

THE STIGMA EXPERIENCES OF THE LIBERIAN COMMUNITY OF THE DFW
METROPLEX DURING THE 2014-15 EBOLA OUTBREAK

by

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ABSTRACT

Following the death of Thomas Eric Duncan, the first U.S. case of Ebola during the 2014-15 Ebola outbreak, Liberians in the DFW Metroplex became closely linked to the Ebola virus. This link created an environment in which members of the Liberian community experienced varying degrees of stigmatization. This stigmatization emanated from both within the Liberian community as well as from members of the general public. These experiences are vital for capturing how members of an impacted community experience stigmatization in the wake of an outbreak of a fear-inducing disease, as well as providing insight into how public officials and community leaders alike can better prepare for future health crises.

I. INTRODUCTION

Stigmatization, the phenomenon by which individuals experience discrimination or some other social disadvantage based on their association with negative characteristics, is a major and ultimately inevitable aspect of health crises such as the recent EVD outbreak. Outside of any physical consequence of contracting a disease in such a case, stigmatization can be one of the most damaging aspects of an outbreak. Individuals who are stigmatized suffer from workplace discrimination and social shunning, which have real impacts on economic, political, and social health.

Much of the literature covering the impacts of past Ebola outbreaks include some examination of stigmatization, but almost always in parallel with an examination of the robustness of the impacted location's medical system. This places the actual experiences of the stigmatized as a lesser concern; previous literature often focuses on ways to improve medical systems so as to increase use of medical facilities, or to increase the efficacy of the medical system in general. This also highlights another crucial aspect of stigmatization: the role of power. Typically, individuals who experience stigmatization lack the power to successfully mitigate stigmatization, particularly if the stigmatized population consists of minority and/or immigrant populations.

With the case of Thomas Eric Duncan, the 2014-15 Ebola outbreak reached the shores of the United States. While his infection and passing was unfortunate, it ultimately provides researchers with the opportunity to examine the impact of a fear-inducing infectious disease in an American context. As the situation unfolded, questions sprung up: In past outbreaks, a crumbling or non-existent medical system could be faulted for spread of contagion; how would the US medical system fare? Are medical personnel

adequately prepared to handle a patient with Ebola? The question that became most interesting to this researcher, however, was: what is the Liberian community in the DFW Metroplex experiencing?

The US has a long and storied history of treating immigrant communities unfairly when it comes to potential spread of disease. Howard Markel has documented how immigrants and minorities have experienced discrimination due to being associated with incoming diseases, regardless of the actual contribution of these communities to disease case counts. Prior to data collection, media reports were already beginning to include Ebola's connection to Liberia in nearly every article, especially (and perhaps naturally) those that covered Duncan's case. Prominent lawmakers called for border closures, and some even hinted at deporting any Liberians – and others from Guinea or Sierra Leone – who were not naturalized citizens. For this researcher, it was apparent that the DFW Liberian community would face some sort of stigmatization, and that an examination of their experiences could prove at least as useful as any examination of the failings or successes of the American medical system.

The research conducted found that Liberians did indeed face stigmatization, and in some expected manners. Some individuals were asked to stay home from work until they could prove they didn't have Ebola – some with pay, some without – while others experienced social shunning. Peers would not engage in physical contact any longer, or request that Liberian children stay away from others. Close association of Liberians with Ebola resulted in some DFW Liberians feeling as though the Metroplex, the state, the nation, even, blamed them for bringing Ebola to the US. There were some aspects of stigmatization that were not suspected: Some Liberians stigmatized one another. Many

stopped frequenting stores owned by other Liberians, while others stopped attending group events, or any activity that involved a large gathering. Some Liberians felt that the crisis strengthened the community, but many also expressed that they felt this would not be a permanent change. And, perhaps most surprisingly, DFW Liberian community leaders reported little to no interaction with health officials throughout the crisis.

It is the opinion of this researcher that the narratives and experiences of the stigmatized allow for more complete emergency preparedness. Regardless of the crisis, there will always be a social aspect that involves an impacted community. It is through understanding how a community may experience a health crisis, from all facets, that the medical community can best serve an impacted population.

The results of this research have been written in article format to make the results more accessible to a broader population. Not only for those in the health care industry, but also for members of the impacted community. Emergency preparedness cannot be the sole burden of the medical system; its participants must also be able to prepare themselves. The best way to assist community leaders is by providing them with examples of the experiences of their constituents, so that they know which areas of concern need to be best addressed for the future. This research also has an applied component, which will involve delivering a presentation to the leadership of the Liberian community. This presentation will focus on areas that appear to be most relevant in bettering community preparedness.

II. THE STIGMA EXPERIENCES OF THE LIBERIAN COMMUNITY OF THE DFW METROPLEX DURING THE 2014-14 EBOLA OUTBREAK

INTRODUCTION

In 2014, an outbreak of the Ebola virus disease (EVD) swept across West Africa; among the most heavily impacted nations was Liberia. In September 2014, Thomas Eric Duncan became the first EVD case in the United States. Duncan was a Liberian national who had traveled to Dallas to visit family members who had immigrated years prior. While seemingly healthy at the time of his arrival, within two weeks he had succumbed to EVD. As a result of Duncan's case, as well as the general fear associated with the potential spread of the disease in the US, members of the Liberian community became heavily associated with EVD, leading to the question: How did Liberians in the Dallas/Fort Worth (DFW) Metroplex experience the 2014-15 EVD outbreak?

An examination of the stigma experiences of Liberians in the DFW Metroplex provides insight into local value systems held by members of the Liberian community and the ways in which stigmatization impacted their social relationships with both Liberians and non-Liberians. Additionally, examining the stigma experiences of Liberians in the DFW Metroplex allows for comparison to stigmatization processes in past EVD outbreaks. The Liberian community in the DFW Metroplex experienced varying degrees of stigmatization. Several factors contributed to the stigma experiences of Liberians in DFW Metroplex, including the level of individuals' interaction within the Liberian community as well as the larger DFW Metroplex; their distance from, and amount of travel to, Dallas, where Duncan was diagnosed; and media exposure depicting Liberians in a negative light, or otherwise associating them with EVD.

