overreacting. Most admit that they ended existing relationships because these relationships were unhealthy even before herpes became an issue. (Schultz-Brooks, 1983)

An approach to counseling with herpetics that is of potential benefit is one that comes from the work of Kobasa (1979). She conducted studies of how stress affected various people. It was found that, given the same amounts of stress, some people coped well while others did not. She called the people who coped well with stress more "hardy" than the poor copers and from this, she suggested that an approach to stress management counseling may revolve around helping clients become more hardy in their responses to stress.

Hardy individuals were found to be high in four general areas when compared to less hardy subjects. Hardy subjects had a stronger commitment to themselves as individuals than did less hardy subjects. This meant that these subjects had a clear sense of their own values, goals, and abilities. They believed in their own importance as individuals. Hardy subjects also had an attitude of vigorousness toward their environments. They believed they could make a difference on the world and worked hard to do so. These subjects had a strong sense of meaningfulness. They believed their lives had a purpose and worked to actualize that purpose. Finally, hardy subjects had an internal locus of control. This meant that they believed they were in control of their lives and that they could make choices and decisions that affected their lives. (Kobasa, 1979)

Counselors could benefit herpetics by helping them to adopt these attitudes of hardiness. If it would be possible to do so, they would be less paralyzed by their condition while they also would be less susceptible to recurrent attacks. Kobasa does not discuss how clients could be helped to become more hardy. Also, there is not research

that suggests that herpetics could benefit from becoming more hardy. These issues are important and could benefit from further research.

In general, the entire topic of counseling with herpetics would benefit from more research. So little is known about the types of counseling that could help herpetics or the types of counseling they would want, that no firm suggestions can be made. Once there is an understanding of what herpetics need and want, more thorough studies of clinical approaches can begin.

Chapter Three

METHOD AND PROCEDURES

Subjects

Subjects for the study were 20 volunteers. The population from which subjects were drawn was that of all people with herpes simplex II. The specific sample for this study was taken from subjects who were participants in a "Herpes Support Group" in St. Louis, Missouri.

The sample consisted of 13 females and 7 males. The mean age of subjects was 30.5 and the standard deviation was 3.72. The mean age at which subjects contracted herpes was 27.5 and the standard deviation was 4.78.

All subjects were volunteers and their confidentiality was maintained by using unsigned questionnaires with no personally identifying information. Subjects were debriefed after the study was completed.

Instrumentation

Two concerns prompted this study, these being, how herpetics felt the virus affected their interpersonal relationships and to whom they would go seeking professional help. A questionnaire was designed to answer the above questions. The questionnaire consisted of eleven items. (See Appendix A) Those items pertain to the sex of the individual, the individual's age, age when herpes was contracted, whether the partner was the same sex or opposite sex of the individual and whether the individual was aware that his or her partner had the virus. Further, items inquired about the individual's current sexual partner and whether that partner was the herpetic from whom he or she

contracted herpes. If the individual was presently sexually involved with someone who did not have herpes, items pertained to disclosure or the act of telling the partner that the individual had herpes.

The last half of the questionnaire contained items attempting to measure the second concern, or the kind of professional help herpetics would seek. Participants in the study were asked to disclose the source they talked to immediately after learning they had herpes. Also, items covered possible coping styles, what issues would be discussed with a counselor and from what professional sources counseling would be sought. Finally, an optional item at the end of the questionnaire asked participants to briefly delineate how their perception of self had changed since contracting herpes. Those subjects who completed this question were interviewed by the experimenter at length and their responses included in the "Discussion" section of this paper. The personal interviews were designed to elicit further information on the written responses of subjects.

The questionnaire was designed after consultation with Dr. Robert Stensrud, Dr. Norman Story and Dr. Robert Lembke. Because this was a survey, validity was tested through giving the questionnaire to 10 University of Northern Iowa students who came to the University Counseling Center. From this, it was determined that the questionnaire measured what it intended to measure.

Procedure

The procedure by which this study was conducted involved two phases. During the first phase, volunteers were solicited through advertisements on television and through newspaper advertisements.

No subjects volunteered, so a second phase was attempted. During this phase, the experimenter volunteered to be the leader of a herpes support group in St. Louis, Missouri.

As the facilitator of the group, the experimenter became familiar with participants and helped direct group meetings. Once there was a feeling of rapport with group members, all members were asked to volunteer as subjects for the study. The participants were told that participation was voluntary and that all information would be kept confidential.

During the group meeting following this announcement, the questionnaire was given to volunteers. It was completed and subjects were debriefed by explaining the purpose of the survey and the questions it sought to answer. Subjects were informed that their results would be pooled with other results, so no individual information would be reported.