BACKGROUND

Stigma

Stigma originated as a concept surrounding construction of identity, particularly with regard to individuals who become associated with a condition or characteristic which moves the individual from a 'normal' social status into a 'discredited' social status (Goffman 1963). The original concept of stigma has largely been used in psychology, with a focus on internalization processes and changes to behavior. This focus tends to exclude the ways in which stigma alters the social life and relationships of the stigmatized (Kleinman 2009, 418). More recently, sociology has re-shaped the concept of stigma by identifying social processes, with effects that are observable on an individual level. This involves breaking stigmatization into identifiable components such as labeling, stereotyping, separation, status loss, and discrimination (Link 2001; Link 2006). Anthropologists utilize this extension of analysis to broaden the examination of stigma to include the moral status of stigmatized individuals. In this context, a stigmatized individual experiences multiple degrees of discrimination. Any time stigmatization arises, it does so through unique social and cultural processes, and it is through understanding local value systems that the impact of stigmatization can be more fully understood (Kleinman 2009).

In health crises, stigmatization is applied to individuals and groups via perceptions of health and illness (Lee 2005:2039), and stigma can be applied even when the associated individual or group does not possess the assumed negative attributes. When suffering from stigma related to health issues, affected populations experience varying levels of discrimination: economic impacts in the form of differential treatment

on the job, which can result in either hostile working conditions or unemployment; social impacts in the form of becoming shunned or excluded from social circles the population previously participated in; and receiving substandard medical care (including outright refusal of treatment by medical professionals) – or the fear of receiving substandard medical care.

Another factor that influences stigmatization during health crises is actual or perceived immigration status. The US has a long history of associating immigrant groups with an influx of infectious disease, regardless of said groups' actual contribution to case counts (Markel 1997; Markel 1999; Markel 2002). The Liberian population in the DFW Metroplex has been around for approximately 30 years, and many individuals within the community are naturalized citizens. Despite this, experiences during the 2014-15 outbreak caused some members of the community to feel as though they will always be seen as Africans. This becomes a problem when significant emphasis is placed on the African roots of the outbreak, focusing on Liberians as a specific threat (Jones 2014, Glionna 2014, Brown 2014, Phillip 2014).

Stigma – Past Outbreaks and Analogues. In past EVD outbreaks, stigmatization has included the shunning of infected – or assumed infected – individuals, destruction of personal property belonging to infected individuals, abandonment by family and loved ones, and loss of livelihoods and jobs (Kinsman 2012; Hewlett 2003; Roo 1998). Studies of past EVD outbreaks also reveal that fear of stigmatization, and the resulting discrimination, contributed to individuals hiding their infected status, resulting in further proliferation of the disease. As a result, stigmatization can have a direct impact on the epidemiology of an infectious disease outbreak. Post-infection, EVD survivors of the

1995 Kikwit outbreak report that they were still stigmatized, or that they still feared being stigmatized, even after successful convalescence (Roo 1998).

Stigmatization in health crises is not limited to instances of EVD, nor does it belong solely to Africans. The 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, which began in Asia, spread to more than two dozen countries and resulted in more than 8,000 reported cases of the disease and over 700 reported casualties. Similar to EVD, SARS is spread via close person-to-person contact, including kissing, hugging, sharing eating utensils, and other means of direct physical contact. Also similar to past EVD outbreaks, the SARS outbreak saw stigmatized individuals shunned by former peers and discriminated against by medical personnel and work associates (Lee 2005).

One of the more well documented SARS cases from the 2003 outbreak involved the infection of the Amoy Gardens residential community in China. One block in particular experienced several cases, which resulted in members from other blocks as well as the general population associating all individuals from the infected block with the SARS virus. The outcome of this association included social shunning, whereby individuals from outside of the infected block engaged in avoidance patterns with those from the infected block; individuals from the infected block finding themselves unable to find work if they identified themselves to prospective employers as living within the infected block; individuals who were still employed finding themselves subjected to work conditions not experienced by other employees; and refusal of treatment by medical professionals. These impacts were experienced regardless of whether an individual from the infected block had actually contracted SARS or not. Mere association with the disease, and the location where the disease seemed prevalent, resulted in stigmatization

for all individuals tied to the location of infection (Lee 2005).

Stigma and the Recent Outbreak. Following past outbreak trends, the recent EVD outbreak clarified the capability of stigma to disrupt social norms that are highly valued in Liberian culture. Many of these norms become apparent upon spending any amount of time observing or interacting with a Liberian: upon greeting, Liberians will shake hands or hug; proximity and physical contact are key ways in which Liberians display affection and appreciation of one another. It is not uncommon for a Liberian to eat off of another's plate, or to share clothing (Patrick 2015).

Traditional Liberian culture is exemplified by physical social interaction; in Liberia EVD forced Liberians to make difficult decisions that had direct impacts on both their physical and social health: In attempts to halt the spread of the virus, for example, Liberians sacrificed being present when family members were sick or in need at the cost of strained and potentially broken relationships. For every instance recounted where physical contact was avoided (whether by ceasing the contact or abating it via avoiding skin to skin contact) there was an instance of a family member unable and unwilling to withhold assistance. In these cases, loved ones are lost – some of whom would have lived had they avoided physical contact (Cooper 2014).

Stigma at Home. Following Thomas Eric Duncan's death, it is undeniable that the media and general public focused a great deal of attention not only on the fear of a global epidemic, but also on finding 'who' should be at fault. Following the US's pattern of associating immigrant communities with disease, media attention closely linked Liberia, and Liberians, with EVD. Much like literature covering prior outbreaks, results from this research reveal that this close association with the virus itself created an environment in

which members of the community ultimately faced varying levels of stigma-borne discrimination, including exclusion from social groups, requests for members of the Liberian community to stay home from work, and experiencing feelings that Liberians were responsible for bringing the disease to the United States.

THE EVD/LIBERIAN CONTEXT

EVD

First encountered in the 1970s, EVD causes a severe, and often fatal, hemorrhagic fever (Peters 1999). The virus can incubate for 2 to 21 days before symptoms present; at this time, the infected individual becomes contagious and can pass the virus to others via contact with infected bodily fluids.

According to the Centers for Disease Control and Prevention (CDC), with the exception of instances involving lab quarantine and infection, there have been seven outbreaks prior to the most recent – and deadliest – outbreak in 2014. All of these have occurred in Africa, and primarily Central and East Africa. These outbreaks resulted in a combined casualty count of approximately 1,021 individuals. In contrast, the 2014 outbreak alone resulted in over 11,000 deaths (CDC(a) 2015).

The recent EVD outbreak originated in West Africa in July of 2014, and the CDC quickly issued travel notices for Guinea, Liberia, and Sierra Leone (CDC(b) 2016). Sierra Leone and Liberia were particularly hard hit, with both reporting over 10,000 total confirmed, suspected, or probable cases by November 2014 (CDC(c) 2016).

Liberia

The Republic of Liberia, founded in 1847 by freed American slaves, has seen many individuals travel to the US for education for decades. However, a major cause of

recent Liberian immigration is related to a two-phase civil war. Phase one began when a rebellion in 1989, under the leadership of Charles G. Taylor, occurred after the confluence of the Gulf War and the disengagement of the US. Lasting until 1996, this phase of the war resulted in over 200,000 casualties and the displacement of hundreds of thousands of Liberians. Despite a ceasefire and peace accord, conflict reignited in 1999 and did not end until 2003 (Munive 2011). Many Liberians immigrated to the US, entering through New York and dispersing further from there. Some traveled for work opportunities, while others traveled to states like Texas to pursue higher education (Ronald 2015).

According to US Census data, the African foreign-born population has grown from approximately 80,000 individuals in 1970 to roughly 1.6 million in 2012. Currently, Texas ranks among the 10 states with the largest African-born populations. Of an estimated 134,000 individuals in the state, roughly 39% are from West Africa. The Dallas/Fort Worth area is home to approximately 61,000 African-born individuals, with Liberians accounting for one of the three largest groups (Gambino 2014). According to Liberian community leaders, approximately 10,000 Liberians live in the DFW Metroplex (Barry 2015).

A community leader associated with the Liberian Community Association of the Dallas/Fort Worth Metroplex (LCA DFW) emphasized that community members are encouraged to meld into the greater community, while retaining cultural values. There is an idea that Liberians should remain a tight-knit community, while not living just among other Liberians. The degree to which Liberian individuals are able to do so is attributed to factors like education, and level of exposure to non-Liberian culture (Frank 2015). The

result is a Liberian community in which some interact primarily with other Liberians, while others interact with both others within the Liberian community and with those outside of the Liberian community.

METHODS

At the start of this project, the researcher collaborated with the LCA DFW. Community leaders belonging to this organization provided the researcher with information regarding community events as well locations of community churches. This organization served as the researcher's entre into the community; community leaders introduced the researcher to individuals at community events, and during one church service, the pastor provided the researcher an opportunity to speak to the congregation about the research project, as well as request participation in the project. It is the researcher's opinion that support from this organization provided vital assistance in the data collection process.

Research was conducted from July 2015 to August 2015. This research project utilized direct and participant observations as well as semi-structured interviews as data collection methods. To be considered for interview participation, individuals needed to be members of the Liberian community that were present in the DFW Metroplex during the outbreak. Non-Liberian participants were considered for participation if they were community, religious, or business leaders with ties to the Liberian community. Observations were only conducted on events or activities directly associated with the Liberian community.

Field notes from observations detailed the general environment of observed locations, as well as social interactions of members of the Liberian community. Often,

these observations also involved brief conversations with members of the community. While not recorded verbatim, these interactions were also documented in field notes. In total, five observations were conducted at a large community event, church services, and a community organization's election voting site.

Open ended interviews were the primary data collection method in this research. Interview topics included but were not limited to immigration process and integration into a new social world, experiences and feelings that occurred both during and after the EVD outbreak, as well as feelings regarding community belonging and feelings of social identity. As the research continued, focus on immigration processes and social integration lessened, though participants were still asked about their experiences with both. All interviews were held in public spaces; each interview was recorded with the consent of the participant, and then transcribed. To preserve confidentiality, the names, locations, and other personal identifiers have been removed or modified.

After data collection was complete, textual data from field notes and interview transcripts were analyzed via content analysis. This analysis method allowed the researcher to observe patterns and themes present in the data, which were then transformed into 'codes'; these codes allowed the researcher to package relevant information into key themes. These themes were then used to inform the results of the research project.

RESULTS

In total, 11 interviews were conducted, with 12 participants. Of these, 10 participants were Liberians residing in the DFW Metroplex. Six of the Liberian male participants were between their late 30's and 40's, while one male was over 60 years of

age. Two of the Liberian female participants were between their late 30's and 40's, while one female was in her 20's. One interview was conducted with a white male who works with an immigration agency, while the other was with a black, non-Liberian male who is a local business leader.

Early in the project, when the researcher thought that immigration experience would be an integral part of the project, the researcher conducted an interview with an employee of the International Rescue Committee (IRC). This interview was designed to provide the researcher with a clearer understanding of immigration processes, both as they relate to incoming immigrants as well as interaction with existing immigrant communities in the DFW Metroplex. As the project continued, it became apparent that immigration history was not as vital to understanding the stigma experiences of the Liberian community in the DFW Metroplex as originally assumed. The researcher held on other interview with a local business leader originally from Nigeria. The rest of the interviews were conducted with members of the Liberian community, including community leaders (both political and religious). Interview participants were recruited primarily via observations, as well as through contacts provided by community leaders.

Results indicated that members of the Liberian community in the DFW Metroplex experienced varying levels of stigmatization. This stigmatization ranged from Liberian parents reporting that their children were excluded from social groups, Liberians receiving requests to stay home from work, and having both non-Liberian as well as Liberian peers avoid physical and social contact. Some members of the community were able to roll these experiences into their day-to-day life in an effort to manage stigmatization. Some participants mentioned media attention as a cause for feelings of

guilt, as well as for creating the impression that Liberians were responsible for bringing EVD to the DFW Metroplex.