Chapter Four

FINDINGS OF THE STUDY

As previously indicated, thirteen of the subjects were female and seven were male. The mean age of subjects was 30.5 with a standard deviation of 3.72. The mean age of males was 30.4 and the mean age of females was 30.5. Participants were the mean age of 27.5 when they contracted herpes with a standard deviation of 4.78. The mean age of males was 27.6 and the mean age of females was 27.2. Nineteen of the subjects contracted herpes from someone of the opposite sex while one contracted herpes from a member of the same sex.

Sixteen of the twenty subjects were not aware that the partner from whom they contracted their initial infection had herpes. Of the four who did know that their partner had the virus, one was told early in relationship, one when the relationship became intimate, one right before sexual contact and one immediately after sexual contact. Fifteen of the twenty subjects were no longer sexually or intimately involved with the partner from whom they contracted herpes. At the time of the study, nine of the fifteen who had left their previous partner had new sexual partners. Six did not have sexual partners currently. Of the new partners, three had herpes and six did not.

Participants were asked whether, since they contracted herpes, they had a sexual relationship with a non-herpetic. Twelve of the twenty subjects responded affirmatively. Of the twelve who were sexually involved with non-herpetics, two told their partners that they had herpes early in the relationship. Four told their partners when the relationship became intimate. None of the twelve told partners

told partners right before sexual contact. One told the partner immediately after sexual contact. Two disclosed long after sexual contact and four had not told their partners at the time of the study.

Subjects were then asked about the sources they talked to after learning they had herpes. All twenty had talked with physicians, one reported having talked to a minister, four met with psychologist, two chose social workers, and one talked with a counselor. None of the twenty sought counseling from a peer counselor, while eight turned to friends or family members.

Subjects were asked to check any coping styles listed on the questionnaire that applied to them: nine subjects reported the coping style of denial, seven were ashamed after learning they had herpes, two claimed to be unconcerned, twelve were depressed, and ten coped by accepting herpes. If subjects could or would go to a counselor to work through the psychological effects of being herpetic, the following issues might be discussed: six would center on disbelief and shock, six would deal with anger and bitterness, twelve would discuss fear of anxiety, thirteen would work through depression, four would explore their mistrust of the opposite sex, seven would disclose a loss of self-esteem, and two would touch upon religion and morals.

Finally, the author wanted to know from what professional sources subjects would most likely seek counseling: two would go to physicians, one would seek help from a minister, nine would choose a psychologist, one would go to a social worker, nine would see a counselor, two would see a peer counselor, and six would turn to friends.

At the end of the questionnaire, subjects could describe in one or two lines how their perception of self had changed since they discovered they had herpes. Six out of the twenty did not respond to the question. Three wrote that their perception of self had not changed since learning they had herpes. The eleven who answered the question described briefly how their self perception had changed. To summarize, most commented that having to learn to cope with genital herpes helped them become better equipped to cope with other difficult aspects of their lives. They were able to reframe their initial feelings of alienation into a sense of being special or set apart from non-herpetics as they had gained a keener appreciation of their general health, physical and mental. Also, because they had grappled with the physical and psychological trauma of having genital herpes, they emerged with pride and a new self love. Many believed these positive feelings were born of the herpes struggle and would never have existed had they not contracted the virus. Finally, two of the eleven added negative descriptions of their self perception. They delineated a sense of being damaged, ugly, marked, scarred and dead inside.

Discussion

That participants were 27.5 years of age when they contracted herpes implies two points. First, it supports previous findings that persons age 18-29 suffer the highest risk of contracting a Sexually Transmitted Disease (STD) in this country. Second, it touches upon part of the reason genital herpes is so devastating to those who contract it. Most are at a stage in their lives when they are contemplating marriage and perhaps parenting. They are involved in

one of the most delicate phases they will ever go through, that of risking being intimate, sexually or emotionally, with a partner. The risks comprise endless possibilities but the risk of being rejected by a primary partner is one that keeps many herpetics "in the closet." Suffice it to say that having genital herpes in one's mid-twenties seems to increase that risk, making the research for an intimate relationship extremely frightening.