Stigma Experience

“Liberia's a small community. And so, the death of Thomas Duncan really had a serious effect on the Liberian community because this is us. This thing impacts us, we're a small people. And I think... sometimes I don't blame the people who are within the community who find ourselves treated from a distance. Especially in the wake of the Ebola crisis, because I think they realized we're a small, closely knit group. And as a result of this thing being transferrable and you have a close knit group of people who could also pose some risk... I visited a church and befriended the assistant pastor. We talked, and I told him where I was from. About a month later, we heard about the Ebola outbreak in Liberia. Well, I went back to visit the same church, and this time the assistant pastor wouldn't even shake my hand. Now, I'm not mad at him, because I understand that, as much as he knows about the Ebola situation, that it is transferrable, and dealing with a people that are so closely knitted that might be at risk...so we've had to endure all of this.” – Patrick

The Liberian community of the DFW Metroplex experienced stigma through their interactions with both other Liberians as well as members of the larger Dallas community. Stigmatization largely centered around individuals engaging in some sort of avoidance pattern; this avoidance came down to fear of transference of disease and harboring an uncertainty about whom the members of the Liberian community spent their time. For members of the Liberian community, stigmatization included being asked to stay home from work, being shunned by former social peers, experiencing members of the public visibly balking upon learning of their Liberian heritage, or having their children banned from classmates' homes. Frank, a leader within the Liberian community, elaborated on the experience of a fellow Liberian: “You work at a hospital. Even if you didn't work at a hospital, the mere fact that you are a Liberian... you leave work and go home. They don't know what you do when you go home, they don't know who you come in contact with. So they have every right to ask you to quarantine yourself.” While this

was presented as a non-discriminatory scenario, it provides an effective example of how some Liberians in the DFW Metroplex were being treated.

While Liberians in the DFW Metroplex were stigmatized by members of the general public, stigmatization also occurred from within the Liberian community. Some Liberians stopped frequenting businesses run by other Liberians, while others avoided group gatherings. Just as with non-Liberians, some members of the Liberian community were apprehensive that their fellow Liberians may have been in contact with the disease. Melissa, a young woman, said: “I mean, just for us, we stayed at home. We didn't know if anyone would have had it or not, so we just stayed at home. And, you know, because of the places where we work and the people we came in contact with...I guess you could say we did stay at home for those purposes.”

During an observation, an elder within the community related a story of the funeral of another respected elder of the community. The turnout for the service was remarkably light, and the reason many stayed home was because the elder had family traveling from Liberia to the States for the service. Members of the community in the DFW Metroplex were uncertain of whom the traveling family had been in contact with, and most did not want to risk their own or their family's health. The elder also expressed that this uncertainty of contact caused many Liberians in the DFW Metroplex to become reluctant about attending large gatherings in general.

This same anecdote came up in a subsequent interview, where Patrick shared: “Frankly, Liberians were suspicious, especially...there was a funeral. An elderly Liberian man had died. Because he was quite prominent in the Liberian community, they selected a very large auditorium, and it was right about that time that we had the Ebola situation.

A lot of Liberians did not attend because they were going to be interacting with a whole group of Liberians who had also received relatives from overseas, and they couldn't ascertain whether his relatives had been affected or not.” Jerry, a business owner, added: “Well, after it was announced that he [Duncan] had Ebola, we as Liberians tried to be cautious such as we were not shaking hands, we were not hugging, we were distant in terms of communication. There was a space between you and other individuals that basically that were not in your household.”

It should be noted that some members of the Liberian community reported either no stigma experiences, or were able to share a positive experience. According to Jerry, “I spend most of my time here in the mid-city area so everything was basically calm, everything was basically the same. ... I personally never went to Dallas. I hardly go to Dallas unless I really have to, I personally did not go to Dallas at that time.”

Jerry also reported no negative changes in business. He offered that he had been in the area so long, everyone knew him and his Liberian heritage, and trusted him. Frank relayed his experience with his employer as a positive one: “Personally, I had the experience, but mine was a good experience. In that my job, unlike some other people who lost their job, my job stood by me. There were news agencies coming here to interview me, and so my job said... it worked for both of us. It worked for them, it worked for me, it worked for my community ...”

Individual and Community Response to EVD and Stigma

“I went to the mall, and we were in the store. And so every time I speak, I have an accent. And then they would ask me, where are you from? I'm not going to lie to them, I would say, I'm from Liberia. And the minute I say I'm from Liberia, I would see that reaction (blanched face reaction), and then I found myself having to say, I am Ebola free ... So being aware of that myself, I tried to ease that fear or that anxiety, and I just joke about it. Even in my classes here at work that I teach. I just kind of say, I introduce myself: I am from Liberia, and I am Ebola free. And everyone would laugh. – Grace

Previous literature on past EVD outbreaks has focused on how EVD victims – or suspected EVD victims – have been treated by members of their community, but little of the literature provides details about individual stigma experiences. While studies of the 1995 Kikwit outbreak (Roo 1998) examined feelings of stigma among EVD survivors via survey, this research of the DFW Metroplex Liberian community captures individual narratives and examines how stigmatized individuals fold those experiences into their day to day life.

Members of the DFW Liberian community expressed the feeling that Liberians became intrinsically associated with EVD itself, with Edith elaborating: “Even for me, watching the news it seemed like Liberia was the one who had invented Ebola. Even though we have heard about Ebola being around a long time ago. But I don't think it was...well, maybe I'm being biased, but I don't think it was being reported in a way to educate people. I think it was reported in a way to single out people, to make us feel like we have done this thing.” Barry, a community leader, had this to say: “Within the DFW area, we did not, we felt...that other nationalities did not accept us, especially Americans, they thought all Liberians had Ebola.” For some, like Grace, responding to stigma involved rolling disclaimers about their heritage and EVD status into everyday interactions.