Sixteen of the subjects were not aware that the person from whom they contracted herpes had the virus. Only four of the subjects knew that they were having sexual contact with a herpetic. This data correlates with previously-cited studies attempting to explain the epidemic proportions of sexually transmitted disease in the United States. Reasons for the spread of STD include some interesting ideas. Women, who are often asymptomatic carriers of STD (including herpes), spread the diseases without realizing it. In fact, both males and females spread STD without realizing they are doing so because the symptoms can easily go unperceived. Also, herpes can be contagious between outbreaks when no symptoms are present. Many females do not know they have herpes because they may have a mild strain of the virus or any sores they might have could be in the vagina or cervix where they would not be easily seen. Often, STD is spread because of a lack of information; individuals simply do not know what their symptoms mean. (Chase, 1983)

Most crucial, however, is the point the data make about communication within relationships. Telling a sexual partner that one has herpes may seem like an impossible task. It involves risk-taking

and an ability to be accurate as well as sensitive to the feelings of the listener. Part of the problem stems from the fact that people are becoming sexually involved before they have an opportunity to get to know their partners emotionally or intellectually. They do not know their partners well enough to feel comfortable disclosing intimacies. (Chase, 1983)

That fifteen of the subjects were no longer with the person from whom they contracted herpes while only five had stayed in the relationship supports another popular belief. Where herpes goes, relationships crumble. Again, the herpetics the author interviewed speak of feeling set apart from non-herpetics in that they have gained inner strength after grappling with the virus. One has to wonder whether herpes is causing the demise of relationships or whether it is simply giving individuals who are involved in unhealthy relationships an excuse for ending them. Most herpetics the author has worked with support the latter. They experience inner growth that gives them the courage to leave a partner they are unsatisfied with.

Only nine of the fifteen herpetics were involved in a primary/sexual relationship with a new partner. Six were not sexually involved with anyone at the time of the survey. This supports what has been previously written about herpetics. (Perlow & Perlow, 1983) They are reluctant to begin dating again after learning they have herpes. What was surprising to the author was that six of the new partners were non-herpetics while only three had the virus. Herpetics talk a lot about dating other herpetics because it would be "safer." In practice the contrary may be true. Twelve out of the twenty subjects had been

involved in sexual relations with a non-herpetic at least once since they had contracted herpes. The issue of telling a partner one has herpes comes forth again. Only two disclosed early in the relationship and four when the relationship became intimate. These numbers are somewhat encouraging as is the fact that none told right before sexual contact. That two told long after sexual contact and four had not yet told at the time of the survey suggests a fear of telling or a reluctance to tell. This is discouraging, not necessarily because the herpetics are doing great physical harm to their partners, but because they are depriving themselves of the opportunity to take risks in relationships.

The other concern that promoted this study had to do with the kind of professional help herpetics did or would seek. All subjects talked with physicians. The reason for this is obvious; doctors were the first professional sources herpetics encountered. A problem might be that individuals with herpes report extreme shock and anxiety during the first few moments they knew of the virus. Perhaps most physicians lack the counseling skills needed at such a time. Seven sought help from a human services professional while eight turned to friends or family. Much has been printed concerning the medical aspect of herpes or the psychological horrors of having the virus yet little on the counseling skills professionals need in order to help herpetics cope. Perhaps friends were sought out of desperation or a dire need to talk to someone who cared. A question arises; do we teach doctors counseling skills or do we make counselors more accessible to herpetics?

Nine subjects reported the coping style of denial, twelve, depression and then, acceptance. Also, there were seven who were ashamed and two who were unconcerned. Most herpetics admit to denying that they contracted herpes when they were first told. Some added that they continue to have difficulty accepting the fact that they have herpes. Many report progressing through emotional stages similar to the stages of grief. Shock and denial are usually experienced when herpetics are first told of the virus. The term "incurable" is sometimes used by doctors, nurses or the media when describing herpes. Anything with such a label automatically causes subjects to think of cancer. It is extremely frightening for herpetics to face the fact that they have a condition that remains, at present, incurable. Whether this term should be used at all when describing herpes is highly debated.

When herpetics move through the stage of shock or denial, they report feeling intense anger, often at the individual from whom they contracted herpes. After the anger dissipates, deep depression sets in and it is often accompanied by shame or a feeling of being damaged and unclean. (Perlow & Perlow, 1983) The resolution stage, or acceptance, had been reached by half of all subjects participating in the study. This is probably due to the nature of support groups. Acceptance had not been attained by all because some were attending the meeting for the first time when they filled out the questionnaire. Others had been members for a year or more.

If the subjects sought counseling, thirteen would choose to work through their depression and twelve, fear or anxiety. Depression seems

to be the most chronic of the stages and can last indefinitely, depending upon the individual and his or her support system.

Depression may be linked with the herpetic's sense of helplessness that the nature of the unpredictable herpesvirus imposes. Fear and anxiety result from the fact that herpes is highly contagious. Most herpetics attribute their fear to the possibility of infecting a partner rather than to any serious complications herpes may have on their own bodies.

Loss of self-esteem was checked by seven of the twenty subjects. This relates to the stigma attached to any sexually transmitted disease. Only six checked both shock and bitterness, probably because most subjects had already worked through those stages during the first few weeks after their initial diagnosis. Only four would choose to discuss a mistrust of the opposite sex and two would touch on religion and morals. The latter is somewhat surprising since much of the herpetic's psychological pain stems from the manner in which he or she learned about sexuality.

Sources of counseling that would be chosen by most of the participants included psychologists and counselors, both receiving nine checks. Most subjects reported that they were currently seeing professionals, mainly psychologists and psychiatrists. Friends rated fairly high also with six subjects choosing this channel. It is encouraging that some herpetics choose to tell friends who may not have herpes. Such disclosures make inner growth and greater insights possible for both herpetic and friend. Only two would choose to talk with a physician. This correlates with comments made frequently by

subjects that their physicians handled their cases insensitively. Finally, one would choose a minister, one a social worker, and two, peer counselors.

Chapter Five

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Although herpes is a disease that has afflicted humanity for centuries, little attention has been focused on it until recently. Popular attention has been drawn to it through the press and professional attention has been drawn to it through more detailed research into its nature. As the number of cases of herpes has increased, however, little attention has been paid to the psychological aspects of being herpetic and the type of counseling that would be appropriate.

The problem posed by this study was to determine how having herpes affected one's interpersonal relationships and to whom herpetics went for professional help. These questions were addressed in order to better focus on the counseling implication of having herpes.

The purpose of the study was to begin to formulate some general information on the perceptions and attitudes of herpetics. To this end, a questionnaire was designed to ask general questions pertaining to how subjects contracted herpes, how herpes had affected their relationships, and who they had gone to in search of professional help.

A review of the related literature indicated that much medical data existed on herpes viruses but little psychological research was available. Part of the problem with studying the psychological aspects of herpes was the stigma attached to being herpetic. People with herpes indicated that they were seldom willing to talk with anyone about their disease because they felt misunderstood. Cultural taboos derived from religious teachings have contributed to this dilemma.

Some research seemed to indicate that herpes was related to stress, so stress management may have been beneficial in helping to prevent recurrences. There was physiological research on the nature of the stress response that tended to substantiate this connection. Research on hardiness as a response to stress seemed to be especially applicable to understanding how to manage herpes attacks.

For this study, 20 volunteers were selected to complete a questionnaire. These subjects were drawn from a population of members of the St. Louis herpes support group. Of the total sample, 13 were females and 7 were males. All subjects were volunteers and were debriefed at the completion of the study.

The questionnaire consisted of items asking subjects to give their sex, age, age when they contracted herpes, sex of their partner at that time, whether the subject knew their partner had herpes, and the nature of their current sex partners. The questionnaire also asked the types of professional help subjects had sought and the types of professional help they would like to seek.

The results of the study suggested that most of the subjects were not aware that the partner from whom they contracted herpes had the disease. Of those who knew their partners had herpes, one had been told early in the relationship, one once the relationship became intimate, one right before sexual contact, and one immediately after sexual contact.

Over half of the subjects reported that, since contracting herpes, they had sexual relationships with non-herpetics. Of these, two had told their partners early in the relationship that they had herpes,

four told their partners when the relationship became intimate, one told their partner immediately after sex, two told their partners long after having sex, and four never told their partners.

All twenty subjects had talked with physicians since contracting herpes. Of the other professionals contacted, one went to a minister, four went to psychologists, two chose social workers, and one talked with a counselor.

When asked what types of coping styles they used to handle the stress of learning they had herpes, subjects reported using diverse strategies. Nine reported using the coping strategy of denial, seven were ashamed, two were unconcerned, twelve were depressed, and ten actively accepted the fact that they had herpes.

Subjects reported that, if they were to go for counseling, there were certain things they wanted to discuss. Six would discuss their disbelief or shock, six would discuss anger or bitterness, twelve would discuss fear or anxiety, thirteen would discuss their depression, four would talk about their mistrust of the opposite sex, seven would discuss their loss of self-esteem, and two would talk about religious or moral issues. Subjects, for this question, could check more than one option.