When interacting with Liberians, one learns very quickly that humor is often used as a defense mechanism, a tool to mitigate the seriousness of the topic being discussed. During an observation, one Liberian – with a sly grin on his face – asked if it was known that EVD was not in Dallas. He followed this up by saying that if EVD were in Dallas, everyone would know because he would be in the next county over; this elicited laughter from the people around him, and offers an example of how Liberians dealt with the environment of fear that developed over the course of the outbreak. Robert spoke to using humor as a defense mechanism, stating: “We strive, in time of adversity, and we immediately turn our adversity into laughter. And then wash it away. So, if you go through this process in the next six months and you talk to Liberians about Ebola, even now, it will be something of fun. They may share with you with laughter that....as if it was not something that was very, very life-threatening.”

For others, their mission became educating those around them about the nature of EVD. This involved discussions of modes of transmission and incubation periods. Edith shared: “But whenever people talk about it, I would just try to educate people to the best of my knowledge about the virus.”

Examining response to stigmatization in this context also offers a window into community action: the LCA DFW felt that they were responsible for educating their community, and held meetings to discuss the disease, while churches offered vigils for friends and family in Africa. Barry mentioned that “And first, what we did as leadership, we kind of let the people know that if they knew anyone that had just come, to take the precautionary steps. Because at that time, we were all not educated about how the disease or virus was transmitted.” The response from the LCA was particularly revealing:

community leaders reported that they only participated in a couple of conference calls with CDC officials; outside of that, they reported that there was no contact with local health officials with regard to EVD. As a result, the LCA took it upon itself to make sure the rest of the community was educated about the disease, and members of LCA leadership acted as community representatives to the media. Barry provided: “So we tried to cope with it and just encourage one another educate one another on the topic. We had church meetings and community gatherings and stuff like that to give information as we got it.” The LCA also reached out to other Liberian associations and organizations for guidance on how to handle potential job discrimination; as a result, the LCA kept lines of communication open not just within the Liberian community of the Dallas Metroplex, but also with other communities and the greater Dallas community.

Another facet of community response involved the donation of supplies and money to those in Liberia who were still dealing with the consequences of the outbreak. Donation drives were conducted by and in collaboration with many organizations; the potentially key insight here is that some Liberians reported a significant increase in participation by the younger generations. Edith stated that, “But for the first time, I saw Liberians come together. For the first time, I saw many groups, many churches - Liberian churches - even young Liberian people who were getting together and trying to form their own organization to raise funds to send gloves and different supplies that the people needed in Liberia.” Overall, the image presented here is one of community buy-in with regard to providing assistance to those in need during a time of crisis.

Influencers on Feelings of Stigma/Guilt

[After the Thomas Eric Duncan media exposure] “If anything, I think Liberians were more afraid to come out, because they didn't want to get singled out. Just being Liberian at that time, people look at you funny ... So I knew when the news came out, you know, I stood there like, oh my god, they're looking at me. So we were just afraid of being singled out ... My own personal story was, I had to ask myself, why at this time I have decided to fall in love with someone who lived in Liberia, okay? Because when he came, he was fine. And then later on he was complaining of headaches! We had traveled to North Carolina and came back and he's complaining of headaches. So watching the news constantly, and hearing what our son is saying, I'm like, could it be true? That he has EVD? Could it be something else? So even though I was encouraging him, to myself I'm saying God, what have you done? (laughs) Why now, you know? So I had to be strong to encourage him, but deep down when I lie down, I questioned it. Is this something, if I take him to the hospital now and give up the whole story, are we going to be quarantined? So yes, the public media has a way of shaping people's views.” – Edith

Because past EVD outbreaks took place in Africa, where there is little to no Western media coverage, there is little literature that examines outside factors that contribute to either stigmatization or feelings of guilt. While Thomas Eric Duncan was the only Liberian to present EVD symptoms in the United States, the media fixated on Liberians in America. The media coverage contributed to creating scenarios in which Liberians were so easily associated with the disease that they felt singled out. Conversely, the media exposure made Liberians in the DFW Metroplex more aware of the risks others were taking to provide aid to Liberia. This sometimes resulted in guilt, as Edith demonstrates: “... my home-room teacher had brought up a story about one of her cousins in New York who had to be deployed to Liberia to deal with this Ebola situation. But she was leaving her daughter over here, so all of them was worried about her. So I'm standing there, being a Liberian, and I felt bad! Because she was leaving her family to go to my country, she could come back or she may not. And that's the way she presented it, so.”

While many Liberians perceived that media coverage increased stigmatization, some found a silver lining: though the coverage was often negative, it nevertheless provided insight into what was happening in Liberia. Robert elaborated: “from my perspective ... the media gave us the international limelight we needed in order for us to have the community find a solution of Ebola ...”

Media coverage also provided information on the individuals who risked their lives to help Liberians. Almost every Liberian that brought up aid workers did so with an almost reverence. During a time of feeling isolated and discriminated against, those who actively helped Liberia – particularly medical personnel – have come to be greatly appreciated and respected by the community. Melissa recounted her feelings on aid workers operating in Liberia:

The doctors that went to Liberia, that was an awesome, awesome thing that they did, and that's all I can say about that. It was very awesome that they took a stand and said, hey, we need to help them. I'm going to help them, regardless of what you say. And the doctor again, who had a family, he had kids, and also the nurse that was along with him. I mean, that much I can say from those who went to help. Very grateful, more grateful, that there are people like him. An eye-opener to all, I can say, that there are good people. There are people that God really sends out, who are rams in that bush for us. To help others that are in need.

In comparison to existing literature, this offers a stark contrast to how medical workers are often treated during EVD outbreaks. In some cases, medical workers were prevented from entering villages that were experiencing EVD cases (or who were at risk for experiencing them), because Africans in the impacted regions associated medical workers with the arrival of EVD. As a result, medical workers were not trusted, and transport to a hospital was something to be feared (Hewlett 2003). Here, however, Liberians in the States were so spatially removed from the outbreak, and saw much more coverage of the situation. As a result, Liberians in the DFW Metroplex found it easier to

see the efforts of medical workers as a welcome and needed response.

DISCUSSION

With everything said and done, what does all of this mean? What does this say about how Liberians in the DFW Metroplex experienced the 2014-15 EVD outbreak? This research demonstrates that stigmatization still occurs in fear-inducing disease scenarios, even if the targeted community only presents minimal risk of transmission. The stigmatization that occurs falls in line with what is seen in past EVD outbreaks, and is similar to stigma experiences found in other severe infectious disease scenarios such as SARS. The stigmatized experience varying levels of potentially discriminatory treatment at work and are shunned from social circles. Liberians in the DFW Metroplex were made to feel responsible for bringing EVD to the States via heavy media coverage.

Specifically, the stigma experiences found in this research line up with the five identifiable components of stigma as presented by Link and Phelan. As noted by the authors, these components are interrelated, and may not necessarily occur in a linear fashion. The first component involves the identification and labeling of differences. Liberians can be readily identified – at least as Africans, in general – through their accent and skin color. These identifiers also serve as a basis for cataloguing differences between this population and much of the greater DFW population. A prime example from this research comes from the participant sharing her experience of being identified as ‘foreign’ at the mall, based on her Liberian accent. The second component, linking to undesirable characteristics, manifests via associating Liberians as Ebola carriers. As one participant put it, “As soon as you said Liberian, the first thing that came out of people’s mouths were Ebola. And so that was an unpleasant feeling and experience” (Barry 2015).

The third component centers around the creation of an Us versus Them mentality, and for this research population the component occurs on more than one level. While there is the assumed Liberian/Non-Liberian divide, there is also a divide between Liberians who have traveled to Liberia or been in contact with someone who has, and those who have not. Stigmatization during the Ebola crisis was not limited to stigma applied to Liberians via the greater DFW population, but was also seen as Liberians avoided fellow Liberians. The aforementioned Liberian funeral example illuminates this point; Liberians became reluctant to interact with anyone who had traveled, or who had come into contact with someone who had traveled, to and from Liberia during the outbreak. The fourth component sees the stigmatized experience discrimination and loss of status. For Liberians in the DFW Metroplex, this was expressed via social avoidance and experiencing differing working conditions from non-Liberians. One participant shared that “I know there was one or two persons who came to me and said 'I lost my job because the people are afraid for me to go back to work'. I know of an instance where somebody went to the hospital, and all attention was called on them simply because they had a relative with them who had come from Liberia” (Frank 2015).

The last component involves the Exercise of Power – this typically refers to an attempt to reverse stigmatization; it highlights the essential role of power. An example provided by Link and Phelan (2006) is a scenario in which individuals with mental health issues would try to frame health care providers as cold, distant pill-pushers, and essentially stigmatize the health care providers. In this study, there were no overt examples at attempting to reverse stigmatization on the whole. Instead, individuals attempted to manage stigmatization by rolling it into their everyday experiences or by

trying to educate those around them, demonstrating low level attempts to push back against stigmatization. While this may prove successful on an individual level, it does not reverse stigmatization for the DFW Liberian population as a whole. Nationally, attempts to shrug off stigmatization included an online campaign designed to separate Liberians from being so closely associated with the Ebola virus (Phillip 2014).

The DFW Liberian community faces two challenges in terms of power: they are both a minority and immigrant community. In the United States, both groups are often associated with a lesser status. Some participants mentioned feeling as if other immigrant communities were more prestigious or better organized than their own, indicating that some members of the community may perceive themselves as being – on the whole – on a lower rung of the social and political spectrum.

This research also reveals ways in which perceptions differ from other EVD outbreaks: reaction to and acceptance of medical aid. Previous literature makes it clear that healthcare workers face an uphill battle when it comes to combating EVD in African nations; there are many assumptions and perceptions that work against the effective spread of medical aid. The stigmatized population of this research, however, have made it abundantly clear that not only is medical aid to Africa seen as a positive, the healthcare workers themselves are nearly venerated. This could be due to a few factors, including the fact that the population of this study is comprised of individuals who have integrated into a Western culture, and therefore do not have the same perceptions and assumptions regarding healthcare and healthcare workers.

Contribution and Suggestions

This research contributes to literature that provides insight into the experiences of stigmatized populations during an infectious disease outbreak. Literature surrounding EVD often focuses on the impact of EVD on healthcare infrastructure, or the role/efficacy of public health preparedness (Gostin 2014, Rohrig 2015, Robey 2015, Smith 2015, Hewlett 2003). While some literature examines the spread of EVD via ignorance and uncertainty regarding disease transmission, or examines successes with contact tracing in the wake of a potential outbreak, rarely are the voices of those who suffer stigmatization in the aftermath of EVD brought forward.

During interviews, many participants revealed that they do not blame people for their reactions, even going so far as to say they might react the same if the conditions had been reversed. On the surface, this seems like a nice sentiment, and establishes an environment in which the DFW Liberian community does not hold a grudge for being so closely associated with EVD. This suggests the presence of symbolic violence, a scenario described by Bourdieu (2002) as occurring when a social agent becomes complicit in their discrimination. This raises several questions, including: why should this community express any sort of acceptance in being treated as less than? What does this acceptance of stigmatization mean to the Liberian community? Did this acceptance mask any other forms of stigmatization? How should this inform interactions between political and health officials and future minority populations facing medical stigma? Ultimately, the presence of symbolic violence is associated with an inequity in power, real or perceived, with the impacted community negatively affected.

The recent outbreak also offers community leaders a glimpse into areas that need

to be addressed for enhanced community resilience in the future: while almost all participants believed that the crisis drew the community closer and made them stronger, most also expressed the belief that this would not last. Community leaders need to find a way to keep the community engaged and cohesive, even when there is no crisis. Some steps to enhanced community engagement are visible: the process for electing the LCA leadership used to be very simple – someone would put an administration together, they would ‘run’, and be voted into office. During the re-election period in the summer of 2015, however, two distinct parties vied for leadership; the current administration, which was in place during the outbreak, and a new contender. This meant that, for the first time, there were actual debates, and there was an actual vote between two candidates. In speaking with community members, it became clear that this was a major development, with individuals expressing how this election term had really galvanized the community. That galvanization was clear: outside and in the lobby of voting spaces, community members were gathered in groups, fervently discussing their opinions about the candidates. There were also significant numbers of young people present, some chanting “The youth are the future” outside the voting location. This is perhaps the most cohesive the Liberian community in the DFW Metroplex has been in years, and the community leadership should be (and are) dedicated to maintaining that engagement.