Conclusions and Recommendations

One significant conclusion that can be drawn from the study is that herpetics are reluctant to inform their partners that they have the virus. Sixteen of the twenty subjects were not aware that the partners from whom they initially contracted the virus were herpetics. This could imply that herpes is being spread innocently because

herpetics are not aware that they have the virus. It also could imply that herpetics are afraid to or do not know how to tell partners that they have herpes. Individuals who infect others with herpes or other common Sexually Transmitted Diseases frequently claim that they did not know they had an infection. It is difficult to believe, however, that the pain accompanying a herpes outbreak would not be noticed. Silent shedding of the herpes virus may account for this, however. Still, most herpetics the author has worked with report that it is quite impossible to be unaware of a herpes outbreak. It is believable that some herpetics are unable to admit to themselves that they have the virus. But, even more believable, is the fact that their fear of the unknown--how their partners will respond--is what prevents them from being open.

Recommendations may include conducting further research on this issue to determine specifically why herpetics are reluctant to disclose that they have this disease. Also, specific studies could be conducted to determine how counselors could best facilitate the development of effective communication skills so herpetics would be better able to be open with partners.

Another pertinent conclusion derived from the study is that herpes seems to play a role in terminating relationships. When asked whether they were presently with the partner from whom they contracted herpes, fifteen of the twenty subjects reported that they were not. Such a response has various implications. Individuals who contract herpes tend to move through stages of coping, the early stages being shock and anger. It is not uncommon for these individuals to vent their anger as

they have a strong need to blame someone for what has happened to them. Herpes leaves people feeling powerless. Pointing the finger of blame is a herpetic's way of taking control. Also, when genital herpes suddenly creeps into the lives of two individuals involved in an intimate relationship, it sometimes reveals infidelity. Finally, the intense anger individuals experience after contracting herpes often becomes a justification for ending relationships that were unsatisfactory before herpes was an issue.

The majority of concerns expressed by herpetics are relationship concerns. It follows, then, that any helping professional working with herpetics needs to be prepared to conduct relationship or marriage counseling. But the interaction of personal and medical factors adds a new dimension to traditional relationship counseling procedures. Counselors, therefore, may benefit from a broader range of knowledge pertaining to counseling and medical information.

Much more needs to be understood about the psychological implications of having herpes. As studies provide such information, it may become possible for counselors and counselor education programs to better address this large and growing need.

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Appendix

Appendix

Questionnaire

1. Sex a.) Female ___ b.) Male ___
2. Present age a.) ___ Age when contracted Herpes b.) ___
3. Was your partner a.) Opposite sex ___ b.) Same sex ___
4. Were you aware that your partner had Herpes? a.) Yes ___
b.) No ___
If yes, at what point in the relationship did she/he relay the information?
 - a.) Early in the relationship ___
 - b.) When relationship became intimate ___
 - c.) Right before sexual contact ___
 - d.) Immediately after sexual contact ___
 - e.) Long after sexual contact ___
5. Are you presently with the person from whom you contracted Herpes?
a.) Yes ___ b.) No ___
If no, do you have a sexual partner at this time? a.) Yes ___
b.) No ___
Does this person have Herpes? a.) Yes ___ b.) No ___
6. Since you contracted Herpes, have you had a sexual relationship with someone who did not have the virus? a.) Yes ___ b.) No ___
If yes, at what point during the relationship did you tell your partner that you had Herpes?
 - a.) Early in the relationship ___
 - b.) When relationship became intimate ___
 - c.) Right before sexual contact ___
 - d.) Immediately after sexual contact ___
 - e.) Long after sexual contact ___
 - f.) Have not told partner ___
7. What sources did you talk to after learning you had Herpes?

| | |
|-----------------------|------------------------|
| a.) Physician ___ | e.) Counselor ___ |
| b.) Minister ___ | f.) Peer Counselor ___ |
| c.) Psychologist ___ | g.) Friends/family ___ |
| d.) Social Worker ___ | |
8. Which of the following describes the manner in which you cope with Herpes?

| | |
|-------------------|--------------------|
| a.) Denial ___ | d.) Depression ___ |
| b.) Shame ___ | e.) Acceptance ___ |
| c.) Unconcern ___ | |

9. If you went, or would go to a counselor, what issues would you

- | | | | |
|----------------------|-----|------------------------------|-----|
| a.) Disbelief/shock | ___ | e.) Mistrust of opposite sex | ___ |
| b.) Anger/bitterness | ___ | f.) Loss of self-esteem | ___ |
| d.) Fear/Anxiety | ___ | g.) Religion/morals | ___ |
| e.) Depression | ___ | | |

10. From what sources would you most likely seek counseling?

- | | | | |
|-------------------|-----|--------------------|-----|
| a.) Physician | ___ | e.) Counselor | ___ |
| b.) Minister | ___ | f.) Peer counselor | ___ |
| c.) Psychologist | ___ | g.) Friend | ___ |
| d.) Social Worker | ___ | | |

Since contracting Herpes, how has your perception of yourself changed?