Community leaders should now also be aware that, regardless of preparation efforts, sometimes things slip through the cracks. Things like effective and continued communication between health care officials and impacted communities. As a result, community leaders should take the time to formalize the more effective methods utilized for communication and information sharing that occurred during the outbreak.

Limitations and Future Research

From the data set, only three interviews were conducted with Liberian females. The lack of female interview participants is likely due to cultural nuance. For example, the researcher asked a male participant if he thought his wife would be interested in an interview; the participant he responded that while she might—and might even hold differing opinions—most women do not feel the need to speak on an issue once their husband or another male authority has spoken to it. Furthermore, one of the female participants was interviewed with her partner, one only consented to an interview after seeking an opinion from a male religious leader, and the other consented to an interview with no qualifiers or additional permissions requested. This participant was younger than the other two, suggesting that this belief and practice may be generational. Attempts to conduct interviews with other Liberian females in the DFW Metroplex resulted in either no-shows or a lack of response.

The lack of female perspective means that an entire facet of stigma experience is potentially lost. Due to average differences in workplace treatment, expected household roles and duties, it is likely that many females experienced stigma differently from their male family and peers. Future research should endeavor to place a greater emphasis on capturing the female voice of an impacted community.

Additionally, the population size of this project was quite small. Ultimately, this makes it more difficult to generalize these results across the entirety of the Liberian community in the DFW Metroplex. One individual reported no stigma experiences whatsoever, this is unlikely to be an isolated incident. Capturing a larger sample size results in capturing a more accurate depiction of what occurred during the Ebola crisis;

more robust data could provide critical insight into the relationship between stigmatization and real or perceived proximity to the originator of stigma – in this case, the death of Thomas Eric Duncan in a Dallas hospital.

CONCLUSION

Liberians in the DFW Metroplex experienced stigmatization as a result of being associated with the EVD virus during the 2014-15 EVD outbreak. This stigmatization arose in the form of being shunned, experiencing workplace discrimination, and being made to feel guilty about the spread of EVD.

This research highlights the similarities of stigma experiences seen in previous African outbreaks, demonstrating that infectious diseases such as EVD have a similar fear-inducing response regardless of population nationality. This research also emphasizes the potential need for an increased and more involved communication between public health and political officials and impacted communities; many Liberians associated the stigmatization they experienced with an overall ignorance of the disease and its transmission. Preparing health professionals to handle the more technical side of a potential epidemic is a starting point, but more involved levels of personal engagement with potential impacted communities should be worked into professional training.

III. APPLIED COMPONENT

In order to make the most of the narratives of the participants of this research, this project has an applied component. Many participants included statements that excused stigmatization, while also indicating that they might have reacted the same if their community had not been impacted. Many participants also suggested that while they feel that the Ebola crisis made their community stronger, this sense of togetherness would not last. In order to share aspects of this project that are the most relevant to the DFW Liberian community, in addition to providing LCA DFW community leaders with this thesis, the researcher will prepare a presentation for the leadership of the LCA DFW that provides an emphasis symbolic violence and the way in which this allows for normalizing stigmatization, as well as highlighting the sentiment that some individuals do not feel that community strengthening will last. This presentation will provide suggestions to address these issues. The slides from this presentation have been included as Appendix A.

APPENDIX SECTION

A: PRESENTATION

APPENDIX A: PRESENTATION

THE STIGMA EXPERIENCES OF THE LIBERIAN COMMUNITY OF THE DFW METROPLEX

Rex Long

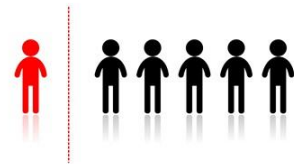
Texas State University

MA - Anthropology

Stigma

- *The phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute.*

- Goffman (1963), "Stigma: Notes on the Management of Spoiled Identity"



Methods

Semi-structured Interviews

- 11 Interviews
- Covered: immigration processes; experiences and feelings during outbreak; feelings of community belonging and feelings of identity

Direct and Participant Observations

- Observed group events such as church services, community celebrations, and community election.

Results – Stigma Experience

I visited a church and befriended the assistant pastor. We talked, and I told him where I was from. About a month later, we heard about the Ebola outbreak in Liberia. Well, I went back to visit the same church, and this time the assistant pastor wouldn't even shake my hand.

Experiences included –

- Social exclusion
- Requests to stay home from work
- Requests to keep children away from friends' homes
- Stigma occurred from without and within the Liberian community

Results – Response to Stigma

Even in my classes here at work that I teach. I just kind of say, I introduce myself: I am from Liberia, and I am Ebola free. And everyone would laugh.

Responses included:

- Incorporating stigmatization into everyday interactions
- Incorporating humor
- Attempting to educate others about Ebola

Results – Influencers of Stigmatization

So I knew when the news came out, you know, I stood there like, oh my god, they're looking at me. So we were just afraid of being singled out ...

Influencers included:

- Media reports that associated Liberians and Liberia with Ebola
- Being made to feel guilty by peers

Discussion

- Symbolic Violence –
“the violence which is exercised upon a social agent with his or her complicity” (Bourdieu and Wacquant 2002, 167)
- Prevailing attitude of “I might have reacted the same way”.

Discussion

- *Here's the thing. Human beings, we have a tendency to fall on our default setting. Okay, we have, after the height of the news coverage and everything, we go back to our normal daily routine. And Liberians are not immune to that either, just like any other human being.*
- *As Liberians, I don't think so. I don't think it's going to be the harbinger that makes us become more strong as a people. We are unique, once this crisis is over everyone of us ... So, at this time we are going back to our own little private life, because there is nothing challenging us again. The crisis is over, there is no ebola, there is nobody dying on a mass scale, so. Personally, I don't see any major united front taking place, going beyond the end of the crisis.*

Suggestions

- In future scenarios, do not make excuses for other peoples' reactions
- In future scenarios, be prepared for being left out of the discussion on a larger level, and be prepared to take action yourselves. Formalize any processes that made information sharing successful during the crisis, and find ways to implement those processes in more common scenarios to build familiarity with formalized communication processes
- Find avenues, such as through fundraising or community building events, to keep Liberians across the DFW Metroplex interacting on a close level. Speak with your constituents to discover specific concerns or beliefs that may inhibit a sense of strengthened community

Thank You!

REFERENCES

- Barry, interview by Rex Long. 2015.
- Bordieu, Pierre, and Loic Wacquant. 2002. *An Invitation to Reflexive Sociology*. Chicago: The University of Chicago Press.
- Brown, DeNeen L. 2014. *Liberian Pastor in Dallas Fights a Fear More Powerful Than Disease*. October 6. Accessed May 2016. https://www.washingtonpost.com/news/post-nation/wp/2014/10/06/liberian-pastor-in-dallas-fights-a-fear-more-powerful-than-disease/?utm_term=d17085335a1d.
- CDC(a). 2015. *Outbreaks Chronology: Ebola Virus Disease*. July 18. Accessed April 2016. <http://www.cdc.gov/vhf/ebola/outbreaks/history/chronology.html>.
- CDC(b). 2016. *Timeline of "What's New"*. April 14. Accessed May 2016. <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/whats-new.html>.
- CDC(c). 2016. *2014 Ebola Outbreak in West Africa - Case Counts*. April 13. Accessed May 2016. <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html>.
- Cooper, Helene. 2014. *Ebola's Cultural Casualty: Hugs in Hands on Liberia*. October 4. Accessed 2015. http://www.nytimes.com/2014/10/05/world/africa/ebolas-cultural-casualty-hugs-in-hands-on-liberia.html?_r=0.
- Frank, interview by Rex Long. 2015.
- Glionna, John M., Hennessey-Fiske, Molly. 2014. *Dallas-area Africans Confront Ebola Fears*. October 2. Accessed May 2016. <http://www.latimes.com/nation/la-na-dallas-liberians-ebola-blame-20141002-story.html>.
- Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Prentice-Hall.
- Gostin, Lawrence O., Hodge Jr., James G., Burris, Scott. 2014. "Is the United States Prepared for Ebola?" *Journal for the American Medical Association* 312(23): 2497-2498.
- Hewlett, Barry S., Amola, Richard P. 2003. "Cultural Contexts of Ebola in Northern Uganda." *Emerging Infectious Diseases* 9(10): 1242-1248.
- Jones, Andrew Jerell. 2014. *Ebola Fears Turn into an Epidemic of Racism and Hysteria*. October 14. Accessed May 2016. <https://theintercept.com/2014/10/21/cant-ebola-become-latest-racist-national-security-issue/>.
- Kinsman, John. 2012. "'A Time of Fear': Local, National, and International Responses to a Large Outbreak in Uganda." *Globalization and Health* 8(15): 1-12.

- Kleinman, Arthur, Hall-Clifford, Rachel. 2009. "Stigma: A Social, Cultural, and Moral Process." *Journal of Epidemiological Community Health* 63:418-419.
- Lee, Sing, Chan, Lydia Y.Y., Chau, Annie M.Y., Kwok, Kathleen P.S., Kleinman, Arthur. 2005. "The Experience of SARS-related Stigma at Amoy Gardens." *Social Science and Medicine* 61: 2038-2046.
- Link, BG, Phelan, Jo C. 2006. "Stigma and its Public Health Implications." *The Lancet* 367: 528-529.
- Link, Bruce G., Phelan, Jo C. 2001. "Conceptualizing Stigma." *Annual Review of Sociology* 27: 363-385.
- Markel, Howard. 1997. *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892*. Baltimore: The Johns Hopkins University Press.
- Markel, Howard. 1999. "When Germs Travel." *The American Scholar* 68(2): 61-69.
- Markel, Howard, Stern, Alexandra Minna. 2002. "The Foreignness of Germs: The Persistet Association of Immigrants and Disease in American Society." *The Milbank Quarterly* 80(4): 757-788.
- Patrick, interview by Rex Long. 2015.
- Peters, C.J., LeDuc, J.W. 1999. "An Introduction to Ebola: The Virus and the Disease." *The Journal of Infectious Disease* 179(Suppl1): ix-xvi .
- Phillip, Abby, Brown, Charity. 2014. *'I am a Liberian, Not a Virus': Campaign Fights Back Against Ebola Stigma*. October 22. Accessed May 2015.
<http://www.washingtonpost.com/news/to-your-health/wp/2014/10/22/i-am-a-liberian-not-a-virus-campaign-fights-back-against-ebola-stigma/>.
- Robey, Thomas E., Brenner, Jay M. 2015. "Working Side by Side, But Not Talking Enough: Accident Causation in Emergency Department Care of Thomas Eric Duncan." *American Journal of Bioethics* 15(4): 59-62.
- Rohrig, R. 2015. " Get the Right Balance - Lessons Learned From the First Ebola Infected Patient in Dallas." *Methods of Information in Medicine* 54: 200-202.
- Ronald, interview by Rex Long. 2015.
- Roo, Ann De, Ado, Bwaka, Rose, Berthe, Guimard, Yves, Fonck, Karolien, Colebunders, Robert. 1998. "Survey Among Survivors of the 1995 Kikwit Ebola Epidemic in Kikwit, Democratic Republic of Congo: Their Feelings and Experiences." *Tropical Medicine and International Health* 3(11): 883-885.
- Smith, Charnetta, Hughes, Sonya M., Karwowski, Mateusz P., et. al. 2015. "Addressing Needs of Contacts of Ebola Patients During an Investigation of an Ebola Cluster in the United States - Dallas, Texas, 2014." *Morbidity and Mortality Weekly Report* 64(5): 121-123.

Swan, James. 2014. "Commentary on Ebola." *Texas Public Health Association* 66(4): 13.